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REBT with Diverse Client Problems and Populations

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Preface

In this volume, leading REBT therapists were invited to write on the application of REBT to a variety of client problems and with a variety of client populations. Each of the contributors was asked to write to a common chapter structure so that readers could see the commonalities and differences in the practice of REBT across the clinical spectrum. What follows is the common chapter structure.

Chapter Structure

1. **Key REBT Theoretical Concepts in Working with (the Clinical Problem or Population)**

In this opening section, the contributors were asked to make clear which aspects of REBT theory they particularly rely on for conceptualization and the reasons for this selection.

2. **Key Best Practice REBT-Based Assessment and Treatment Strategies and Techniques in Working with (the Clinical Problem or Population)**

In this section, contributors were asked to consider what we referred to as 'best practice' assessment and treatment strategies and techniques which emanated from within REBT. Contributors were asked to detail the research findings on these REBT strategies and techniques and to make clear where no such research exists.

3. **Treatment Guidelines from the Empirically Supported Therapy Literature that Can Inform Best Practice in REBT with (the Clinical Problem or Population)**

In this section, contributors were asked to make clear which non-REBT treatment guidelines that are supported by research they use to inform best practice REBT and how they incorporate these into REBT.

4. **Brief Case Example**

In this section, contributors were asked to outline a brief case example that illustrated points 1–3 above.

5. **What I Have Learned about Using REBT with (the Clinical Problem or Population)**

In this final section, contributors were asked to show:

- How they accommodate clients' individual differences in their practice of REBT with the client problem or population. We suggested the following factors here amongst others: client gender, ethnicity, socio-economic status and intelligence.
- The do's and don'ts in the practice of REBT with the featured client problem or population.
- Which aspects of REBT they consider deliver the most benefit for change and which don't.

REBT is a dynamic approach and has evolved over time as Ellis's piece details in Volume 1. We have sought to show in this book how REBT therapists conceive of best practice with a range of clinical problems and populations by drawing on what is most valuable within REBT and what is most valuable outside REBT.

London, UK — Windy Dryden
Melbourne, Australia — Michael E. Bernard
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Michael Hickey

Key REBT Theoretical Concepts in Working with Anxiety Disorders

There are several disorders that are included in the classification of anxiety disorders (e.g., Generalized Anxiety Disorder, Social Anxiety Disorder, Panic Disorder, Agoraphobia, and specific phobias), but this chapter will primarily focus on the clinical similarities among these disorders and how Rational Emotive Behavior Therapy (REBT) concepts, methods, and current research can be applied across the treatment of the various anxiety disorders. Since its inception, REBT has been a therapy utilized for numerous emotional problems and psychological disorders (Ellis, 1962) and recent meta-analytic research (David, Cotet, Matu, Mogoase, & Stefan, 2017) has provided strong support for REBT as an efficacious transdiagnostic approach. REBT practitioners can therefore utilize REBT effectively across various anxiety disorders as opposed to the use of disorder-specific treatment protocols.

When working with anxiety disorders, the conceptualization of anxiety as an unhealthy negative emotion is essential to facilitate change with clients. Among the cognitive behavioral therapies, REBT uniquely posits a theory of emotion that involves a qualitative as opposed to a quantitative change in emotion (Ellis, 1962). Instead of reducing the intensity of the emotion, REBT emphasizes the importance of changing the unhealthy negative emotion to one that is healthy because it promotes goal achievement. REBT therapists help their clients to change their unhealthy anxiety to concern as opposed to simply reducing their anxiety, as this indicates the presence of irrational belief(s) (Harris, Davies, & Dryden, 2006).

In REBT, anxiety is conceptualized as an unhealthy negative emotion because it leads to maladaptive functioning. In addition to uncomfortable and potentially unhealthy physiological effects (tachycardia, muscle tension, gastrointestinal dis-

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turbance etc.), anxiety also results in a range of escape and avoidance behaviors, including procrastination and lack of assertiveness, that can have a substantial negative impact on an individual's functioning. Furthermore, time spent ruminating about one's worries, as commonly observed in individuals with Generalized Anxiety Disorder (GAD), can interfere with attention, concentration, sleep etc. A prominent theme among anxiety disorders is overestimation of threat. Humans have evolved to the point of creating danger when danger is not truly present through the role of cognition and meta-cognition, or thinking about our thoughts.

Therefore, when working with anxiety disorders, it is essential for the REBT therapist to help clients understand that it is their rigid and extreme irrational beliefs (iBs) about feared activating events (As) and not the events themselves that largely determine their emotional consequence of anxiety (emotional Cs) and its associated behavioral consequences (behavioral Cs). Since anxiety involves overestimation of threat, a common irrational belief that is found in individuals with anxiety disorders is awfulizing. Most individuals with problematic anxiety engage in some form of awfulizing, where they predict that the consequences of a specific situation are much worse than the actual outcome. In doing so, we are sending a signal to our brains that we truly are in danger which then activates the sympathetic nervous system, as if there is a true presence of threat or harm. Arntz, Rauner and Van den Hout (1995) referred to this inference of danger based on subjective anxiety as "ex-consequentia reasoning" which likely plays a role in the development and maintenance of anxiety disorders.

Resulting physiological sensations are often very uncomfortable and individuals who hold irrational beliefs about these sensations may experience a secondary emotional disturbance of anxiety about their anxiety. From an REBT conceptualization, this is largely a result of frustration intolerance and/or further awfulizing, (e.g., "I can't stand the feeling of my heart racing. It is terrible."). Reiss, Peterson, Gursky and McNally (1986) label this phenomenon as anxiety sensitivity which they describe as an individual difference variable consisting of beliefs of the experience of anxiety that then contribute to further anxiety (secondary emotional disturbance).

In addition to the extreme irrational beliefs of awfulizing and frustration intolerance, clients with anxiety also hold many rigid demands. Demands for certainty, demands for comfort, and perfectionistic demands are just a few examples of demandingness in anxiety disorders (Dryden, 2012). Albert Ellis theorized that demandingness is at the core of emotional disturbance (Ellis, 1962) and that these absolutistic demands lead to derivative beliefs, including self/other downing, awfulizing, and "I-can't-stand-it-it is" (Ellis, 1998), or what is presently referred to as frustration intolerance (DiGiuseppe, Doyle, Dryden, & Backx, 2014).

Examination of the nature of irrational beliefs provided some empirical evidence that awfulizing, frustration intolerance, and global evaluations of worth/self-downing are all associated with demandingness, however the investigators emphasized that the nature of this direction is unclear (Szentagotai et al., 2005). For example, it is unclear if demandingness is primary or secondary to awfulizing. Therefore, when working with anxiety disorders, it is important that therapists do not get caught up with only challenging anxiety-inducing demands, but to pay close attention to the derivatives.

Challenging awfulizing or frustration intolerance beliefs may subsequently change demandingness without directly addressing the demand. For example, a client may experience anxiety following the end of a romantic relationship because she believes that she must find a new partner because being alone would be intolerable. By addressing the frustration intolerance of being alone, she may no longer have the demand to be in a relationship.

In addition to awfulizing, and frustration intolerance, self-condemnation and globalization of worth are additional derivative irrational beliefs that lead to anxiety for many individuals. Specifically, assisting clients in achieving unconditional self-acceptance, may be particularly helpful in working with clients with ego-anxiety. Individuals with social anxiety, for example, may believe that if they are thought of negatively by others, then it is an indication of their worth. As a result, they have a tendency to avoid situations where they may be evaluated negatively by others, as this would confirm their belief that they are a failure, unlovable, etc.

Challenging irrational beliefs and replacing them with rational beliefs will assist clients in confronting the activating events that trigger their fears. Behavioral exercises have always been a key component in REBT across various presenting problems and are particularly important in weakening irrational beliefs and strengthening rational beliefs. Albert Ellis frequently cited his own behavioral experiment to overcome social anxiety, by creating a homework assignment of initiating over 100 conversations with women on park benches on a daily basis for a month in the Bronx Botanical Garden (Ellis, 1998). Though he was rejected by the majority of women, through his experience, he realized that the outcomes were neither awful nor intolerable. This exercise is an illustration of the behavioral component, or "B" in REBT and over eighty years later, similar approaches are being utilized in modern cognitive behavioral therapies in the form of exposure therapy with great efficacy.

Foa and Kozak (1986), for example, emphasized the role of emotional processing, where fear is represented in memory structures. In Foa and Kozak's description of emotional processing, incorporation of novel information into existing memory structures results in either increased or decreased emotional responding. In therapy, it is suggested that these fear structures must first be activated and then information that is incompatible with the fear structure should be incorporated. This is done through exposure, where a client systematically confronts feared stimuli and obtains corrective feedback regarding their catastrophic overestimations of threat, and their ability to tolerate uncomfortable emotions and cope with adversity. REBT therapists can help clients to strengthen this process by rehearsing the rational beliefs that are consistent with the corrective feedback obtained through exposure (e.g., "Though having panic symptoms on a train are highly unpleasant, they are not terrible and intolerable.) While exposure therapy has gained empirical support and clinical attention as its own separate treatment approach, it is commonly integrated in effective CBT for anxiety disorders and has always been a component of REBT.

A final key REBT theoretical concept in working with anxiety disorders is the elegant solution. Research shows that incorporation of a client's worst fear is essential to include in the fear hierarchy when taking a client through an exposure therapy protocol (see Abramowitz, Deacon, & Whiteside, 2011). This is consistent with REBT's

concept of the elegant solution, where clients are encouraged to confront the worst case scenario and change their rigid and extreme beliefs about it in order to change their anxiety to concern. For example, instead of only examining the likelihood of a feared event occurring, REBT therapists work with their clients to confront what would happen if the feared event actually occurred during the process of cognitive restructuring to illicit and weaken the anxiety-inducing irrational beliefs. By systematically challenging these extreme beliefs, it helps to set the stage for effective exposure and likely facilitates a client's willingness to engage in difficult exposure tasks. Likewise, successful engagement in exposure exercises will provide confirmatory evidence contrary to the client's extreme catastrophic beliefs in a bidirectional process.

In summary, several theoretical concepts of REBT are integral in the successful treatment of anxiety disorders ranging from REBT's theory of emphasis on qualitative change of emotion to the importance of implementing behavioral exercises and exposure to weaken irrational beliefs. The following section will illustrate specific ways to utilize these key theoretical concepts in the assessment and treatment of anxiety disorders.

Key Best-Practice REBT-Based Assessment and Treatment Strategies and Techniques in Working with Anxiety Disorders

Assessment Strategies and Techniques

REBT interventions are hypothesis-driven and therefore it is essential to properly assess a range of factors including common activating events, inference themes, core irrational beliefs, maladaptive behaviors, and maintaining factors to effectively treat individuals with anxiety disorders.

As previously discussed in this chapter, anxiety sensitivity is a variable that may increase aversiveness of anxiety experiences, and predisposes people to the development of fears and anxiety disorders (Reiss et al., 1986). Reiss and colleagues further propose that individuals with high anxiety sensitivity exhibit increased alertness to anxious stimuli, worry, and motivation to avoid. Since cognitive processes across most anxiety disorders involve persistent worry, awfulizing/catastrophizing, rumination or obsessions, probability overestimation, frustration intolerance, selective attention, and selective memory, all of these factors should be assessed early in treatment.

Behavioral assessment, which involves identifying escape and avoidance behaviors, and safety behaviors, should also be conducted. When assessing a client's cognitive and behavioral symptoms when working with anxiety disorders, it is helpful to conduct a formal functional assessment (Abramowitz et al., 2011). This includes identifying external As (e.g., crowds of people) as well as internal As (e.g., increased

heart rate). It is important to be aware that internal As can be in the form of thoughts, beliefs or images as well. A client may experience an intrusive thought about harming her child, and as a result believe that she is a horrible person. Therefore, clients should then be asked to identify thoughts, beliefs, and/or images that accompany these As that lead to anxiety. Often clients will provide inferences (e.g., everyone will think I'm stupid). The REBT therapist can then utilize the technique of inference chaining to help the client get to the core irrational belief(s).

When identifying the beliefs that promote the client's anxiety, it is also important to identify the feared consequences when confronting the internal or external As (e.g., If I have the thought of hurting my child, it means I actually will). This is an example of thought-action fusion, which is commonly present in individuals with Obsessive-Compulsive Disorder (OCD). It is important to assess these feared consequences so that proper psyhoeducation can be provided and also so that they can be later integrated into exposure exercises.

The next step is to identify the client's maladaptive behaviors that reinforce the client's irrational beliefs and fears. Clients with anxiety disorders often engage in safety-seeking behaviors which may be either overt, which can be observed (e.g., taking a benzodiazepine prior to giving a lecture) or covert, which cannot be directly observed (e.g., praying silently for God's forgiveness each time a person has an unwanted thought or image). Reassurance seeking is another common safety behavior observed in anxiety disorders and therefore should be assessed. Assessment of safety behaviors can be conducted by asking clients what they do to make themselves feel better when they experience anxiety. This will also help the REBT practitioner to identify escape and avoidance behaviors. If the client does not report escape or avoidance, it is recommended that the therapist directly ask the client about these behaviors as they are most likely present in one form or another. Information obtained from the functional assessment can be used to construct a fear hierarchy for exposure exercises, which also involves fading of safety behaviors. This process will be further discussed later in the treatment strategies section.

Secondary emotional disturbance is also important to assess when initially working with clients with anxiety disorders. Individuals with anxiety disorders often experience co-occurring depression, secondary anxiety, shame, anger, guilt etc. For instance, since anxiety often leads to avoidance behaviors, clients with anxiety may not be engaging in reinforcing activities such as socializing with friends and partaking in hobbies which can then contribute to secondary depression. If the client identifies a secondary emotional disturbance, it is recommended that the therapist have a discussion with the client about how this may interfere with treatment, and perhaps it may be beneficial to address the secondary disturbance first.

In addition to the assessment methods described above, there are numerous measures that can help REBT therapists to assess baseline severity of anxiety symptoms and can be used as an ongoing tool to assess treatment progress and outcome. While there are several anxiety disorder-specific measures and inventories, the following measures are more consistent with assessment of anxiety through a transdiagnostic approach.

The Beck Anxiety Inventory (BAI) for example is a valid and highly utilized measure to assess severity of anxiety and is non-disorder specific (Beck & Steer, 1993). The BAI is a 21-item self-report inventory that allows clients to rate the severity of their anxiety during the past week on a likert scale. Ease of administration and scoring in addition to the brevity of this inventory make it a popular assessment tool for anxiety. Items on this scale are highly focused on the experience of common physiological sensations associated with anxiety and therefore REBT therapist can utilize this scale by reviewing with clients the items that they endorse as most severe and identify the activating events associated with the symptoms and any accompanying irrational beliefs either about the events or the sensations themselves.

Another measure that assesses the construct of anxiety sensitivity as discussed earlier in this chapter is the Anxiety Sensitivity Index-3 (ASI-3; Taylor et al., 2007). The ASI-3 is the third edition of the original ASI (Reiss et al., 1986) and is an 18-item self-report questionnaire that spans three dimensions: physical, cognitive, and social concerns and can be helpful to guide REBT therapists in working with the client to prioritize the order and extent to which these dimensions are targeted in therapy. For example, high scores on the ASI-3 physical dimension, indicates that the client is experiencing anxiety activated by beliefs of frustration intolerance regarding the somatic aspects of anxiety. The REBT therapist can then work with the client to expose themselves to these sensations with the goal of developing improved frustration tolerance.

Finally, the State-Trait Anxiety Inventory (STAI; Spielberger et al., 1983) is a 40-item self-report questionnaire that is designed to assess both anxiety as a transitory emotional state (state anxiety) and the behavioral disposition to respond anxiously (trait anxiety). In addition to parsing out anxiety as a transitory state or one driven by characterological/personality traits, this inventory can also help differentiate anxiety from depression and can be used for clients of varying socio-economic status with a required sixth grade reading level. While the previously mentioned inventories place high emphasis on the physical manifestations of anxiety, the STAI trait anxiety scale can assist REBT therapists in assessing highly ingrained irrational beliefs (e.g., "I feel inadequate) that may be a target for more rigorous cognitive restructuring.

Treatment Strategies and Techniques

After a thorough assessment, effective treatment of anxiety disorders includes psychoeducation, motivation building, modifying cognitive processes, relaxation training, and exposure and or exposure and response prevention (ERP), and fading of safety behaviors.

Psychoeducation is a key component in REBT and should not be overlooked. In fact, it not only provides clients with information about the rationale for treatment, but it can also serve as an intervention in and of itself. For example, when clients with panic disorder understand that their panic symptoms are a result of activation of the sympathetic nervous system and is likened to a "false alarm", and that the sensa-

tions are not an indication of a heart attack for example, they may experience some immediate relief. During the stage of psychoeducation, REBT therapists help clients to see how their unhealthy negative emotion is interfering with their functioning and goals, which can also be illustrated during assessment. As previously indicated, an understanding of the B-C connection is also necessary for clients to benefit from the therapy. Furthermore, it is critical that clients understand that the therapy will be collaborative and will require a lot of effort and hard work on the client's part, with emphasis on the importance of out of session homework and exercises.

REBT therapists can also utilize motivational enhancement strategies to help compliance and improve treatment outcomes. Westra and Dozois (2006) found that adding a brief pre-treatment motivational interviewing (MI) component to a CBT treatment protocol resulted in participants rating higher treatment expectancy, greater CBT homework compliance, and the group receiving MI as pretreatment evidenced a significantly higher number of individuals making clinically significant gains in management of their anxiety symptoms. It is therefore recommended that REBT therapists familiarize themselves with MI techniques, and at a minimum employ cost-benefit analyses of engaging in treatment. In addition, asking clients to describe what their life would be like if they weren't experiencing debilitating anxiety can be a helpful way to build motivation. At this point, a client can set clear and realistic emotional and behavioral goals and begin modifying cognitive processes.

Several cognitive strategies are available for REBT therapists to put into practice when working with anxiety disorders, one being cognitive restructuring. Cognitive restructuring in REBT involves identifying the client's inferences and then socratically questioning the client to uncover their core irrational beliefs leading to the anxiety. Dryden (2012) outlines common threat-based inference themes related to self-esteem (e.g., prospects of failure, rejection, disapproval, and loss of status) and those not related to self-esteem (e.g., prospects of loss of self-control, loss of order, uncertainty regarding safety, experiencing discomfort, and experiencing unwanted internal thoughts, feelings, urges, and images). Once the inference theme(s) are identified, inference chaining is employed to assist clients in identifying their rigid and extreme irrational beliefs regarding their inferences. Anxiety inducing irrational beliefs can be assessed, which typically have two components: a demand and a derivative of that demand as previously discussed in this chapter. For purposes of efficiency, I often identify the most anxiety inducing irrational belief and work on that belief first. Next, the cognitive restructuring process involves helping the client question the rigid and extreme nature of their beliefs by employing logical, empirical and pragmatic questions. In doing so, clients change their irrational beliefs to rational alternatives, which can be used to formulate rational coping statements that are to be repetitively rehearsed.

If clients engage in excessive rumination or get unhealthily engaged in questioning and debating beliefs, they may benefit from strategies based on cognitive defusion, an acceptance-based strategy often implemented in Steven Hayes' Acceptance and Commitment Therapy (ACT) that involves labelling intrusive or anxiety inducing thoughts or beliefs (see Masuda et al., 2010). For example, instead of thinking, "I am worthless if I get rejected," a client may change this to, "I am having the thought

that I am worthless if I get rejected." Labeling the intrusive thought can help to take the meaning away from it and thus reduce the perception of threat.

In addition to the strategies mentioned above, REBT lends itself to methods to interrupt the process of excessive worry and rumination. Ellis (1998) encouraged the use of meditation, yoga, Jacobsen's progressive muscle relaxation, and other relaxation strategies, which I frequently incorporate into treatment of anxiety disorders, both in session and for out of session homework assignments. Diaphragmatic breathing is another strategy that can be used to provide immediate physiological relief to clients. I demonstrate and practice this breathing technique with the client in session and have the client practice it for homework for at least a week prior to implementing it as an intervention. Some clinicians argue that relaxation serves as a form of distraction which can then reinforce the perceived threat of the feared stimulus. This may be the case for some individuals, so it is important to assess the function of relaxation. If a client can understand that they can tolerate uncomfortable sensations and that there is no true threat, they may benefit from implementing relaxation or distraction to help them re-engage in behaviors consistent with adaptive functioning and goal achievement.

Following relevant cognitive strategies, exposure therapy is essential to reinforce the cognitive interventions. When preparing clients for exposure therapy, it is important that they understand the rationale and that it will require dedication and hard work on the part of the client. Concepts of negative reinforcement, habituation, extinction, emotional processing, and self-efficacy can be explained in a client friendly way. For example, to illustrate the role of negative reinforcement and habituation, an example of jumping into a cold pool can be used. It is very uncomfortable at first, and if you jump right out, you show yourself that it is too uncomfortable to tolerate and as a result every time you jump into a cold pool, you jump out to escape the aversive experience (negative reinforcement). If you decide to stay in the pool and tolerate the uncomfortable cold sensation, your body adapts to the feeling and you show yourself it is tolerable (habituation). REBT therapists can also highlight how the client's beliefs will change with this experience. They are obtaining evidence that they can tolerate their uncomfortable feelings and sensations if they confront them.

Exposure and response prevention (ERP) involves having the client confront stimuli that trigger fear/anxiety to gain corrective feedback regarding irrational beliefs and their ability to cope without engaging in neutralizing or safety seeking behaviors. Exposure can be done in vivo, where the client directly confronts a feared stimulus or through imagery, but typically involves a combination of the two. Construction of a fear hierarchy where clients identify a series of anxiety-activating events in order of least to most distressing is the next step. The goal is to have the client face the feared situation, learn that they can tolerate the discomfort, and gain corrective feedback regarding extreme beliefs. Following exposure exercises, the REBT therapist should process what they have learned and contrast it to their irrational beliefs. This allows for emotional reprocessing as discussed previously in this chapter.

In addition to in vivo exposure, Abramowitz et al. (2011) differentiate three types of imaginal exposure, which include preliminary, primary, and secondary imaginal exposure. Preliminary imaginal exposure is helpful to utilize with clients who are

hesitant to engage in an exposure exercise. REBT therapists can utilize this approach to prepare clients for direct confrontation of the feared stimulus. For example, a socially anxious client who is preparing for an exposure task of initiating a conversation at a party can benefit from rehearsing this situation through imagery prior to the actual in vivo assignment.

Primary imaginal exposure involves direct confrontation of the feared stimulus. This can be particularly useful when a client's fear cannot be replicated in vivo. For example, a client with health illness anxiety fears contracting an STD from utilizing a public restroom. The REBT therapist can collaborate with the client to develop an imaginal script that involves the client utilizing a public restroom, subsequently going to a doctor to get tested, and then receiving results that confirm that she did indeed contract the STD. In this scenario, the client is confronting her worst fear in a controlled environment repeatedly. Through repeated rehearsal, the goal is for habituation to take place.

While primary imaginal exposure only involves imagery, secondary imaginal exposure can be used to augment in vivo exposure exercises by having the client use imagery while in an actual exposure situation. For example, if a client's in vivo exposure involves asking a romantic interest for her phone number, the client can imagine this person rejecting him as he engages in the actual exposure task. This can help reduce unhelpful distraction and also allows the client to experience his worst case scenario through imagery, even if it doesn't unfold during the in vivo exposure task. If the client does not encounter rejection in some form, it will not provide an opportunity to practice unconditional self-acceptance.

Finally, when conducting exposure, it is important to prevent responses or rituals that reinforce the perceived threat of the feared stimuli. Many clients rely on these safety behaviors to confirm that they are not in actual danger. When safety behaviors or compulsions are being utilized by clients, it is essential to fade and eventually eliminate these behaviors to experientially change their beliefs that they "need" them to be safe. As the client reduces and eliminates these behaviors, the REBT therapist can empirically point out that the evidence is contrary to their original beliefs.

Treatment Guidelines from the Empirically-Supported Therapy Literature that Inform Best Practice in REBT with Anxiety Disorders

In the empirically-supported therapy literature, cognitive behavioral therapies have a prominent presence with much emphasis on the treatment of anxiety disorders. A recently published article by David et al. (2017) examined the effectiveness and efficacy of REBT as part of a meta-analysis of 84 published studies. Medium effect sizes were found in reduction of anxiety symptoms postintervention, which provides good support for the empirical status of REBT in the treatment of anxiety disorders. Moreover, there are innumerable non-REBT specific studies examining the

efficacy and effectiveness of CBT for anxiety disorders. Several meta-analytic studies have provided evidence for the efficacy of CBT for various anxiety disorders (e.g., Feske & Chabless, 1995; Westen & Morrison, 2001; Stewart & Chambless, 2009; Ougrin, 2011). Stewart and Chambless (2009) conducted a meta-analysis of effectiveness studies of CBT for several adult anxiety disorders (panic disorder, social anxiety disorder, PTSD, GAD, and OCD) in clinical practice. As with many, CBT was broadly defined and included treatments with cognitive components, behavioral exposure components, or a combination thereof. Pretest—posttest effect sizes were large for disorder-specific symptoms measures for all anxiety disorders included in the study. Comorbid depression symptoms were also significantly reduced from pretest to posttest with large effect sizes for panic disorder, PTSD, GAD, and OCD and a medium effect for social anxiety disorder. This meta-analysis was particularly noteworthy because it illustrated the effectiveness of CBT for anxiety disorders in typical clinical settings in contrast to highly controlled research settings as is found in RCTs, providing flexibility in the use of treatment strategies as allowed for in REBT. In addition, these results support that while inference themes may differ among the various disorders, it appears that the targeting of core irrational beliefs lead to improved outcomes, regardless of the specific nature of the anxiety disorder.

One of the fundamental questions regarding the application of the research to clinical practice is deciphering the active ingredients of the treatment protocols that are investigated. Many randomized controlled trials (RCTs) that examine the efficacy of CBT for various anxiety disorders include protocols that involve a combination of rational emotive and cognitive behavior therapy (RE&CBT) techniques (e.g., cognitive restructuring, behavioral exposure, relaxation etc.). Feske and Chambless (1995) conducted a meta-analysis comparing CBT to exposure only treatment for social anxiety and found that exposure with and without cognitive modifications were equally effective in the treatment of social phobia. It was suggested that cognitive change in individuals with social phobia can be achieved through exposure alone. It is therefore important that REBT therapists not get caught up in only utilizing cognitive strategies. Though cognitive restructuring can effectively prepare clients to engage in exposure exercises, some clients may get "stuck" and not progress without a more intense behavioral exposure protocol. As previously discussed, clients' beliefs change by gaining evidence contrary to their catastrophic beliefs through corrective experience.

Contrary to the findings of the aforementioned study, Ougrin (2011) conducted a systematic review and meta-analysis examining the efficacy of exposure therapy versus cognitive therapy in anxiety disorders. In this study, there was no significant difference in efficacy between exposure and cognitive therapy for outcome measures across RCTs investigating PTSD, OCD, and panic disorder. However, cognitive interventions were superior to exposure in social phobia. It was hypothesized that a possible reason for this difference is that exposure for social anxiety may not be as effective because of the brief duration of many social encounters. In this case, REBT therapists may want to make sure that when conducting exposure therapy, the clients are remaining in the situation long enough for habituation to occur and for the client to not be negatively reinforced by prematurely escaping/ending the situation. For

social anxiety, the use of confederates in session where the therapist can moderate the length of the social interaction may be a helpful strategy to combat this challenge.

A recent study examined changes in threat-related cognitions and experiential avoidance in group-based transdiagnostic CBT for anxiety disorders (Espejo, Gorlick, & Castriotta, 2017). The transdiagnostic model involves moving away from targeting specific disorders and examining the benefits of treating multiple anxiety disorders with a single protocol. In this study, both threat perception and experiential avoidance significantly decreased over the course of treatment and mediated changes in fear ratings. Moreover, changes in experiential avoidance was a greater predictor in reduction of fear hierarchy ratings. These findings lend support that cognitive restructuring techniques can be effectively applied across multiple anxiety disorders to decrease perception of threat and that exposure methods are crucial to changing experiential avoidance.

While CBT is considered the gold standard for treatment of anxiety disorders and has been emphasized in this section based on the plethora of empirical studies in the research literature, Acceptance and Commitment Therapy (ACT) has been shown to be a highly viable treatment alternative to CBT in an RCT comparing the two modalities (Arch et al., 2012). Findings from this study showed similarities in both immediate and long-term impact of both treatment approaches. Regarding differences, CBT resulted in higher quality of life, while ACT resulted in greater psychological flexibility. There are some shared components of ACT and REBT that are noteworthy. Acceptance, psychological flexibility, and value-oriented living are key elements of both modalities, though specific approaches to achieving the two may vary. Arch et al. (2012) noted that there is still work to be done on identifying the shared versus unique mechanisms of change. Nevertheless, this research provides a sound rationale for REBT therapists to utilize value and acceptance-based approaches in their work. For example, helping a socially anxious client improve his unconditional self-acceptance may reduce beliefs of self-condemnation allowing him to attend social gatherings that he may have otherwise avoided.

When examining the research findings presented in this section, a common theme appears to emerge. REBT therapists can benefit from being flexible in their approach. Research strongly supports a transdiagnostic approach in the treatment of anxiety disorders and therefore, REBT therapists can use their common skills in cognitive and behavioral interventions, many of which are reviewed in this chapter, without having to rely on disorder-specific manualized treatments.

Brief Case Example

The following case example illustrates the use of REBT in assessment and treatment of a client with social anxiety. Maria is a 22 year-old Caucasian young woman who recently graduated from university and presents with a history of social anxiety that has been present since early adolescence. While she maintained relationships with a few close friends from elementary school, she encountered significant challenges

when it came to making new friends. Although she had a desire to cultivate new relationships and be involved in clubs and organizations at her school, her anxiety interfered with her desires. In the time she did not spend socializing, she was able to dedicate significant ample time to her studies and was accepted into a prestigious university. Her patterns from high school continued throughout her four years of higher education. Maria had difficulty establishing and maintaining relationships, and avoided dating and extracurricular activities out of fear of being judged as not being outgoing enough and not being attractive enough. Maria eventually obtained her degree in marketing, but found herself feeling depressed as she remained without a job six months following her graduation. This is when Maria decided it was time to seek therapy.

At the time of Maria's first session, it was clear that her anxiety and depression were having a significant impact on her functioning. I asked Maria to briefly explain what brought her to therapy and what she wanted to work on, which began the goal setting phase of treatment. Maria explained that she was feeling both depressed and anxious. When asked which emotion she wanted to work on first, she decided that her anxiety has been interfering with her goals of meeting new friends, dating, and interviewing for jobs and concluded that if she worked on her anxiety, it would likely improve her depression.

Once her goals were explicitly identified, the process of assessing her irrational beliefs that were leading to her unhealthy anxiety and subsequent behavioral avoidance began. When asked for a specific example of when her anxiety interfered with her functioning, Maria discussed a recent offer for a job interview. Upon receiving the call, she immediately found herself becoming anxious, and on the morning of the interview, she cancelled it. At the time, Maria thought she was going to be judged as incompetent and that she would look stupid. Through the process of inference chaining, it was revealed that Maria held a number of irrational beliefs that were causing her anxiety. She believed that she must gain the approval of the interviewer and that she could not stand the idea of "looking stupid" because this type of evaluation from the employer would confirm that she was a failure. Early in therapy, it became clear that this was a common theme when it came to Maria's social difficulties. For example, she avoided opportunities to meet friends or to go on dates because she believed that any negative opinion or form or rejection would confirm that she was unworthy and unlovable. By holding and rehearsing these irrational beliefs, Maria got herself so anxious that it became difficult to tolerate the feelings of anxiety to the point where she believed she needed to avoid anxiety activating events at all cost. As a result, when she avoided any form of rejection or negative evaluation, her avoidance was powerfully reinforced due to brief periods of relief from her anxiety.

The treatment plan involved helping Maria understand the connection between her irrational beliefs and her anxiety. It was also important to get Maria to see that her avoidance of putting herself in situations where she may be evaluated negatively was only strengthening her irrational beliefs and leading to more avoidance. This psychoeducation in addition to motivation building, which involved having Maria think about how her life would be different if she was able to manage her anxiety allowed for a smooth transition into the process of cognitive restructuring.

A key initial component to cognitive restructuring involved addressing Maria's global evaluations of worth. By challenging her beliefs that her worth was defined by others' opinions of her, Maria was also able to begin to see that perhaps negative opinions and rejection from others aren't so terrible and intolerable. As a result, Maria was also able to recognize that it was unhelpful and illogical to place such unrealistic demands on herself when it came to needing approval from others. After a few sessions of cognitive restructuring, Maria was able to replace her irrational beliefs with rational alternatives. For example, she now began to tell herself, "While I would like to be approved by others, I don't absolutely need this approval." "If someone thinks I am stupid, unattractive, or a failure, their opinion does not define me." "It may be unpleasant, but certainly not the worst thing in the world."

The next step was to help Maria put her new beliefs to use and to start confronting certain situations that she had been avoiding for the majority of her life. Utilizing Maria's behavioral goals as a guide, a series of exposure exercises were collaboratively designed. Exposure exercises, both in vivo and imaginal, were constructed in the order of Maria's anticipated distress, ranging from moderate to high on a SUDs scale of 0–100. The hierarchy was comprised of a number of exposure exercises which ranged from creating an online dating profile, reaching out to potential romantic interests, attending various social gatherings and initializing conversations, and partaking in mock job interviews. When designing the hierarchy, it was important to incorporate Maria's feared consequences. Therefore, it was necessary that she confront being rejected and also being potentially viewed as awkward, unattractive, incapable etc. Exposure tasks therefore included intentional rejections (e.g., starting conversations at a café until someone ignored her or was rude to her). Since there is a lack of control over the environment during in vivo exposures, imaginal exposures were also included in the hierarchy. For example, imaginal scripts were designed where Maria would be judged, ridiculed, and rejected. This was important so Maria would be able to confront what she feared, work on tolerating the anxiety and discomfort, and then continue to reinforce the belief that her worth was not defined by the negative reactions or opinions from others. As Maria continued to confront the things that she had been avoiding for so long, her irrational beliefs were further weakened while her rational beliefs were strengthened. She obtained direct evidence that rejection was unpleasant, but not terrible or intolerable, as she always survived the unpleasant experiences without catastrophic outcome. By pushing herself to confront her activating events and experience anxiety, she also learned that the unpleasant physiological experiences that accompanied her anxiety were uncomfortable yet tolerable. Maria was able to do things that she never believed were possible prior to therapy, which helped build her self-efficacy. With each successful exposure exercise, she became more willing to push herself toward taking actions to help achieve her goals of cultivating friendships, dating, and actively interviewing for jobs.

After a few months of therapy, Maria had developed some friendships by engaging in social gatherings in her community. While she had not yet achieved a relationship, Maria no longer experienced the crippling anxiety when she went on dates because her worth was no longer dependent upon the opinions and approval of others.

What I Have Learned About Using REBT with Anxiety Disorders

Accommodating Individual Differences: Client Gender, Ethnicity, Socio-Economic Status, Intelligence and Other Factors

When using REBT with clients with anxiety disorders, as with all clients, it is necessary to be aware of individual differences regarding culture, ethnicity, socio-economic status, sexual orientation, intelligence etc. It is important to not only be aware but to also be educated about these differences. Asking clients about their cultural or religious beliefs for example, not only provides important information for the therapist, but it also demonstrates to the client that the therapist is taking the time to understand the client as an individual. This can strengthen the therapeutic alliance and build trust, which can improve therapy outcome. Building trust with clients who experience fear and anxiety is essential to the relationship, particularly as they are challenged to confront distressing beliefs and uncomfortable emotions. Anxious clients will likely be more treatment compliant and less prone to premature termination when a strong and trusting therapeutic alliance exists.

More specifically, clients may present with anxiety due to irrational beliefs that have been strongly modelled and reinforced in their cultural upbringing. For example, a client who comes from a family with conservative religious views may present with intense anxiety because he fears being disowned by his family for coming out as gay. I would recommend validating the client's fears, take time to understand his background and his family's religious beliefs, and then assess for support systems. Refrain from challenging the inference regarding his family disowning him. Unfortunately, this may be the case and it is important that the client is prepared to cope with this worst case scenario.

I have also treated clients from diverse backgrounds, whose family and peers view anxiety as a personal weakness. They have adopted beliefs that experiencing anxiety is an indication of flawed character. As a result, they may enter treatment hesitantly and may also be sceptical about the effectiveness of therapy. In these circumstances, it is particularly beneficial to assess for secondary emotional disturbance (e.g., shame or embarrassment) and to identify and challenge the irrational beliefs that are causing these emotions, as they will likely interfere with treatment of the primary emotional disturbance.

When working with clients with lower intelligence levels or other cognitive deficits, I tend to be more didactic than when treating clients of average or higher intelligence. The REBT hypothesis-driven theoretical approach is particularly useful here. If an anxious client of lower intelligence has difficulty identifying her beliefs that are causing her anxiety, I would offer hypotheses (e.g., I wonder if you are telling yourself it would be terrible if you don't do well on this project?"). In addition, I spend less time on cognitive restructuring at the beginning of therapy and tend to

take a more behavioral approach. The utilization of exposure exercises to gain evidence contrary to the client's irrational beliefs and then reiterating the discrepancy is likely more effective than having them come up with them on their own prior to a behavioral intervention.

It is also important to take into consideration a client's socio-economic status (SES) when working with clients presenting with anxiety. Financial stressors are frequently cited as activating events for anxiety, which I have often seen in clients with generalized anxiety disorder. For this presenting problem, I may alter my approach during the process of cognitive restructuring. An individual of high SES may be worried about an upcoming job interview and awfulizing about the financial consequences of not obtaining the job. It may be more effective to use empirical and logical disputes with this client to help the client see that his awfulizing is extreme and inconsistent with reality. A client in a similar situation, but of low SES, may be also be awfulizing about the financial implications of not obtaining the job. This individual has no savings or other financial resources on reserve and may not be able to pay her rent or adequately provide for her children if she remains unemployed much longer. With this client, I would likely not place emphasis on challenging the awful nature of her feared consequences, but rather utilize a functional disputation approach. Helping her to challenge the functional nature of ruminating and awfulizing about her situation is only going to make it worse and interfere with her problem solving abilities. After helping this client change her unhealthy anxiety to necessary concern, we can then work on preparation for her interview and future problem solving.

The Dos and Don'ts

The Dos

It is critical for REBT therapists to assess and address their clients' beliefs about the functionality of maintaining anxiety. Some clients believe that if they change their anxiety, it will impede them in accomplishing their goals. For example, they may erroneously believe that they have to be anxious in order to do well on a paper, succeed on a job interview, or be prepared for a first date. Here, it is important to highlight the difference between anxiety and concern. Over time, clients will likely see that they do not have to place rigid demands on themselves regarding their performance and therefore experience anxiety to succeed. By changing these demands to preferences, they can learn that they are capable of accomplishing their goals without the uncomfortable sensations and other maladaptive behaviors (e.g., procrastination) that accompany anxiety.

While there is a place to utilize logical, empirical, and philosophical disputation methods, I rely highly on the functional/pragmatic dispute during cognitive restructuring when anxiety is the presenting problem. As referenced throughout this chapter, many clients with anxiety disorders engage in awfulizing. It is important to

use good clinical judgment when it comes to the use of certain disputation strategies. For example, a client presents with anxiety about having a panic attack on a train. Through inference chaining it is revealed that the client's fear is that he will die from a heart attack and that would be awful. I would not ask the client to provide evidence that dying would not be 100% awful. Instead, I would help the client to see that his extreme belief is only making himself more anxious through a functional/pragmatic disputation approach.

If clients are presenting with intense anxiety during a session and are having difficulty assessing their cognitions, do take the time to employ relaxation strategies. Diaphragmatic breathing can be done with the client and does not take long (5–10 min) to induce relaxing physical sensations. Once the client's physiological arousal has reduced, it may be easier for her to concentrate on the cognitive interventions.

When utilizing exposure methods with clients, make sure that the client understands the rationale for exposure and is well-prepared. It is important to assist clients in developing tolerance for discomfort. In my experience, disputation of frustration intolerance can greatly maximize the effectiveness of exposure therapy. Help clients identify other scenarios where they initially believed they could not tolerate a situation or a feeling and point out the evidence to the contrary.

The Don'ts

As a general rule in REBT, and especially when working with anxiety disorders, don't begin cognitive restructuring before the client understands the B-C connection. A client may become defensive and/or feel invalidated if this occurs. Much of the work with anxiety disorders involves confronting, both cognitively and behaviorally, their fears. This understandably takes a lot of hard work and commitment on the client's part. Without a trusting therapeutic alliance, clients may be hesitant to engage in the process.

While it is important to provide psychoeducation at the beginning of therapy, don't allow this to continue over the course of treatment, as this can lead to reinforcement of reassurance seeking behaviors. Due to demands for certainty among many anxious individuals, they are likely to continue to seek reassurance from their therapists. For example, when a client with panic disorder engages in interoceptive exposure, she may seek reassurance from the therapist that she will not have a heart attack. It is important that the therapist redirect the client to the exercise and encourage utilization of her own coping strategies.

During cognitive restructuring, don't jump immediately to challenging inferences. A socially anxious client may think that he will be ignored by every single person he approaches at a party. While this may be an unlikely scenario, it is not impossible. Therefore, it is important to have the client assume that this may be the case. The therapist can then utilize inference chaining to get to the core disturbance. In this case, the client's core irrational beliefs may be that if he is ignored by every person, it would prove that he is a total loser and that would be terrible. Once the therapist

challenges these beliefs of self-condemnation and awfulizing, it can be helpful to return to the inference and then examine the likelihood of it being true.

When exposure is being conducted, don't force a client into an exposure therapy exercise. While it is important that the therapist strongly encourage the client to engage in exposure, it is not the role of the therapist to force this (e.g., don't push a hesitant client into a subway train, even if riding the subway for one stop was the planned exposure exercise). Instead, the REBT therapist can identify and challenge the client's irrational beliefs that are keeping her from taking this step. If this is unsuccessful, the therapist and client can then re-examine the exposure hierarchy and create an intermediary exercise that the client may be more successful in confronting.

Also regarding exposure, don't have a client engage in an exposure exercise that you, the therapist, are unwilling to do. One of the main goals of exposure is to show the client, through experience, that their beliefs are extreme and that their perceived threat is much greater than the actual threat. If an REBT therapist is unwilling to do an exposure exercise with the client, they can be inadvertently reinforcing the belief that there is actual danger. In addition, modelling the exposure exercise for the client can help with effective implementation.

When working with specific phobias, don't spend much time on cognitive restructuring. Research shows that effective behavioral treatment for phobias can often be conducted in a single exposure therapy session (see Abramowitz et al., 2011). In addition, individuals with certain specific phobias (e.g., fear of small animals) are likely to be experiencing disgust, which has less of a cognitive component and therefore warrants emphasis on a more behavioral exposure treatment approach to build tolerance of the uncomfortable visceral sensations that accompany disgust.

Which Aspects of REBT Deliver the Most Benefit for Change and Which Don't

Addressing secondary emotional disturbance in individuals with anxiety disorders is one of the most beneficial aspects of REBT. Since many anxious clients have anxiety about their anxiety, treatment may be ineffective or move at a very slow pace if the meta-anxiety is not dealt with. For example, if a client believes he can't tolerate the discomfort of anxiety, he will continue to engage in safety-seeking behaviors that ultimately only enhance the perception of threat. Therefore, addressing the core irrational belief of frustration intolerance can be very helpful to affect change in clients, as it not only assists them in managing the uncomfortable sensations that accompany anxiety but it also can prepare them to engage in exposure, which is essential in effective treatment of most anxiety disorders.

When it comes to cognitive restructuring of irrational beliefs, I find that utilizing functional/pragmatic questioning delivers the most benefit for change. When clients see that holding on to their rigid and extreme beliefs is not changing their feared consequences but only making it more difficult to cope with them, clients are more

motivated to readily question the function of their demands and derivatives of (e.g., self-depreciation, awfulizing, and frustration intolerance). While empirical and logical questioning can be helpful in certain circumstances, some anxious clients may become argumentative, which can lead to unproductive debates. Therefore, I find the functional/pragrmatic questioning to be more beneficial than empirical and logical questioning techniques. In addition, clients appear to gain evidence inconsistent with their irrational beliefs when they actually engage in exposure exercises without their safety behaviors. In other words, the empirical status of their irrational beliefs is often changed through experience rather than just asking for evidence against their irrational beliefs.

REBT often endorses the need for rigorous disputation/questioning of irrational beliefs to change unhealthy negative emotions. For many anxious clients, this strategy may not be very beneficial. For clients who have a tendency to ruminate, rigorous disputation may actually keep a client engaged in their anxiety-provoking thought patterns. Some clients may even beat themselves up for not successfully ridding their anxiety through their questioning strategies leading to a vicious cycle. For these clients, I recommend working on questioning beliefs in session, but also providing distraction strategies and ways to re-engage in activities when they begin to ruminate outside of session. Over time they will learn that they can still function and engage in productive behaviors even in the presence of disturbing thoughts.

In conclusion, REBT is a transdiagnostic approach that has been proven to be effective in the treatment of anxiety disorders. There are several aspects of REBT that overlap with other forms of CBT and share similar treatment strategies including cognitive restructuring, exposure and response prevention, relaxation training etc. It is essential that REBT therapists engage in thorough assessment and adapt these interventions to help clients achieve their stated goals, while being flexible in their approach. The empirically informed assessment and treatment guidelines based on current research cited in this chapter can serve as a valued asset to all REBT therapists who work with anxiety disorders.

References

Abramowitz, J. S., Deacon, B. J., & Whiteside, S. P. H. (2011). *Exposure therapy for anxiety: Principles and practice*. New York: The Guilford Press.

Arch, J. J., Eifert, G. H., Davies, C., Plumb Vilardaga, J. C., Rose, R. D., & Craske, M. G. (2012). Randomized clinical trial of cognitive behaviour therapy (CBT) versus acceptance and commitment therapy (ACT) for mixed anxiety disorders. *Journal of Consulting and Clinical Psychology, 80,* 750–765.

Arntz, A., Rauner, M., & Van Den Hout, M. (1995). "If I feel anxious, there must be danger": Ex-consequentia reasoning in inferring danger in anxiety disorders. *Behaviour Research and Therapy, 33,* 917–925.

Beck, A. T., & Steer, R. A. (1993). *Beck Anxiety Inventory Manual*. San Antonio, TX: Psychological Corporation.

David, D., Cotet, C., Matu, S., Mogoase, C., & Stefan, S. (2017). 50 years of rational-emotive and cognitive-behavioral therapy: A systematic review and meta-analysis. *Journal of Clinical Psychology, 00,* 1–15.

DiGiuseppe, R. A., Doyle, K. A., Dryden, W., & Backx, W. (2014). *A practioner's guide to rational emotive behavior therapy* (3rd ed.). New York: Oxford University Press.

Dryden, W. (2012). *Dealing with emotional problems using rational-emotive cognitive behavior therapy: A practitioner's guide*. New York: Routledge.

Ellis, A. (1962). *Reason and emotion in psychotherapy*. New York, NY: Carol Publishing Group.

Ellis, A. (1998). *How to control your anxiety before it controls you*. Secaucus: Carol Publishing.

Espejo, E. P., Gorlick, A., & Castriotta, N. (2017). Changes in threat-related cognitions and experiential avoidance in group-based transdiagnostic CBT for anxiety disorders. *Journal of Anxiety Disorders, 46,* 65–71.

Feske, U., & Chambless, D. L. (1995). Cognitive behavioral versus exposure only treatment for social phobia: A meta-analysis. *Behavior Therapy, 26,* 695–720.

Foa, E. B., & Kozak, M. J. (1986). Emotional processing of fear: Exposure to corrective information. *Psychological Bulletin, 99,* 20–35.

Harris, S., Davies, M. F., & Dryden, W. (2006). An experiment test of a core REBT hypothesis: Evidence that irrational beliefs lead to physiological as well as psychological arousal. *Journal of Rational-Emotive and Cognitive-Behavior Therapy, 24,* 101–110.

Johnstone, K. A., & Page, A. C. (2004). Attention to phobic stimuli during exposure: The effect of distraction on anxiety reduction, self-efficacy and perceived control. *Behaviour Research and Therapy, 42,* 249–275.

Masuda, A., Twohig, M. P., Stormo, A., Feinstein, A. B., Chou, Y., & Wendell, J. (2010). The effects of cognitive defusion and thought distraction on emotional discomfort and believability of negative self-referential thoughts. *Journal of Behavior Therapy and Experimental Psychiatry, 41,* 11–17.

Ougrin, D. (2011). Efficacy of exposure versus cognitive therapy in anxiety disorders: Systematic review and meta-analysis. *BMC Psychiatry, 11,* 200.

Reiss, S., Peterson, R. A., Gursky, D. M., & McNally, R. J. (1986). Anxiety sensitivity, anxiety frequency and the prediction of fearfulness. *Behaviour Research and Therapy, 24,* 1–8.

Spielberger, C. D., Gorsuch, R. L., Lushene, R., Vagg, P. R., & Jacobs, G. A. (1983). *Manual for the State Trait Anxiety Inventory*. Palo Alto, CA: Consulting Psychologists Press.

Stewart, R. E., & Chambless, D. L. (2009). Cognitive-behavioral therapy for adult anxiety disorders in clinic practice: A meta-analysis of effectiveness studies. *Journal of Consulting and Clinical Psychology, 77,* 595–605.

Szentagotai, A., Schnur, J., DiGiuseppe, R., Macavei, B., Kallay, E., & David, D. (2005). The organization and the nature of irrational beliefs: Schemas or appraisal? *Journal of Cognitive and Behavioral Psychotherapies, 5,* 139–158.

Taylor, S., Zvolensky, M. J., Cox, B. J., Deacon, B., Heimerg, R. G., Roth-Ledley, D., et al. (2007). Robust dimensions of anxiety sensitivity: Development and initial validation of the Anxiety Sensitivity Index-3. *Psychological Assessment, 19,* 176–188.

Westen, D., & Morrison, K. (2001). A multidimensional meta-analysis of treatments for depression, panic and generalized anxiety disorder: An empirical examination of the status of empirically supported therapies. *Journal of Consulting and Clinical Psychology, 69,* 875–899.

Westra, H. A., & Dozois, D. J. A. (2006). Preparing clients for cognitive-behavioral therapy: A randomized pilot study of motivational interviewing for anxiety. *Cognitive Therapy Research, 30,* 481–498.

REBT and Depressive Disorders

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Key REBT Theoretical Concepts in Working with Depressive Disorders

Brief Description of the REBT Key Theoretical Constructs

Rational-emotive behavior therapy (REBT) emphasizes the role of irrational beliefs as causes of emotional disturbance (i.e., dysfunctional emotions, like depression). REBT relies on the ABC model (Ellis, 1994), where the activating event (A) is further interpreted in a rational or irrational manner (B), thus leading to functional or dysfunctional emotions and behaviors, respectively (C). In the case of depression, a negative activating event (usually related to loss) is irrationally appraised by demand-

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ingness and self-downing beliefs, and thus, as a result, the dysfunctional emotion and its associated behavioral consequences (e.g., inactivity) occur.

The REBT Conceptualization of Depression and Relation to Other Major Theories

In REBT, *demandingness* is considered to be the most important irrational belief causally involved in the onset of depression, together with its derivatives namely *self-downing/life-downing* (Ellis, 1987). In this sense, Ellis (1987) argues that the other prominent cognitive-behavioral theories of depression may well explain why someone would become sad or disappointed in the face of adversity, but they miss a central element differentiating those who become functionally sad from those who become depressed, namely *demandingness*. For instance, Beck's theory of depression (Beck, 1976) introduces the cognitive triad: a negative view of oneself, a negative view of the world and a negative view of the future. That is, depressive people see themselves negatively, as unworthy or unlovable, they see the world as bad and the future as hopeless. Ellis (1987) argues that this is not enough for someone to feel depressed, although it is obvious why that person would be sorrowful and disappointed. For depression to occur, the person would have to make *demands* (i.e., not just preferences) on himself/herself, the world, and the future, demands which would then have to be contradicted by reality. For example, if I have a negative image of myself (e.g., I am not lovable), but I hold rational beliefs regarding this (e.g., "I wish I were more lovable, too bad that I am not, but I can do something to improve it or even leave with it"), then I would not become depressed when confronted with "proof" that I am not lovable, instead, I would feel sad and disappointed. Even if cognitive distortions like overgeneralization, discounting the positive, faulty inferences, etc. operate as false proof and lead me to the wrong conclusion that I am not that lovable or not that competent, these distortions would not lead to depression unless I would also hold to the irrational belief that "I must/ought to/absolutely have to be lovable, competent, worthy". Additionally, Ellis argues that it is much more likely to have such cognitive distortions if they arise from demands, rather than from rational beliefs. It is imposing demands on the self which likely leads to depression, as discussed in the research section below. In a similar manner, thinking that the world is a bad place and the future is grim does not make one depressed unless there are demands imposed on the world and the future (e.g., "the world *must* be fair, the future *should* be bright").

The theory emphasizing learned helplessness as the main causal factor for depression (Seligman, 1981) posits that people become depressed when they expect negative, uncontrollable future events, and when they tend to attribute internal ("it's about me"), global ("it's about everything in my life"), and stable ("it will always be like this") causes to negative events and attribute external ("it's the circumstance, not me"), specific ("just this matter"), and unstable ("just this once") causes to positive

events. Indeed, thinking like that can make one quite sad and discouraged, but, again, Ellis (1987) argues, feeling depressed doesn't automatically arise from these thinking patterns, unless demandingness is prominent. If I didn't pose demands on reality, I could think something like "Too bad so many negative things keep happening to me and I wish I could control them. I wish these events wouldn't be about me as they are, I so mush dislike it that all the things in my life are bad, and that the future looks the same. But this is how it is and I will still try to live a reasonably good life with what I have". In a similar manner, Ellis explains how behavioral theories of depression, which emphasize lack in reinforcements and excesses in punishments in one's life as causes for depression (e.g., Lewinsohn, 1974) account for people feeling sad or unhappy with their lives, but not clinically depressed. Unless I don't believe that life *should*, *must* be rewarding, I will not become depressed, although I may be sad when life offers more than my share of misfortune and gives little in return.

However, imposing absolutistic demands on oneself, life, and the future does not necessarily lead to psychological disturbance (Ellis, 1997). Sometimes, significant activating events don't occur, so irrational beliefs don't get to be triggered. This is rare, since, sooner or later, we all suffer disappointments. In most cases, people resort to defense mechanisms, which allow them to distort reality, such as the irrational beliefs to remain unchallenged. For instance, I could engage in self-deception, telling myself something like "My colleagues are not happy with my work performance, but I'm sure they're wrong" or "I didn't take the job because, deep inside, I never wanted it". Other defense mechanisms include rationalization, distraction, withdrawal, or substance use (Ellis, 1997). Still, although at times these mechanisms can be useful, they have obvious downsides, such as the fact that cutting away from reality actually keeps you farther away from your goals and desires.

Empirical Evidence Linking Irrational Beliefs to Depression

Several studies have found positive relations between irrational beliefs and depression (e.g., Nelson, 1977; Prud'homme & Barron, 1992). A recent meta-analysis (Vîslă, Flückiger, Grosse Holtforth, & David, 2016), found a medium sized relation between irrational beliefs and depression, $r = 0.33$, 95% CI [0.26; 0.39], with 47 studies included in the analysis. Also, the same meta-analysis found that the relation between irrational beliefs and depression is double in magnitude when a stressful event is present, $r = 0.67$ (vs. $r = 0.30$), $p < 0.001$ and when this is a personally relevant event, $r = 0.43$ (vs. $r = 0.26$), thus supporting the ABC model of REBT. But what does this relation tell us about the causal role of irrational beliefs in depression? Initially, many studies used instruments which comprised items related to negative affect in addition to irrational beliefs, so it was unclear what the scales were really measuring (Browne, Dowd, & Freeman, 2010). Later studies used instruments with better discriminant validity, such as the Belief Scale (BS, Malouff & Schutte, 1986) and found evidence of irrational beliefs discriminating between depressed and non-depressed individuals, with the relation between irrational beliefs and

depression remaining significant after controlling for general negative affectivity (McDermut, Haaga, & Bilek, 1997). However, these correlation studies could not point to a causal link from irrational beliefs to depression, as they could have been merely correlates. Also, the general irrational beliefs measured by the scales may not capture well enough the idiosyncratic set of beliefs patients display in relevant clinical settings (Browne et al., 2010). The studies conducted by Solomon, Haaga, Brody, Kirk, and Friedman (1998) and Solomon, Arnow, Gotlib, and Wind (2003) tried to remedy these shortcomings. The study of Solomon et al. in 1998 compared remitted-depressives with never-depressed participants in terms of irrational beliefs measured with the BS and with the Articulated Thoughts in a Simulated Situation paradigm (ATSS, Davidson, Robins, & Johnson, 1983). If irrational beliefs are a vulnerability factor, and not a correlate of depression, the two groups would differ on irrational beliefs (with the remitted-depressives obtaining higher scores), even though none of the groups was depressed at the time of the study. Results showed no differences between the two groups in terms of irrational beliefs, neither with the self-report measure, neither when primed with the ATSS. Instead, irrational beliefs correlated with negative mood more strongly in the remitted-depressed group. Even if this study did not seem to support the REBT hypothesis, another study conducted by Solomon et al. in 2003 used a more specific measure of demandingness in relation to oneself, the Specific Demands on the Self scale (SDS, Solomon, 1998), an instrument indicating the number of significant life domains, on which the person imposes demands on oneself (e.g., mental abilities, achievement at work or school), and showed that remitted depressives show a significantly higher level of self-demands compared to the never-depressed participants. Therefore, using a more individualized measure of self-demands, we can discriminate between remitted-depressives and never-depressed individuals. This points to a prominent role of self-downing, in addition to demandingness, in triggering depressive mood.

Another study (Macavei, 2005) compared clinically depressed participants, dysphoric participants (with high levels of depression, but no clinical diagnosis) and normal controls in terms of irrational beliefs measured with the Attitudes and Beliefs Scale 2 (ABS2, DiGiuseppe, Leaf, Exner, & Robin, 1988). Results showed that the three groups differed among themselves in the expected direction with the depressed and the dysphoric groups obtaining higher levels of irrational beliefs than the control group, and the depressed group with a higher level of irrational beliefs than the dysphoric group. Regarding specific irrational beliefs, self-downing and awfulizing best differentiated depressives from the dysphoric group. In a different study (David, Schnur, & Belloiu, 2002), demandingness as a primary appraisal process, and self-downing, low problem-focused potential and low positive future expectations as secondary appraisal processes best accounted for the explained variance in depression (73%, $p < 0.01$).

An important line of study which can investigate the empirical support of the REBT model of depression is the mechanisms of change analysis conducted in the context of randomized control trials. One prominent example is the study conducted by Szentagotai, David, Lupu, and Cosman (2008), which analyzed the mechanisms of change for depressive symptoms in three treatment groups: REBT, Cognitive Therapy

(CT), and pharmacotherapy. Results showed that irrational beliefs as measured by the ABS2 change similarly in all three groups, as do distorted inferences and attitudes, supposedly the mechanisms of change in CT. However, only in the REBT condition did irrational beliefs measured in the Articulated Thoughts in Simulated Situations (ATSS) paradigm significantly reduce from pre to post test, meaning that the other conditions altered only those irrational beliefs which were easily accessible verbally. Also, importantly, at follow-up, a change in implicit demandingness (measured by the ATSS) was more strongly associated with reduced depression and relapse prevention.

So far, although some studies point to the causal role of irrational beliefs, particularly demandingness in depression, the data is not yet conclusive. In order to gain more comprehensive information in this matter, more studies with powerful designs should be conducted in the future (e.g., randomized trials with mechanisms of change analyses, longitudinal studies, experimental designs with currently and remitted-depressives). Also, the measurement of irrational beliefs continues to be problematic, as current measures seem too general and particularly vulnerable to demand characteristics (after restructuring demandigness in therapy, we can expect someone to answer with "I prefer, but do not demand"), thus pointing to the need of developing measures with higher ecological validity, which could capture more closely the irrational beliefs seen in clinical practice.

Key Best-Practice REBT-Based Assessment and Treatment Strategies and Techniques in Working with Depressive Disorders

Key Best-Practice REBT-Based Assessment

An accurate clinical assessment is critical for the effective treatment of depression. The REBT assessment of depressive disorders is a process which can be achieved at two levels: (1) before the need for treatment has become manifest, or (2) once depressive symptoms are identified and psychological intervention is sought. In the first case, assessment involves a screening analysis for depression at the public health level, as a primary prevention program. Once depressive symptoms are identified, the purpose shifts from screening to accurate differential diagnosis, understanding symptom severity, and identifying co-occurring psychological or medical disorders that may influence treatment. The general aim of the REBT assessment in working with depressive disorders is first to define depression, once clinically diagnosed, in terms of life problems and then to identify (by the ABC model), in relation of each life problem, the client's erroneous information processes, his/her dysfunctional thoughts underlying negative emotions and maladaptive behaviors, and to separate them from functional ones.

REBT's standard assessment sequence involves the analysis and evaluation of A (activating event) and C (consequences) before B (beliefs). Once the practitioner

identified the "A" and "C", the next step implies the assessment of client's thinking style, with the aim to identify the dysfunctional thoughts that underlie the maladaptive consequences. A number of assessment methods, described below, have been developed to elicit irrational/rational beliefs, and functional/dysfunctional emotions and behaviors when working with depressive disorders. The assessment techniques described below are therapy oriented, psychometric instruments being described in another chapter.

Assessment techniques	Description of techniques
Theory driven questioning	Questions derived directly from the REBT theory focus the client response on "hot cognitions", rather than automatic thoughts. By using these types of questions, the client's response becomes specific and can predict possible cognitive mechanisms related to dysfunctional consequences
Guided discovery/Socratic questioning	This technique is based on a guided discovery approach that allows clients to reach their own conclusions. This technique involves asking the client questions which (1) the client has knowledge of the answer to, (2) draw the clients' attention to relevant information, (3) move the clients' perspective from concrete to abstract, and (4) permit the clients to apply the new information to construct a new conclusion (Padesky, 1993). Four steps have been proposed (Padesky, 1993): (1) asking informational questions, (2) listening, (3) summarizing, and (4) synthetizing or analytical questions
Role playing	The role playing technique involves the simulation of an interaction between the client and the therapist or a group, in a clinical setting (Norton & Hope, 2001). Through this technique, the practitioner can recreate different social situations that will trigger the clients' dysfunctional beliefs and consequences. To obtain positive results by using the role playing technique, the clients play themselves, while the therapist plays the role of the other participant in the dialogue
Imagery	To assess client's irrational/rational beliefs, the therapist can use the imagery technique that involves recalling an activating event associated with dysfunctional beliefs and consequences. The content of the image can be realistic or metaphoric
Daily records	This technique involves that the client is instructed to complete a self-monitoring form or to keep a diary, with the aim of recalling dysfunctional cognitions and consequences. Usually, the self-monitoring is prescribed as homework
Rational stories	Rational stories are creative methods that can be used to help children and adolescents assess their dysfunctional/functional beliefs and consequences, by identifying with a character that represents a functional or dysfunctional thought, emotion or behavior. Some of the most widely used stories are "The Story of Retman" (www.retman.ro; David, 2010) and "Rational Stories for Children" (Waters, 1980)

(continued)

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Assessment techniques	Description of techniques
Board games	This method can be a useful one to identify rational and irrational beliefs in children and adolescents. Some of the most popular board games for children are developed by Berg (1990)
Sentence completion	This type of exercise requires that clients fill in the blanks of an incomplete sentence (Friedberg, Mason, & Fidaleo, 1992). The technique requires patients to say what they think in a specific activating event, when a given emotion is experienced (i.e. "When X happens, I think Y, and I feel Z")

Clients with depression are often fatigued and have difficulties concentrating, facts that can affect the assessment process, for example, the process of reporting past events. Therefore, clinicians are encouraged to observe clients' behaviors and to encourage them to participate in the assessment process, even when treatment-interfering symptoms may be present.

The REBT assessment is an ongoing process that informs the client of his/her cognitive vulnerabilities and the therapist about the treatment progress. Therefore, developing and validating assessment tools and techniques is very important. For this reason, the REBT assessment field, is constantly developing, and is currently focused on the use of technology and electronic devices in the evaluation process. Some of the most promising ways to use technology in REBT clinical assessment for depressive disorder are summarized below.

Modern assessment techniques	Description of techniques
Virtual reality assessment	Virtual reality (VR) integrates real-time computer graphics, body motion tracking devices, visual devices and other sensory devices that help the patient to be present in the generated virtual environment. Exposure to activating events in controlled environments, controlled by the therapist activates cognitive processes (Macavei & McMahon, 2010)
Computer assisted rating scales	This modern assessment technique is the most widely used in the REBT assessment field, and consists of structured interviews and questionnaires that can be administered on a computer and can be self-administered (Wright, Wright, Albano, Basco, Goldsmith, et al., 2005)
Neuroimaging	This technique refers to the use of electronic devices for visualizing specific neural areas of the brain, for example the pathways of brain activity in depression (Gotlib & Hamilton, 2008)

Although the therapy oriented assessment techniques described below are used in the standard REBT assessment protocols, randomized clinical trials are needed to confirm their validity in the assessment of depression. This research gap is also found in the case of computerized assessment techniques, which even if it represents

a new and promising line of research in the REBT assessment field, more studies are needed to prove their validity in the assessment of depression.

Key Best-Practice REBT—Strategies and Techniques

Several early qualitative and quantitative syntheses (Engels, Garnefski, & Diekstra, 1993; Lyons & Woods, 1991) evaluated the efficacy of REBT and showed it to be significantly better than placebo or no treatment, and equally efficient with other therapies, with medium effect sizes. Recently, a new and comprehensive meta-analysis (David, Cotet, Matu, Mogoase, & Stefan, 2017), which investigated the effects of REBT interventions, as well as their mechanisms of change, was published. For depression, the between group analysis showed significant medium effect sizes of $d = 0.54$ at posttest, and $d = 0.67$ at follow-up, while the within group analyses revealed an effect size of $d = 0.52$ at posttest, respectively $d = 0.32$ at follow up.

The most relevant study arguing for the efficacy of REBT for depressive disorders is a randomized clinical trial (David, Szentagotai, Lupu, & Cosman, 2008) that compared REBT with cognitive therapy, and with pharmacotherapy (i.e., SSRI medication—*fluoxetine*). The clinical trial involved 170 participants which had a diagnosis of major depressive disorder, without psychotic symptoms (David et al., 2008). Results revealed that REBT held similar results with cognitive therapy and pharmacotherapy at posttest. Moreover, REBT had significant better results than pharmacotherapy at follow-up assessments (David et al., 2008). Also, it was shown that REBT was more cost-effective, and had better cost-utility than pharmacotherapy, and held similar results regarding effectiveness and cost-utility as cognitive therapy (Sava, Yates, Lupu, Szentagotai, & David, 2009).

Another randomized clinical trial (Iftene, Predescu, Stefan, & David, 2015) investigated the effects of REBT for major depressive disorder in a youth sample compared with pharmacotherapy (i.e., SSRI medication—*sertraline*), and with the combination of REBT and pharmacotherapy. The data showed that REBT improved subjective, cognitive, and biological outcomes in youths to a similar degree as pharmacotherapy, and the combination of the two interventions (Iftene et al., 2015). The results regarding the clinical response rate presented the same pattern, with no differences between the three groups (Iftene et al., 2015).

Based on the empirical data presented above, REBT was included in several international guidelines. In the case of depressive disorders, REBT was included as a probably efficient treatment in the *Research Supported Psychological Treatments List of the Division 12* of the American Psychological Association (APA). APA's Division 12 states that the most important aspect that distinguishes REBT from other CBT approaches in treating depression is its greater focus on decreasing demandingness beliefs, increasing unconditional self-acceptance, and tackling meta-emotions, such as depression about depression.

Another major clinical guideline which recommends REBT as an viable intervention for depressive disorders is the one from *The National Institute for Health and*

Clinical Excellence Guidelines (NICE; National Institute for Clinical of Excellence, 2009). NICE guidelines, as well as the APA ones, included REBT as a probably efficient intervention for depression based on the above mentioned randomized clinical trial, stating that: "comparing rational emotive behavioral therapy with antidepressant medication and the findings were promising in terms of end of treatment depressive symptoms and positive in terms acceptability and preventing relapse at 6 months' follow-up" (The National Institute for Health and Care Excellence, 2009).

The REBT treatment protocols for depressive disorders are focused on identifying and changing the irrational thinking style of clients. In depressive disorders, the treatment is focused on finding and changing demandingness and self-downing beliefs. Another primary objective of REBT for depression is the development of patients' unconditional self-acceptance. Last but not least, treatment focuses on reducing the secondary emotional problems. Standard REBT therapy sessions consist of seven steps that need to be followed carefully by therapists: (1) making an update, followed by a mood check; (2) making the transition from last session; (3) setting the agenda; (4) reviewing the homework; (5) discussing the problems to be approach in that session; (6) assigning a new homework; (7) reviewing the session and feedback.

The optimum number of REBT intervention sessions for depression is 20 individual—50-minute therapy sessions (David, Kangas, Schnur, & Montgomery, 2004). A prototypical REBT intervention lasts 14 weeks, including 12 weeks of full treatment and 2 weeks of follow-up meetings which are focused on termination of therapy.

First part of therapy, including weeks 1–4 should focus on general clinical conceptualization, building therapeutic relationship, psychoeducation, and developing a problem list, followed by approaching each problem from the list based on the ABCDEF model of REBT. In the following 4 weeks, the therapist should focus on tackling and decreasing irrational beliefs, meanwhile developing rational beliefs. Also, it is recommended to encourage clients to take a larger perspective and investigate possible links between their problems, and to investigate possible common causes, such as general irrational beliefs. The final part of the therapy should prepare clients to deal with their problems in the absence of the therapist, generalizing what they learned in the real life, in their ecological environment. Also, clients are taught skills in order to avoid relapses and to manage possible dependency problems. NICE guidelines (The National Institute for Health and Care Excellence, 2009) have some general recommendation for using CBT interventions (which include REBT) for depression differently based on categories of severity of depression. For example, for mild and moderate depression, low-intensity CBT interventions including 10–12 weeks of therapy are indicated. On the other hand, for severe depression, the recommended length of the therapy is 6–9 months.

In order to be successful, REBT interventions for depression should include behavioral, cognitive, and emotive techniques. Usually, in the incipient phases, especially in the case of severe depression, behavioral techniques are recommended (e.g., behavioral activation) in order to implicitly change the cognitions of the clients. Also, increasing the activation level of the clients will facilitate the later implementation of cognitive and emotive techniques, which are more likely to be successful in the

absence of emotional supersaturating. On the other hand, for mild and moderate depression, the therapy can be started with cognitive and experiential techniques.

After changing the main irrational cognitions (usually demandingness and self/life-downing beliefs) in the first phases, through behavioral or cognitive techniques, it is recommended, when possible, to also tackle the A part of the ABC model, namely the activating events which occurs in the client's life. This is most often accomplished using problem solving techniques, teaching clients every step of the process to deal with specific problems. In crisis situations, especially when suicide ideations are present, the C component of the ABC model, dysfunctional emotions, should be targeted first by using coping skills because in these special situations, other techniques are less likely to be successful. After the crisis has passed, usual steps of the therapy should be followed taking into account the severity of the disorder.

Cognitive Techniques

Cognitive techniques are used to change dysfunctional beliefs in relation to an activating event. For mild and moderate depression, the therapy can be started with cognitive techniques. In the case of severe depression, it is not recommended to use cognitive techniques at the beginning of therapy, behavioral techniques being recommended (e.g., behavioral activation) in order to implicitly change the cognitions of the clients. Cognitive techniques include a series of exercises, like monitoring forms, cognitive restructuring, role plays, guided imagery, and coping cards. One of the most common REBT cognitive techniques is *restructuring irrational beliefs* (Dryden & Branch, 2008). There are three types of restructuring (Phadke, 1982): (1) detecting—looking for dysfunctional beliefs (i.e. "must"), (2) debating—asking questions that will help the client to give up irrational beliefs (i.e. "Where is the evidence?"), and (3) discriminating—helping the client to distinguish between rational and irrational beliefs. One of the most widely used models for restructuring irrational beliefs is the ABCDE model. The ABCDE process/form include the following six steps: (1) *A (Activating events)*—the psychotherapist teaches the patient to identify an activating, upsetting event; it is very important that only a simple description of the facts, not interpretations, be mentioned/discussed in this step; (2) *C (Consequences following the events)*—at this stage, the patient must note the consequences of the event: dysfunctional negative consequences (e.g. depression, anger), dysfunctional behaviors (e.g. isolation), and physical symptoms (e.g. faster heart beats, sweating); (3) *B (Irrational Beliefs)*—the client has to understand that in order to change the dysfunctional consequences, the way of thinking must be changed. The first step is to identify these irrational beliefs; (4) *D (Debating Irrational Beliefs)*—the client should fight with identified irrational beliefs by debating them, using empirical, logical and/or pragmatic arguments; (5) *E (Effective Rational Beliefs)*—after debating irrational beliefs, the clients need to change them with functional alternatives, among which: (a) *preferences beliefs*—beliefs that express the desire, but accept possible failure, (b) *realistic evaluation of badness*—beliefs that express that a situation is bad,

but not catastrophic, (c) *high frustration tolerance*—beliefs that express tolerance to unpleasant situations, and (d) *unconditional acceptance*—contextual evaluations of myself, others, or life; 6) *F (Functional Consequences)*—the psychotherapist discuss with the client the new effects, the functional affective (e.g. sadness), behavioral (e.g. walking), and/or physical (e.g. energy) consequences.

Behavioral Techniques

One of the REBT assumption is that cognitive change is often facilitated by behavioral change (Emmelkamp, Kuipers, & Eggeraat, 1978). Usually, in the incipient phases, especially in the case of severe depression, behavioral techniques are recommended in order to change the irrational beliefs of the client. Behavioral techniques include activities that teach patients to cope with negative situations. Such techniques include: activity scheduling, distraction, exposure etc. (MacLaren, Doyle, & DiGiuseppe, 2016). Behavioral techniques can be homework assignments, offered in order to change patients' irrational beliefs, to develop pragmatic, empirical and logical arguments of their rational beliefs. Some of the most used REBT behavioral techniques in depression are activity planning, the use of rewards and penalties, and distracting techniques. For example, the distraction technique can be used as a homework exercise, by which the patient learns to distract himself from dysfunctional negative thoughts, to focus on certain environmental stimuli (i.e. birds sound, watching a comedy).

Emotive Techniques

Emotive techniques (i.e., songs, metaphors, humor) are meant to change irrational dysfunctional beliefs by developing functional emotions. An emotive technique that is constantly used by the therapist during sessions is building a therapeutic relationship relying on unconditional acceptance. Promoting a relationship based on unconditional acceptance makes the client feel accepted as a human being, regardless of the mistakes he made in the past, and despite the fact that the therapist does not approve the patient's dysfunctional behaviors. In REBT therapy, the therapist uses a number of emotive techniques, like stories, metaphors, poems, parables, as adjuncts to cognitive restructuring techniques (Ellis & Abrams, 1994). Another emotive technique often used in REBT therapy is the shame-attacking exercise (i.e., wearing bizarre clothes). This exercise aims to expose the client to situations where he/she may feel publicly ashamed, with the ultimate goal to develop his/her unconditional acceptance and tolerance to frustration/discomfort.

Alternative Therapy Methods

Even though there are studies showing the efficacy and effectiveness of REBT, there are certain aspects that can be improved. After reviewing the state of the art theory and practices in the field of REBT for depressive disorders, it would be helpful to identify strategies for developing the access to these techniques, to maximize intervention efficacy and cost-effectiveness. One promising solution for increasing the access to evidence-based REBT protocols for depressive disorders and to decrease the costs of delivering these programs, is the use of technology, like virtual reality therapy. Virtual reality (VR) is a computer generated three-dimensional world, which can be experienced through specific devices such as head mounted displays and three-dimensional displays. An important feature of VR is that it gives the patient the possibility to interact with the virtual world, and during this interaction the user is not just a mere observer, but an active participant in the 3D world that changes and responds to his actions (Riva, Molinari, & Vincelli, 2002). In the case of patients with major depressive disorder, VR can be used as a mean of delivering classical techniques, such as attention distraction (focusing on VR stimuli), behavioral activation (exposure to virtual reality environments) or shame attacking in VR environments. Other options developed to increase patient access to REBT treatments for depression are classical therapies delivered on the Internet (iCBT), or the use of therapeutic robots, with or without therapist involvement.

Treatment Guidelines from the Empirically-Supported Therapy Literature that Inform Best Practice in REBT with Depressive Disorders

As we showed in the previous section, research regarding the efficiency of REBT for depression is showing good results, the therapy being included in the international clinical guidelines as a probable efficient treatment for this disorder. However, more work is needed in order to constantly improve REBT interventions for depression, so that it could be recognized as a well-establishes, strong empirically supported therapy. Therefore, in this section we will briefly summarize the status of non-REBT interventions with strong empirical support, and we will show how REBT can be improved by incorporating some of the research-based effective techniques coming from these interventions.

According to the *Research Supported Psychological Treatments List of the Division 12* of the American Psychological Association (APA), there are six psychological interventions, which have strong empirical evidence for their efficacy. In the following paragraphs we will shortly present which specific techniques from different empirically-supported therapies could be integrated in REBT therapy. We believe that the integration of these techniques in REBT protocols could significantly improve its efficacy and effectiveness.

Cognitive Therapy (CT)

Even REBT and Cognitive Therapy have a lot of common points, CT also focusing on changing unhelpful cognitive processes, the main difference between the two approaches is the fact that CT techniques are much more oriented on dealing with inferential cognitions, rather than evaluative ones, like in REBT. Therefore, incorporating techniques targeting specific inferential beliefs could add to REBT intervention for depression, sometimes being more useful in therapy to tackle first inferences, and then evaluative beliefs. The most important cognitive distortions, which imply dysfunctional inferences, are all-or-nothing thinking, overgeneralization, mental filter, disqualifying the positive, magnification, jumping to conclusions, and emotional reasoning. Also, REBT could gain by adding from CT strategies which focus on information processing deficits, selective attention, and memory biases toward the negative.

Behavioral therapy (BT)

Many elements of BT are also incorporated in REBT, especially when speaking about behavioral activation. On the other hand, one important aspect of BT which can bring advantages for REBT is the special focus on the role of the supportive persons. The strategy implies that the client to find potential persons which might help him/her accomplishing some therapy goals or doing some activities from the behavioral activation list. BT assumptions states very clearly that the chances to overcome depression are significantly higher when support for your adaptive behavior from close persons is strong.

Interpersonal Psychotherapy (IPT)

Interpersonal Psychotherapy is an approach that focuses mainly on the changes in client's interpersonal environment, the goal being to tackle both stressful life events and social support by improving interpersonal relations. REBT could benefit from this type of interventions by incorporating specific techniques which have the role to cope with specific interpersonal difficulties associated with the development and/or maintenance of the depressive symptoms. Research from IPT field showed that there are four main areas of life events which are more likely to be triggers for depression, namely grief, conflicts, major live changes, and loneliness/social isolation. When possible, REBT for depression also attempts to change life events that may activate depression symptoms, but improving the protocols with specific research-based techniques for different areas, coming from IPT, could bring major improvement in the way we approach the A component of the ABC model.

Problem-Solving Therapy (PST)

Giving the fact that PST it is an intervention that is considered to be under the cognitive-behavioral umbrella, the techniques and strategies coming from this therapy should be easy to integrate in the REBT conceptualization. Even REBT protocols for depression have an important problem-solving component, some improvements and developments are needed in order be in line with latest research-based techniques. PTS does not target only practical aspects of the solving problems processes, but also takes into account other factors, focusing on two main dimensions: (1) problem orientation (beliefs, attitudes, and emotional responses to problems or to coping abilities), and (2) problem-solving style. Research identified two types of orientation toward problem, negative or positive, and three styles of resolving-problems: rational, avoidant, and impulsive/careless. Taking into account these inter-personal differences, and also incorporating strategies for overcoming major obstacles in the problem-solving process (i.e., cognitive overload, poor emotion regulation skills, biased cognitive processing, or hopelessness) could also represent a major progress for REBT interventions for depression, especially because persons diagnosed with depression very often have poor problem-solving abilities.

Brief Case Example

In this section, we exemplified a complete REBT therapy process in working with depressive disorder, on a specific case. Andrea's case presented here is intended to illustrate an evidence-based REBT approach.

Case Description

Andrea came to therapy at the suggestion of her family doctor, because she accused a poor general state, lack of energy and persistent sadness. Andrea is 42 years old, she is a single mother of a 15-year-old teenager, and works as a secretary at a local high school. Andrea had divorced a year ago, because her husband had been unfaithful to her, and she made the decision to move to her parents' home, with her son. Her main concerns regard the fact that she does not leave the house anymore, she no longer likes to do anything, and thinks she is no longer attractive. Because she feels a constant need for sleep, she is in bed for most of the time and she's blaming herself for being a bad mother. Andrea said she thought many times that the world would be a better place if she did not exist, that her child would certainly be happier and fulfilled without her. Andrea thought she was a burden for others.

The REBT Process

For a better understanding of the REBT therapy process in working with depressive disorders, we structured the implementation of the intervention in three phases.

Phase 1. Goal Clarification and the First Steps (Weeks 1–4)

In the first phase of the REBT therapy process with Andrea, the objectives were: (a) to assess the severity of depression and etiopathogenetic mechanisms—establishing a nosological diagnosis, completing therapeutic tools for the analysis of symptoms intensity (i.e. Beck Depression Inventory), and use of therapy oriented assessment techniques for causal factors analysis (i.e. Socratic questions to assess irrational and rational thoughts); (b) achieving psycho-education—education for the psychotherapy process and REBT; (c) assessing and developing realistic treatment expectations; (d) discussing the general conceptualization of depressive disorders—the ABC model was used to conceptualize Andrea's problems; (e) developing the problem list—the nosological diagnosis was translated into Andrea's specific life problems; (f) building the therapeutic relationship—characterized by empathy, unconditional acceptance, congruence, and collaboration (e.g., goal consensus, alliance, feedback); (g) practicing the ABC cognitive/ABCDE models—exercising cognitive restructuring, and (h) assigning homework—self-monitoring mood and behaviors, exercising ABC and ABCDE models, behavioral experiments that tests irrational beliefs.

Based on this protocol, in the first sessions the therapist focused on developing the clinical conceptualization, building therapeutic relationship with Andrea, psychoeducation, and developing a problem list, followed by approaching each problem from the list based on the ABCDEF model of REBT.

Phase 2. Implementation of the Plan (Weeks 5–8)

In the second phase of the REBT therapy process with Andrea, the objectives were: (a) to change irrational beliefs and develop rational ones—this work continues throughout the entire process and the therapist's role is only to guide the patient; (b) to practice new thinking patterns and functional behaviors, and (c) to give homework: the ABCDE model, activity planning, shame-attacking exercises, behavioral experiments.

In the following weeks, the therapist focused on changing and decreasing Andrea's irrational beliefs, and developing rational ones, on development and establishment of a daily program, the ultimate goal including conducting behavioral experiments (i.e. reading two pages of a book). Also, the therapist encouraged Andrea to take a larger perspective and investigate possible links between her problems, and to investigate possible common causes, such as general irrational beliefs. After changing the main irrational cognitions, when the depressive symptoms were no longer clinical, the

therapist has approached the A part of the ABC model, the activating events which occurs in Andrea's life. For this goal the therapist used problem solving techniques to teach Andrea every step of the process to deal with specific problems.

Phase 3. Generalization, Monitoring and Feedback (Weeks 9–12)

In the second phase of the REBT therapy process with Andrea, the objectives were: (a) to generalize rational thinking to real life situations; (b) to develop Andrea's independency as her own therapist; (c) to discuss relapse prevention, and (d) to offer homework: the ABCDE model in real-life situations, activity planning, identifying future problems.

During the final phase of the therapy, the therapist has focused on developing Andrea's independence, to deal with her problems in the absence of the therapist, generalizing what she learned in the real life. Andrea developed her skills to avoid relapses.

What We Have Learned about Using REBT with Depressive Disorders

Accommodating Individual Differences: Client Gender, Ethnicity, Socio-Economic Status, Intelligence and Other Factors

Achieving and maintaining change through psychotherapy is a process which can be influenced by an unlimited number of factors. While choosing an evidence-based psychological treatment is essential in efficiently treating emotional disorders, unaccounted individual differences might affect the outcome of such an intervention. In order to maximize the efficacy of the therapy, it is important to accommodate for individual differences and to personalize the treatment in accordance with the client's needs. This process should be guided by both research data and clinical judgment. Several factors which should be taken into account when offering REBT for depressive disorders are related to client gender, ethnicity, socio-economic status, cognitive functioning and intelligence, religious beliefs etc.

Women are twice as likely as men to experience depression (Nolen-Hoeksema, 2001) and there is consistent data showing that the prevalence, incidence and morbidity risk of depressive disorders is higher in women beginning at mid-puberty and throughout adult life (Piccinelli & Wilkinson, 2000). In this context, it has been suggested that it might be important to understand the ecology of depression in terms of sex role in order to efficiently treat depression (Franks, 1982). The cognitive processes which generate depressive symptoms are the same for both depressed women and men, but it was argued that society tends to reinforce more the nega-

tive messages that women tell themselves, for example the fact that they have less control over their environment and they need to be submissive, dependent or passive (Wolfe, 1985), which are related to depressive thinking. These sex-role stereotypes are thought to contribute to the development of irrational beliefs which lead to emotional and behavioral consequences like self-defeating behaviors or depression over lack of control (Wolfe & Naimark, 1991). The available data suggest that REBT for major depressive disorder is equally effective for both women and men (David et al. 2008). However, it was suggested that in case of women, REBT for depression should focus more on restructuring hopeless, helpless and self-downing cognitions given the fact that these types of thoughts are more frequently reinforced by the society in case of women (Wolfe, 1985). Also, Wolfe and Naimark (1991) assert that effective REBT with women would also mean that we should address sex-role issues with our client, challenge our own stereotypes and model nonsexist beliefs and behavior for our clients.

Another factor that might influence the effect of REBT is intelligence and cognitive functioning. Because REBT is a cognitive therapy, it is important to briefly assess the cognitive functioning of the client given that the treatment would make use of his ability of meta-thinking (thinking about thinking). In case of young children, mentally retarded individuals, people with dementia, severely psychotic individuals, teaching them rational coping statements might be more suitable than using Socratic restructuring (Ellis, 1980) given the level of cognitive functioning required for that. Also, it seems that highly intelligent people learn rational beliefs easier than people of lower intelligence (e.g., Wilde, 1996a, 1996b). But in light of these aspects, there is no data indicating that REBT for depression works only with highly intelligent people. However, in general, it is recommended to adjust the treatment according to the client capacities. Some strategies work best with bright, articulate, reflexive individuals (e.g., conjunctive phrasing, self-discovery; DiGiuseppe, Doyle, Dryden, & Backx, 2014), than with less intelligent or non-introspective clients. In these later cases, adjusting therapy would sometimes mean changing only one of his/hers irrational beliefs with which the client most resonates (Dryden & Branch, 2008), using more didactic means for restructuring thoughts and using operant principles to encourage the client to exercise these rational replacements between therapy sessions. Also, to our knowledge, there are no data showing that REBT for depression works differently as a function of socio-economic status, however an important aspect might be to adapt the language used in the therapy to the one used by the client.

The cultural or ethnic values of the individual might affect the therapy outcome if not flexibly approached. REBT is considered to be a choice therapy which "allows clients to personally select their goals and values, but informs them about the self-defeating, and society defeating results of their rigid, absolutistic adherence to their selections" (Ellis, 2002, p. 195). REBT focuses on cultural or familial rules only when they are followed rigidly and inflexibly and it does so only when clients are getting dysfunctional emotions or maladaptive behaviors they would like to change. Although it was assumed that culture has a significant influence on the development and extent of irrational beliefs (Ellis & Grieger, 1977), there is no data showing that

REBT for depression has different effects as a function of culture and ethnicity. It might be useful as a therapist to be multiculturally open-minded (i.e., know as much as you can about your client's culture) in order to make use of all the resources which will make the case for a better restructuring process. Values and religious beliefs might be other factors that could impede the therapeutic process. Accommodating the intervention to be more religiously meaningful may make it more vivid and more easily understandable for religious believers, while the beliefs and commitment of religious clients can be utilized to reduce distress and strengthen treatment gains (Nielsen, Johnson, & Ellis, 2001).

The Dos and Don'ts

There are several rational-emotive behavioral therapy works which discuss the most important dos and don'ts when working with clients while using this type of therapeutic approach (e.g., Dryden, 2006; Grieger, 1991). On the other hand, there is little specific guidance available on what to do and do not do when using REBT with clients suffering from depressive disorders. However, based on these general guidelines, the REBT protocols for depression (e.g., David et al., 2004) and the characteristics of these disorders, several recommendations can be highlighted. First, it is highly recommended to identify and target demandingness as the central irrational belief involved in depression. When this belief is not readily identified, its presence can be inferred from its derivatives, but it is changed only when the patient accepts its clinical conceptualization (David et al., 2004). Self-rating is an important part of every person's emotional disturbance and especially in case of people suffering from depression. Thus, challenging ideas about self-worth and promoting unconditional self-acceptance should be a central part of the REBT treatment. As in many cases depression is associated with psychomotor retardation or agitation, an active-directive stance meant to engage the client might be recommended. However, the pace of the therapeutic process should be accommodated to the client's needs (e.g., give them enough time to think and answer the questions), while being flexible and building a strong therapeutic alliance. Given the difficulties in thinking and concentrating, it is important to help the client stay focused while checking out that the client understands the substantive point.

There are also several aspects that, while not attended, might diminish the efficacy of REBT for depression. First, therapists should not overlook that fact that often the client experiences secondary problems as a consequence of their emotional disturbance. Failing to focus on secondary problems (e.g., depression/guilt/shame about depression) might slower and detract the process of change. Second, it is important not to fall prey to the client' self-pity and victimization and to try to protect and please him/her while not changing the must's and self-ratings (Grieger, 1991). Also, the therapist should not fall into the trap of expecting automatic change once the client has insight and motivation. Powerful restructuring requires going beyond objectively understanding and sloganizing irrational and rational beliefs, to really

think about their irrationality while practicing as homework the rational statements using a range of methods that do not only involve the glib parroting of rational beliefs. Finally, is important not to give up or panic when therapy is not progressing the way you expected or when you made some errors. Most of the times, therapy and change are not smooth processes but rather full of obstacles and resistance. Thus, is important to continually adapt while trying to find the strategies that work best for that particular client. Finally, it is important not to forget to attend to and acknowledge the client's feelings (some might be confused, other ashamed or unaware about what they feel) or to forget that the therapy involves a relationship between two human beings whose quality might affect the therapy outcome.

Which Aspects of REBT Deliver the Most Benefit for Change and Which Don't

The REBT protocol for depressive disorders includes three main components: (1) behavioral activation, (2) changing specific irrational beliefs and (3) changing general irrational beliefs (David et al., 2004). Other components that might be added are a problem solving or a coping skills module. There are several studies showing that irrationality is associated with depressed mood (Macavei, 2005; Solomon et al., 2003). To our best knowledge, there are no component analysis investigating the most efficient component of REBT for depression, but there is indirect evidence that suggest that challenging irrational beliefs is a mechanism of change. Specifically, data indicate that in a clinical trial comparing the efficacy of REBT, CT and pharmacotherapy for depression, REBT is associated with reductions in irrational beliefs which are in turn associated which changes in depressed mood (Szentagotai, David, Lupu, & Cosman, 2008). Also, changes in implicit demandingness seemed more strongly associated with reduced depression and relapse prevention at follow-up. Another important part of the treatment is the behavioral activation component. Although most REBT handbooks and clinical guides focus on cognition, behavior change is an important part of the intervention as highlighted by Ellis (1962, p. 334): "Rational emotive therapy is one of the relatively few techniques which include large amounts of actions, work and "homework" assignments of so called nonverbal nature." In fact, it was suggested that this component might explain the similarity of REBT and CT in the treatment of depression (David et al., 2008). On the other hand, problem solving (e.g., solving practical problems) and directly developing coping skills are not essential components of the treatment for depressive disorders. Future studies should directly investigate the contribution of individual components of REBT in order to dismantle the specific role of each of them.

References

Beck, A. T. (1976). *Cognitive therapy and the emotional disorders*. New York: International Universities Press.

Berg, B. (1990). *The self-control game*. Dayton, OH: Cognitive Counseling Resources.

Browne, C. M., Dowd, E. T., & Freeman, A. (2010). Rational and irrational beliefs in psychopathology. In D. David, S. J. Lynn, & A. Ellis (Eds.), *Rational and irrational beliefs in human functioning and disturbances* (pp. 149–171). Oxford: Oxford University Press.

David, D. (2010). *Retmagia şi minunatele aventuri ale lui Retman. Poveşti raţionale pentru copii şi adolescenţi [Retmagic and the wonderful adventures of Retman. Stories for children and adolescents].* Cluj-Napoca: RTS Cluj.

David, D., Cotet, C., Matu, S., Mogoase, C., & Stefan, S. (2017). 50 years of rational-emotive and cognitive-behavioral therapy: A systematic review and meta-analysis. *Journal of Clinical Psychology*. https://doi.org/10.1002/jclp.22514.

David, D., Kangas, M., Schnur, J. B., & Montgomery, G. H. (2004). *REBT depression manual; Managing depression using rational emotive behavior therapy*. Romania: Babes-Bolyai University (BBU).

David, D., Schnur, J., & Belloiu, A. (2002). Another search for the "hot" cognitions: appraisal, irrational beliefs, attributions, and their relation to emotion. *Journal of Rational-Emotive & Cognitive-Behavior Therapy, 20,* 93–131.

David, D., Szentagotai, A., Lupu, V., & Cosman, D. (2008). Rational emotive behavior therapy, cognitive therapy, and medication in the treatment of major depressive disorder: A randomized clinical trial, posttreatment outcomes, and six-month follow-up. *Journal of Clinical Psychology, 64*(6), 728–746. https://doi.org/10.1002/jclp.20487.

Davison, G. C., Robins, C., & Johnson, M. K. (1983). Articulated thoughts during simulated situations: A paradigm for studying cognition in emotion and behavior. *Cognitive Therapy and Research, 7,* 17–40.

DiGiuseppe, R. A., DiGiuseppe, R., Doyle, K. A., Dryden, W., & Backx, W. (2014). *A practitioner's guide to rational-emotive behavior therapy*. New York: Oxford University Press.

DiGiuseppe, R., Leaf, R., Exner, T., & Robin, M.W. (1988). *The development of a measure of rational/irrational thinking.* Paper presented at the World Congress of Behavior Therapy, Edinburgh, Scotland.

Dryden, W. (2006). *First steps in REBT. A guide to practicing REBT in peer counseling*. New York: Albert Ellis Institute.

Dryden, W., & Branch, R. (2008). *Fundamentals of rational emotive behaviour therapy: A training handbook*. New-York: Wiley.

Ellis, A., & Grieger, R. (1977). *Handbook of rational-emotive therapy*. New York: Springer.

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

Ellis, A. (1980). Rational-emotive therapy and cognitive behavior therapy: Similarities and differences. *Cognitive Therapy and Research, 4*(4), 325–340.

Ellis, A. (1987). A sadly neglected cognitive element in depression. *Cognitive Therapy and Research, 11*(1), 121–145. https://doi.org/10.1007/BF01183137.

Ellis, A. (1994). *Reason and emotion in psychotherapy* (re ed.). Secaucus, NJ: Birch Lane.

Ellis, A. (1997). Must musturbation and demandingness lead to emotional disorders? *Psychotherapy: Theory Research, Practice, Training, 34*(1), 95–98.

Ellis, A. (2002). *Overcoming resistance: A rational emotive behavior therapy integrated approach*. New York: Springer Publishing Company.

Ellis, A., & Abrams, M. (1994). *How to cope with a fatal disease*. New York: Barricade Books.

Emmelkamp, P. M., Kuipers, A. C., & Eggeraat, J. B. (1978). Cognitive modification versus prolonged exposure in vivo: A comparison with agoraphobics as subjects. *Behaviour Research and Therapy, 16*(1), 33–41.

Engels, G. I., Garnefski, N., & Diekstra, R. F. (1993). Efficacy of rational-emotive therapy: A quantitative analysis. *Journal of Consulting and Clinical Psychology, 61*(6), 1083–1090.

Franks, V. (1982). *Psychotherapy and women: Letter No. 79.* Belle Mead, NJ: Carrier Foundation.
Friedberg, R. D., Mason, C., & Fidaleo, R. A. (1992). *Switching channels: A cognitive-behavioral work journal for adolescents*. Sarasota, FL: Psychological Assessment Resources.
Gotlib, I. H., & Hamilton, J. P. (2008). Neuroimaging and depression: Current status and unresolved issues. *Current Directions in Psychological Science*, *17*(2), 159–163.
Grieger, R. M. (1991). Keys to effective RET. In M. E. Bernard (Ed.), *Using rational-emotive therapy effectively a practitioner's guide* (pp. 35–67). New York: Springer Science & Business Media.
Iftene, F., Predescu, E., Stefan, S., & David, D. (2015). Rational-emotive and cognitive-behavior therapy (REBT/CBT) versus pharmacotherapy versus REBT/CBT plus pharmacotherapy in the treatment of major depressive disorder in youth; a randomized clinical trial. *Psychiatry Research, 225*(3), 687–694. https://doi.org/10.1016/j.psychres.2014.11.021.
Lewinsohn, P. M. (1974). A behavioral approach t o depression. In R. M. Friedman & M. M. Katz (Eds.), *The psychology of depression: Contemporary theory and research*. New York: Wiley.
Lyons, L. C., & Woods, P. J. (1991). The efficacy of rational-emotive therapy: A quantitative review of the outcome research. *Clinical Psychology Review, 11*(4), 357–369. https://doi.org/10.1016/0272-7358(91)90113-9.
Macavei, B. (2005). The role of irrational beliefs in the rational emotive behavioral theory of depression. *Journal of Cognitive and Behavioral Psychotherapies, 5*(1), 73–81.
Macavei, B., & McMahon, J. (2010). The assessment of rational and irrational beliefs. *Rational and Irrational Beliefs: Research, Theory, and Clinical Practice*, 115–147.
MacLaren, C., Doyle, K. A., & DiGiuseppe, R. (2016). *Rational emotive behavior therapy (REBT): Theory and practice*. London: Sage Publications Inc.
Malouff, J. M., & Schutte, N. S. (1986). Development and validation of a measure of irrational beliefs. *Journal of Consulting and Clinical Psychology, 54,* 860–862.
McDermut, J. F., Haaga, D. A. F., & Bilek, L. A. (1997). Cognitive bias and irrational beliefs in major depression and dysphoria. *Cognitive Therapy & Research, 21,* 459–476.
Nelson, E. (1977). Irrational beliefs in depression. *Journal of Consulting and Clinical Psychology, 45,* 1190–1191.
Nielsen, S. L., Johnson, W. B., & Ellis, A. (2001). *Counseling and psychotherapy with religious persons: A rational emotive behavior therapy approach*. Mahway, NJ: Erlbaum.
Nolen-Hoeksema, S. (2001). Gender differences in depression. *Current Directions in Psychological Science, 10*(5), 173–176.
Norton, P. J., & Hope, D. A. (2001). Analogue observational methods in the assessment of social functioning in adults. *Psychological Assessment, 13*(1), 59–72.
Padesky, C. A. (1993). *Socratic questioning: Changing minds or guiding discovery*. In A keynote address delivered at the European Congress of Behavioural and Cognitive Therapies, London (Vol. 24).
Phadke, K. M. (1982). Some innovations in RET theory and practice. *Rational Living, 17*(2), 25–29.
Piccinelli, M., & Wilkinson, G. (2000). Gender differences in depression. *The British Journal of Psychiatry, 177*(6), 486–492. https://doi.org/10.1192/bjp.177.6.486.
Prud'homme, L., & Barron, P. (1992). The pattern of irrational belief associated with major depressive disorder. *Social Behavior and Personality*, 20, 199–212.
Riva, G., Molinari, E., & Vincelli, F. (2002). Interaction and presence in the clinical relationship: Virtual reality (VR) as communicative medium between patient and therapist. *IEEE Transactions on Information Technology in Biomedicine, 6*(3), 198–205.
Sava, F. A., Yates, B. T., Lupu, V., Szentagotai, A., & David, D. (2009). Cost-effectiveness and cost-utility of cognitive therapy, rational emotive behavioral therapy, and fluoxetine (Prozac) in treating depression: a randomized clinical trial. *Journal of Clinical Psychology, 65*(1), 36–52. https://doi.org/10.1002/jclp.20550.
Seligman, M. E. P. (1981). A learned helplessness point of view. In L. P. Rehm (Ed.), *Behavior therapy for depression*. New York: Academic Press.

Solomon, A. (1998). *The Specific demands on self scale.* Unpublished manuscript, Stanford University.

Solomon, A., Arnow, B. A., Gotlib, I. H., & Wind, B. (2003). Individualized measurement of irrational beliefs in remitted depressives. *Journal of Clinical Psychology, 59*(4), 439–455. https://doi.org/10.1002/jclp.10081.

Solomon, A., Haaga, D. A. F., Brody, C., Kirk, L., & Friedman, D. G. (1998). Priming irrational beliefs in recovered-depressed people. *Journal of Abnormal Psychology, 107,* 440–449.

Szentagotai, A., David, D., Lupu, V., & Cosman, D. (2008). Rational emotive behavior therapy versus cognitive therapy versus pharmacotherapy in the treatment of major depressive disorder: Mechanisms of change analysis. *Psychotherapy: Theory, Research, Practice, Training, 45*(4), 523–538. https://doi.org/10.1037/a0014332.

The National Institute for Health and Care Excellence. (2009). Depression: the treatment and management of depression in adults. *Clinical Guidelines*, CG90.

Vîslă, A., Flückiger, C., Grosse Holtforth, M., & David, D. (2016). Irrational beliefs and psychological distress: A meta-analysis. *Psychotherapy and Psychosomatics, 85*(1), 8–15.

Waters, V. (1980). *Series of stories for children: Cornelia Cardinal learns to cope; Fasha, Dasha and Sasha Squirrel; Flora Farber's fear of failure; Freddie Flounder; Maxwell's magnificent monster*. New York: Institute for Rational Living.

Wilde, J. (1996a). The efficacy of short-term rational-emotive education with fourth-grade students. *Elementary School Guidance and Counselling, 31*(2), 131–138.

Wilde, J. (1996b). The relationship between rational thinking and intelligence in children. *Journal of Rational-Emotive and Cognitive-Behaviour Therapy, 14*(3), 187–192.

Wolfe, J. L. (1985). Women. In A. Ellis. & M. Bernard (Eds.), *Clinical applications of rational-emotive therapy* (pp. 101–127). New York: Plenum Press.

Wolfe, J. L., & Naimark, H. (1991). Psychological messages and social context strategies for increasing RET's effectiveness with women. In M. E. Bernard (Ed.), *Using rational-emotive therapy effectively a practitioner's guide* (pp. 265–301). New York: Springer Science & Business Medica.

Wright, J. H., Wright, A. S., Albano, A. M., Basco, M. R., Goldsmith, L. J., Raffield, T., & Otto, M. W. (2005). Computer-assisted cognitive therapy for depression: maintaining efficacy while reducing therapist time. *American Journal of Psychiatry, 162*(6), 1158–1164.

REBT and Suicide

Ennio Ammendola

Key REBT Theoretical Concepts in Working with Suicide

Suicide is a leading cause of death worldwide, killing more than 800,000 people each year (World Health Organization [WHO], 2014). For therapists, the assessment, management, and treatment of suicidality is one of the most challenging and stressful clinical tasks (Jobes, 1995).

To date, Rational Emotive Behavior Therapy (REBT) has failed to offer a clear conceptualization of suicidal thinking and behavior. Moreover, there has been a paucity of research on REBT treatment for the patients at risk of suicide. Indeed, the REBT literature has shown only marginal interest in applying the principles of REBT to the study of suicide. In 1989, Albert Ellis published an article in the *Journal of Individual Psychology* entitled "Using Rational-Emotive Therapy (RET) as Crisis Intervention: A Single Session with a Suicidal Client" in which he claimed that RET was also useful with crisis intervention in the case of a patient at risk of suicide. Consistent with Albert Ellis' initial notion of the effectiveness of RET with patients at risk of suicide, Ellis and Newman (1996) authored the only book that speaks directly to the issue of suicide and the application of REBT to a suicidal population. Their work represented the first REBT self-help guide for the patients at risk of suicide, and was intended to provide the patients with a better understanding of the factors that led them to consider suicide, as well as a guide to surviving a suicidal crisis. It is my intention in this chapter to present a novel REBT theory of suicide and suicidality that I have developed to better understand the developmental stages that potentially lead someone to attempt suicide. A theory of suicide is critical because facts in the absence of a theoretical context, are not sufficient to advance the field's collective knowledge about the causes of suicidal behaviour (Gunn & Lester, 2014). This novel theory, entitled "the Suicidaction Potential Theory" (SPT), conceptualizes

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any suicide attempt as a sequence of "activation phases." The SPT is a three-phase model (see Fig. 1) that conceptualizes the construct of suicidality as a gradual process rather than a static construct. The SPT maps the relationships among background factors such as biological factors, environmental factors, and psychosocial stressors; relationships among suicidal cognitions, suicidal emotions, and suicidal behaviors; and, finally, relationships among rumination factors, habituation factors, and the unconditional suicidality identity (USI), which is itself characterized by the presence of the triangle anti-self, death, and suicide. In brief, the SPT suggests that suicidal attempts result from the complex interplay of factors that represent several "activation phases," which lead someone to attempt suicide. The first phase is represented by biological, physiological, and psychosocial stressors in terms of life events, which represent the background factors that (if activated or not) determine the transition or lack of transition to the next phases. If these background factors become activated suicidal triggers, then the suicidality formation proceeds to the next phase represented by suicidal cognitions, suicidal emotions, and suicidal behaviors. These three factors are not activated in a predetermined order, but they are susceptible to the patients' suicidality narrative. Each narrative is unique and can initially activate one factor over the others, but it is important to recall that these three factors need to be clearly identified before advancing to the next and final phase. The third phase is comprised of three factors as well, but contrary to phase two, they follow a linear progression of rumination factors first, habituation factors second, and the USI factors third. Consistent with the SPT description, the patients attempt suicide at the USI stage, and in case they survive, then they tend to reactivate the same three phases again.

Definitionally, the word suicide describes the act of taking one's own life but does not describe the process of contemplating suicide, a process better described by the term "suicidality." The SPT introduces a new way of conceptualizing some of the most important factors that lead the patients to consider suicide. The traditional framework of REBT has, since its inception, emphasized the three main psychological aspects of human functioning: thoughts, emotions, and behaviours, with the understanding that these three processes are almost always intertwined and interrelated, and that changes in one will often produce changes in the others (DiGiuseppe, Doyle, Dryden, & Backx, 2014). While I continue to subscribe to this framework, it has become apparent to me in working for the last decade with many patients at imminent risk of suicide that these three core psychological components, in and of themselves, do not fully address the process of escalation from suicidal ideation-to-action.

Several theories have sought to provide a conceptualization of this "suicidal ideation-to-action" trajectory. These theories include the Interpersonal Theory (IPTS) (Joiner, 2005), the Integrated Motivational-Volitional Model (IMV) (O'Connor, 2011), the Three-Step Theory (3ST) (Klonsky & May, 2015), and the Fluid Vulnerability Theory (FVT) (Rudd, 2006). These theories are in agreement in positing that the development of suicidal ideation and the progression from suicidal desire to a suicidal attempt are distinct processes with distinct explanations (Klonsky, Saffer, & Bryan, 2017).

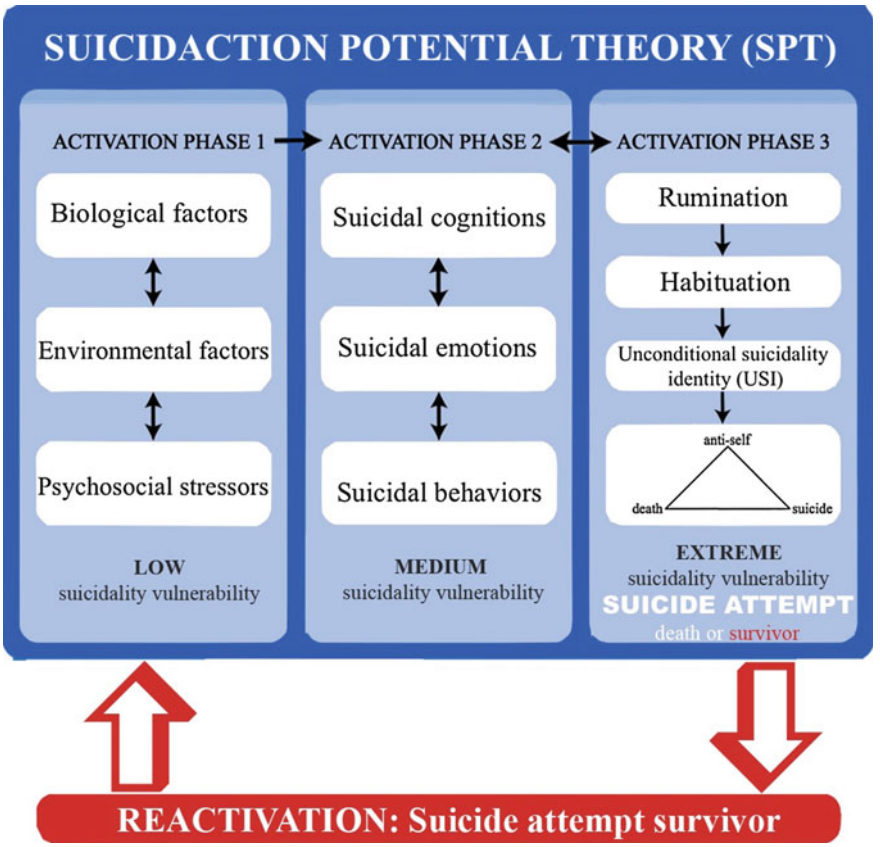

Fig. 1 Suicidaction Potential Theory. © 2017 Ennio Ammendola

In developing the SPT, I conceived of an "ideation-to-action" framework as well for understanding suicidality as process of escalation that culminates in the taking of one's own life.

Key areas of the SPT are described as follow:

Biology, Environment and Psychosocial Stressors: these three components represent the immediate and initial activation in the patient who has been contemplating a suicide attempt.

Behavioral Response: the patient's behavioral response describes, quite simply, actions taken within the suicidality process context.

Emotional Response: at the beginning, the patients' emotional responses are often characterized by unhealthy negative emotions (UNEs) such as anxiety, depression, guilt, shame, hurt, unhealthy anger, unhealthy jealousy, and unhealthy envy (Dryden, 2009).

Belief System: often, the patients' cognitive responses, which serve as the foundation of therapeutic work, are characterized by extreme and rigid beliefs, such as a awfulizing beliefs, frustration intolerance beliefs, depreciation beliefs, and demandingness (Dryden, 2009).
Rumination: in this stage, the patients struggle to consider alternative perspectives or to see the possibility of alleviating their suffering. Rumination leads to overthinking (in this case suicidal overthinking), which Nolen-Hoeksema (2006) described as the process of going over a situation in one's mind, fixating on the feeling it provokes, rehashing things that have happened before, worrying about the future, and being unable to make decisions in the present.
Habituation: it is the patient's tendency to become accustomed to and comfortable with their current ways of thinking to the point that their suicide beliefs become their "only" cognitive reality.
Unconditional Suicidality Identity (USI): it is the final step in the process that culminates in the full activation of the SPT. Indeed, the USI represents the deadly triad of anti-self, death, and suicide. The term unconditional underscores that, at this stage, the patients have accepted their condition of wanting to end their lives and see suicide as non-negotiable—the only solution for their current suffering. Finally, one may also define it as suicidal blindness.

Key Best-Practices in REBT-Based Assessment Treatment in Working with Suicide

A critical principle of REBT is that therapists don't prioritize to change the A (practical solution) unless there is a good reason to do it. On the other hand, my work with the patients at imminent risk of suicide has forced me to reconsider this position. The presence of suicidal thinking is so overwhelming for the patients that in order to control it, they focus solely on the A, which in REBT terms directly translates into a specific suicidal "A" (the suicidal situation/trigger). At times, I have found more effective to work immediately on the A because most suicide narratives are based on the description of the A (This happened to me…) rather than on B (Life should not be so hard) or C (I feel depressed/suicidal). The patients at imminent risk of suicide use suicidal narratives characterized by thinking that is so constricted that they are no longer aware that a thinking process is even involved in their narratives. Furthermore, at times the IBs are implicit instead of explicit. The therapist tries to identify the IBs by asking "What were you thinking when you felt_____about_____" and the patient replies "I wasn't thinking about anything in particular." Therapist sometimes interpret this response as a form of resistance, but the patients sometimes have only implicit IBs and are unable to describe them. For many patients at risk of suicide, important material remains walled off from conscious awareness. Indeed, studies show that implicit cognitions predict suicidal behaviors (Nock et al., 2010), and the

responsibility of the REBT therapist is to help these patients to understand the role of "B" rather than to avoid "B" because it is hard to retrieve in session.

Knowing that struggling to abandon A-C thinking is regarded by REBT as an important error in cognition (Dryden & Neenan, 2012), therapists need to work with A-C thinking patterns with the patients at imminent risk of suicide. In working with the patients at imminent risk of suicide, I have noticed that most of them present information in A-C rather than B-C terms. I think that the A-C connection is preferred by the patients because it is consistent with restrictive/narrowing cognitive thinking and the presence of implicit cognitions. When thinking about suicide, the patients tend to restrict their attention and analytical skills to one suicidal episode. In so doing, they bypass their beliefs in focus instead on the A-C connection. In terms of a psychological economy, the patients are able to "optimize" their experience of suicidality with the following construction: "Something happened (A) and I feel suicidal (emotional C) so it makes sense to kill myself (behavioral C)." Moreover, I have noticed that the patients at risk of suicide tend to present short statements about wanting to end their life, and I have often noticed with surprise that they rarely combine IBs. It is rare to hear in session: "I am worthless and this is terrible so I must kill myself". Qualitatively, it seems as though a "suicidal economy" leads the patients to formulate short but effective sentences about their decision to kill themselves. Indeed, they tend to utilize only one of the following IBs: "I cannot stand this pain and I have decided to stop everything" (frustration intolerance), "I am so worthless that I have decided to kill myself" (global evaluation of human worth), "I absolutely must kill myself to solve my problems" (demandingness), and finally, "It is terrible what it is happening to me, I am going to stop this" (awfulizing).

Although this perspective may in fact be valuable to the patient in that it optimizes the experience of suicide, it is nonetheless problematic because it does not allow patients to spend precious time identifying their IBs and subsequent B-C connections. The A-C connection does not represent a problem for the patients because they seek a practical solution to their problems, which of course poses a problem for the REBT therapists who don't prioritize changing the A (practical solution) unless there is a good reason to do it.

Unfortunately, some therapists disregard the importance of the initial A-C connection and force the patients to generate suicidal thinking patterns immediately. If forced, the patients are not yet ready to work on the B-C connection, and this pressure leads to therapist-patient resistance. To address this struggle proactively, I have developed a new way of utilizing the original ABC model (activating event/beliefs/consequences). The new sequence is represented by an ABBC approach (activating event/bypassing beliefs/consequences) that prevents therapists from forcing the patients to generate thinking patterns prematurely. By utilizing the ABBC model in its general form, it emerges that A stands for an event, BB stands for bypassing the belief (still implicit) about that event, and C stands for the consequences (usually emotional) of holding the belief B. Indeed, the ABBC enables the patients to realize that when they disturb themselves, they do it in a specific situation (A) and that their emotional disturbance (C) is largely explained also by implicit irrational beliefs (BB) that they are not aware they hold in situation (A) in which the

disturbance is experienced. In adapting Shea's (2002) work on suicide assessment to my REBT theoretical principles, I have reframed the A with respect to 4 major components of the patient's suicidality: the Past A (activating event from previous attempts), the Recent A (activating events that are not imminent risk factors but are still freshly remembered by the patient), the Present A (activating event at the centre of the patient's attention in our current session), and finally, the Immediate A (the A that puts the patients at high risk of attempting suicide).

Another risk of addressing the B and C before having fully worked on the A is the invalidation of the patient's narratives. Hollander (2008) defines validation as the ability to communicate to the patients that the therapist understands his or her experience. At times, the patients have interrupted me while I addressed the B-C connection prematurely, saying "You do not understand what I am telling you….it happened because of my partner…not because I was depressed or I was telling myself something." Since the patients at imminent risk of suicide need immediate assistance, the therapist faces the following dilemma: "Do I need to identify a specific aspect of the A or do I just use the general A that the patient shared with me?" The patients usually highlight some details within the A narrative and I always attune myself to them. Specifically, I use an approach with the suicidal patients outlined by Dryden (2013), who revised the ABCs of REBT and emphasized a focus on the part of the situation (in our case the suicidal situation) that "activates" the patients' beliefs rather than the situation itself (p. 84).

Finally, I suggest first working on the A-C connection without introducing the B into therapeutic work. Only after having engaged in such a validating dialogue do I invite the patients to focus on their cognitive patterns, and only after that I do educate them about their B-C connections.

I Am Feeling "Suicidal"

At present, there is scant research on REBT and suicide, but some previous data in its application to suicidal adolescents suggested that adolescents contemplating suicide did so in connection with beliefs and/or irrational cognitions (originating with "B") (Wood, Barker, & Turner, 1991). Consistent with this finding, a review by Brown, Beck and Steer (2000) highlights many unhealthy emotions associated with irrational beliefs, such as anger, guilt and shame, and psychopathological conditions including depression, anxiety, and suicidal thoughts.

It is not uncommon in session to hear "I feel suicidal." Feeling suicidal in strict REBT terms is not one of the unhealthy negative emotions (UNEs), and I do not redirect suicidal patients to other emotions. Rather, I invite them to experience the suicidal feeling without trying to rename it because such reframing would not validate their emotional state. Moreover, I do not wish to interrupt their suicidal narrative. I tend to reframe the feeling of "being suicidal" in REBT terms by using one of the UNEs later in rather than at the beginning of sessions. If I force the patients to reframe their suicidal feelings in UNEs terms, they often react by telling me:

"What do you know about feeling suicidal? You have never felt like this in your life." Perhaps REBT therapists will one day come to regard "feeling suicidal" as a UNE and "feeling life-giving" as an HNE.

REBT and the Gradient Nature of Suicidality

The most important task in working with the patients' suicide narratives is to identify the moment when they activated the suicidal "crisis." As REBT therapists, it is imperative that we understand the unique degree of vulnerability of each patient in order to figure out why certain situations carry considerably greater risk than others. Another important aspect of the intervention is educating the patients about the nature of suicidality. It is critical that therapists help the patients to develop a "suicide vocabulary" in order to improve their understanding of their own experience. I have struggled for several years in my efforts to educate the patients in this regard, and have often found myself providing explanations that were too abstract or academic. Yet while walking in Manhattan one day, I was struck by an image on a billboard depicting a gigantic domino and thought to myself: "To explain the gradient nature of suicidality, I need to use something simple like a domino metaphor!" The domino effect metaphor has been very helpful in that it helps the patients to understand that suicidality is not a phenomenon that happens out of the blue/overnight but rather develops over a long period of time as a result of many different factors. In the domino metaphor, all of these factors are represented by each of the pieces of the domino set, and in explaining it to the patients, I always describe each piece of the domino set as representing one factor in their experience of suicidality. Since I first conceived of the domino metaphor, I have added two ideas that I believe help the patients to understand their experience. First, I tell the patients that not all domino structures are the same—some are linear and easier to identify while others are very long and geometrically complex. Second, I explain that before we identify the pieces of the domino structure, we must first have a better understanding of when and why the first piece fell. Finally, I explain that our collaborative work requires steadying those pieces that are poised to fall next. I have found that this explanation gives the patients a sense of control that has been previously lacking in their struggle with suicidal thoughts and impulses. While the patients are usually open to this notion of preventing the next domino pieces from falling, one patient told me: "I like seeing my pieces going down because this is the only solution…I am not going to be the one who stops them for sure!" In such instances, I introduce a more advanced explanation in order to engage the patient's attention. Specifically, I educate the patients about the three main phases of their suicidal development: (1) what happened at the outset at this sequence of events to trigger the unfolding of a suicidal trajectory, (2) what is happening in the present moment, and (3) what it is going to happen if they do not decide to work on preventing the further toppling of domino pieces.

At the initial stage, the patient usually acknowledges the domino pieces that have already fallen and are able to describe the events that set in motion his or her emotional

downward spiral. At this stage, I always ask the patients: "When you saw the first piece going down, did you try to stop it or were you passively witnessing the rest of the pieces going down?".

Furthermore, it is in this middle phase that I have found that most patients seek help from therapists. They share that they have seen the first pieces fall but are now trying to do something about it or are trying to understand why they are still unable to solve their problems. At this stage, most of the clinical material that can be used to formulate an intervention amounts to: "I am still going down…rescue me!" or "I am doing already something but unsuccessfully, please help me!" Additionally, in the end phase, clinical interventions are future-oriented and help the patients to see that they are capable of taking action to help themselves and relieve their suffering. The most important intervention in this phase entails helping the patients to work toward unconditional suicidality acceptance (USA). This work requires communicating to the patients that "even if you have been feeling suicidal and you have attempted to kill yourself previously, it does not mean that there is nothing that can be done to help you. You need to acknowledge/accept the reality that 'being suicidal' is not going to disappear and will occasionally resurface but that you can still have a productive life and pursue your future by feeling life-giving as a HNE."

Finally, in working with the patients at risk of suicide, I have come to understand that the conventional framework of a single, weekly 45-min session is inadequate. Indeed, the scheduling of sessions (how many days per week and duration of the session 45/60/90 min) must occur in a dimensional rather than categorical manner. Moreover, such decisions should be made based on whether the patient poses a low, moderate, or imminent risk to him or herself.

REBT for Suicidality: Empirically–Supported Treatment Guidelines

Despite the magnitude of suicide as a worldwide phenomenon, a considerable gap still exists between what is known about suicide and what we must know in order to develop effective preventive treatments. Indeed, it remains unclear what specific strategies are effective at reducing suicidality (Weinberg & Klonsky, 2009). Nonetheless, a new study shows that most people who attempt suicide have some kind of encounter with the healthcare system in the weeks or months before the attempt, such as a visit to a physician (Ahmedani et al., 2015). Overall, the Institute of Medicine (2015) reported that over 90% of suicides in the U.S. are associated with mental illness. The assumption that people who kill themselves are mentally ill has led the contemporary research on suicide to focus mostly on mental illness, thus shifting focus away from a "stress-model" understanding of suicide, which emphasized stressors such as school, family, work and social problems.

Consistent with the mental illness model of suicide, Goldblatt and colleagues (2012) reviewed all the publications in the three main international suicide research

journals such as Archives of Suicide Research (ASR), Crisis, and Suicide and Life-Threatening Behavior (SLTB) for the years of 2006–10. In all three journals, they found a preponderance of epidemiological and risk factors studies ranging from 41 to 45%. In SLTB, 67% of the studies were conducted in the United States, which makes the results less generalizable to other sociocultural contexts. One question worth considering is whether finding the same quantitative risk factors as in previous studies represents a useful contribution to the research on suicide prevention. It could logically be assumed that more qualitative research is needed to help answer the question of why people kill themselves (Kral et al., 2016). Furthermore, one interpretation of these findings is that the focus on empirical data on mental illness could suggest that receiving inpatient treatment is more effective at preventing suicide, although there is no research to support this notion. Inpatient treatment has proven perhaps ineffective for suicidality because the typical length of staying in inpatient care in the US is inadequate (Pottick, McALpine, & Andelman, 2000). Surprisingly, a recent meta-analysis during the period from January 1, 1946, to May 1, 2016 on the risk of suicide, found that a recent psychiatric hospitalization was the single greatest suicide risk factor, and that the post-discharge suicide rate was roughly 100 times the global suicide rate during the first 3 months following discharge (Chung et al., 2017). It should be noted, however, that, the continuity of care after inpatient treatment is still poor (Appleby et al., 1999), and this may explain some of the relationship between psychiatric hospitalization and suicidality.

Although compelling evidence from randomized clinical trials (RCTs) on evidence-based psychotherapy to prevent suicide is limited, a number of RCTs suggest that certain interventions do effectively treat suicidality and reduce suicidal ideations. Cognitive Behavioral Therapy for Suicide Prevention (CBT-SP) with recent suicide attempters was found to be effective because previous attempters were 50% less likely to reattempt than participants who received enhanced usual care (EUC) (Brown et al., 2005). Supporting this study, REBT therapists need to be selective when choosing to implement cognitive, emotive, or behavioral strategies. The interchangeability of these strategies gives REBT therapists a degree of flexibility when implementing the disputation. If the patient's IB is already available, they can use cognitive strategies; they can use role-playing or rational-emotive imagery as emotive strategies to improve a patient's emotional changes; finally, they can implement exposure or risk-taking exercises as behavioural strategies to change the beliefs that certain behaviors are too dangerous to take. Emerging research (Comtois et al., 2011) also supports the notion that participants who receive collaborative assessment and management of suicidality (CAMS), an approach that focuses on identifying causes of suicidal ideation and treatment goals, experienced a significantly greater and sustained reduction of suicidal ideations at 12 months post-treatment compared to treatment as usual (TAU). In support of these findings, it becomes very important for the REBT therapist to establish with the patients the specific long-term goals of therapy within the first few sessions as well as weekly short-term treatment-plan goals. For example, an REBT therapist can ask, "How can you accomplish your goals of connecting with others if you don't go out and allow yourself to talk to others?" In addition, Dialectical Behavioral Therapy (DBT), a form of cognitive behavioral

treatment for the patients who meet the criteria for Borderline Personality Disorder and who are at risk of suicide, has been found to be more effective in reducing suicide attempts relative to community treatment by expert (Linehan et al., 2006). As a consequence, REBT therapists help patients to progress toward unconditional self-acceptance (USA) in order to acknowledge their suicidality fallibility and flaws by fully accepting themselves, their existence, and their right to live and be as happy as they can even if they are currently coping with their suicidality (Ellis & Harper, 1961).

Finally, mentalization-based treatment (MBT), a psychoanalytically-oriented partial hospitalization program also focusing on BPD, was found to be more effective than general psychiatric services in reducing suicidal and self-mutilatory acts (Bateman & Fonagy, 1999).

Moreover, pharmacology research indicates that clozapine for schizophrenia was the first FDA-approved medication in 2003 with anti-suicide effects. Cipriani, Pretty, Hawton and Geddes (2005) also found Lithium to be more effective than other medications in preventing suicide, although this literature does not include full scale RCTs.

Finally, the evidence for the effectiveness of antidepressants for suicide prevention is mixed: studies showed that Selective Seretonin Reuptake Inhibitors (SSRIs) were associated with a lower suicide risk in adults with depression, but there is also evidence that they increase suicidality in adolescents (Cuffe, 2004). REBT therapists should always take into consideration patients' use of medication, response to the medication, doses, and the side effects.

Limits of Research on Suicide Prevention

Although there is evidence that some psychotherapies are effective for reducing suicidality, limitations must also be acknowledged. Brown and Jager-Hyman (2014) underlined several limitations to the current state of the research on suicide prevention, including the paucity of RCTs to detect deaths by suicide, the exclusion from research of the patients at imminent risk of suicide, and the limited number of psychotherapy RCTs focusing of many at-risk populations, including older adults, veterans, military members service, lesbian, gay, bisexual, transgender, queer, and finally Native Americans. An additional and critical gap is the absence of consensus among researchers regrading terms and definitions used to describe suicide attempts, ideations and other related behaviors. This limitation poses significant challenges for the implementation of psychotherapy manuals.

Clearly, much work remains to be done to develop a comprehensive understanding of suicidality in research. Still, a review of treatment manuals for empirically supported psychological treatments for suicidal patients from 1970 to 2007 revealed that the most efficacious treatments in reducing suicidal risk were those implementing common interventions such as: a clear treatment framework, a defined strategy for managing suicide crises, a close attention to affect, an active-participatory therapist

style, and the use of exploratory and change-oriented interventions (Weinberg et al., 2009).

Brief Case Example

The patient is a 42-year-old male referred for therapy by his wife following the resurfacing of suicidal thoughts. The patient was 24 when he was diagnosed with Bipolar Disorder 1 after experiencing his first manic episode, during which he experienced reports racing thoughts, struggled to concentrate, and was unable to sleep for two days. This episode coincided with his first hospitalization and after this initial episode, the patient experienced two additional manic episodes and several episodes of depression. It is during these depressive episodes that the patient experienced suicidal thoughts. For the past few weeks, the patient has felt unusually depressed and found it increasingly difficult to concentrate at work. He reports having experienced intense suicidal thoughts and was unable to focus on his daily responsibilities. The patient was often unfocused, unmotivated, and lethargic. He has called in sick on several occasions, which is quite unlike him. Lacking energy, he spends most of his sick days in bed and sleeps often. Lately he has also been very self-critical, and his negative thoughts have led him to contemplate suicide. This episode is not his first experience of suicidality, he attempted to kill himself five years earlier by overdosing on psychotropic medication. Finally, he also presents with ruminative thinking, and his main clinical profile is characterized by self-downing, shame, depressive thinking, and suicide as "solution to all my problems."

In working with this patient, my REBT conceptual framework was based on three key elements that are not always sequential in their application: assessment, "Understanding the Person in the Context of his Suicidality" (UPCS), and intervention.

Assessment Phase

My initial assessment is focused on two of the most important factors in the healing process: the therapeutic alliance and the patient's willingness to have a purposeful collaborative relationship with me in treatment. Furthermore, after having established these foundational elements of treatment, I devote considerable attention to the following tasks: assessing the patient's relationship to the phenomenon of suicidality ("Just the idea that it is there, it is reassuring to me to go on in my life because I know that I can rely on it if everything goes bad"); asking the patient about his feelings about having survived possible previous suicide attempts, ("How do you explain the fact that you are sitting here in the room with me and you are still alive?"); assessing for risk factors (these risks do not describe specifically the patient I am working with but they represent factors that can be applied to a larger population), for protective factors (factors that make the patients less likely to consider suicide) and for risk

predictors (which indicate the presence of an imminent likelihood to kill themselves (Shea, 2002).

"Understanding the Person in the Context of His Suicidality" (UPCS)

Following the assessment phase, I emphasize what Dryden (1998) described as "Understanding the Person in the Context of his Problems" (UPCP). In applying this concept to working with this suicidal patient, I refer to it as the "Understanding the Person in the Context of his Suicidality" (UPCS). I considered the application of the UPCS with this patient in terms of:

1. **Basic information about the patient's suicidality**: Unusually depressed, increased difficulties concentrating at work, often unfocused, unmotivated, and lethargic. Lacking energy, sleeps often, very self-critical (I am not good enough for my family; I am not a good father; I am not a good husband), negative thoughts (I cannot stand to spend the rest of my life like this) leading him to contemplate suicide (I absolutely must kill myself to solve my problems).
2. **The patient's relationship with suicidality**: "I know that suicide is there for me in case I need it. When I think about suicide, I think about a way to escape."
3. **Time table in which the patient developed suicidality for the first time and for subsequent episodes**: He was 24 years old, hospitalized, and given a diagnosis of Bipolar disorder 1. After this initial episode, the patient has had recurrent episodes in which he experiences suicidal thoughts, mostly when under stress at work or at home.
4. **Suicide attempts**: One by overdosing on psychotropic medication.
5. **Risk factors**: stress at work and/or not taking medication; **Protective factors:** his two sons and his wife; **Risk predictors**: stress at work, not taking medication, and staying by himself.
6. **Suicide crisis**: "I am not good enough" and "People are going to see how sick I am."
7. **Coping mechanisms**: Reading, listening to music, taking a walk with the dog, going out with his two sons.
8. **Suicidal contextual C**: Depression, shame, and anxiety about his depression.
9. **Suicidal contextual A**: Inability to leave his bedroom.
10. **Suicidal contextual IBs/RBs**: "I am not good enough"; "People are going to see how sick I am"; "I am not good enough for them"; "I am not a good father"; "I am not a good husband"; "I cannot stand to spend the rest of my life like this"; and "I absolutely must kill myself to solve my problems."

Intervention

In working with this patient for a total of three months, I have implemented an REBT treatment sequence consisting of nine steps, which are all based on the information gained during the UPCS phase.

Step 1 was making sure that his suicidality was the main presenting problem of our sessions and educating the patient about the nature of his suicidality as "crisis activated."

Step 2 was introducing the patient to the ABC model of suicidality. In this case, I did not utilize the ABBC model because the IBs were explicit and clearly provided by the patient. In doing that, I made sure to reframe the A with respect to its four major components: (1) Past A (activating event from previous attempts) "I was hard for me to concentrate at work"; (2) the Recent A (activating events that are not imminent risk factors but are still freshly remembered by the patient) "Lacking energy and feeling lethargic most of the time"; (3) the Present A (activating event at the center of the patient's attention in our current session) "People in my community looking at me as a sick person"; finally, the Immediate A (the A that puts the patients at high risk of attempting suicide) "Inability to leave his bedroom."

Step 3 was to identify the emotional C and the behavioural C. The patient identified depression, shame, and anxiety about his depression as UNEs and isolation as behavioural C. At this point, I invited the patient to focus on the most distressing emotional C, and the patient identified depression. I could have worked on the meta-emotional first by assessing his primary problem in terms of anxiety about feeling depressed, but I avoided it because the patient's cognitive constriction did not allow him to manage the presence of two emotions at the same time. At this point, I had to educate the patient about the relationship between depression and suicidality. I explained to the patient that my explicit treatment target was his suicidality and that I was going to systematically focus on it throughout my intervention.

Step 4 was to assess the patient's IBs in terms of demandingness, awfulizing, frustration intolerance, self-condemnation, and other condemnation. In order to assess the patient's IBs, I used the standard question, "What were you telling yourself about A to make yourself feel suicidal?" At the beginning, the patient was somehow vague or too abstract. Then I decided to ask more specific questions such as "Were you aware of any suicidal thoughts in your mind?"; "What was on your suicidal mind then?"; "Are you aware now, with me, of what you were thinking when you felt suicidal?" The patient was more sensitive to this level of specificity and he provided several IBs. Some IBs motivated by his lack of energy, sleeping often, or being very self-critical were "I am not good enough for my family"; "I am not a good father"; and "I am not a good husband." Another recurrent IB was "I cannot stand to spend the rest of my life like this," which most of the time led to him contemplate suicide in terms of "I absolutely must kill myself to solve my problems." Additional IBs were "I am not good enough" or "People are going to see how sick I am." While assessing for IBs, I notice something in the patient's thinking style that is not unusual when working with a patient at risk of suicide: his reassuring relationship with his

suicidality in terms of **"**I know that suicide is there for me in case I need it. When I think about suicide, I think about a way to escape that is always available."

Step 5 was to help the patient connect his IBs with C. I helped the patient with the understanding that anytime he thinks of any of these IBs, then he has to deal with his feeling of suicidality. I did it by asking the patient, "Can you see that if you keep telling yourself any of these IBs, you will make yourself feel suicidal?"

Step 6 was the process of disputing the patient's IBs. Since the patient shared several IBs that were clearly all related to his suicidality, I invited the patient to choose the IB that most characterized his suicidology and he chose "I absolutely must kill myself to solve my problems." At this point I helped the patient to notice that there was no evidence to support his absolute demands because he was still alive in front of me after overcoming several suicidal crises and hospitalizations.

Step 7 was to encourage the patient to generate a rational alternative to his IBs. I prefer having the patient generate the RB without suggesting it myself, unless the patient is unable to identify any RBs. The patient was able to generate the following RB: "It would be desirable in life not to feel suicidal at times, but it does not mean that I need to get my desire met all the time. I can still go on with my life and there is no reason that I must kill myself anytime I have suicidal crises. I know that these crises are temporary and I have already been able to cope with several of them, which proves that I have the ability to overcome them. The fact that I am still alive validates my point."

Step 8 was encouraging the patient to deepen his understanding in order to discriminate his IBs from his RBs, his UNE from his HNE, and finally his IBs-UNE from his RBs-HNE. In doing that, I have utilized a method utilized by DiGiuseppe (1991) that consists of disputing both patients' IBs and RBs to the point that they see the reason for their irrationality and for their rationality.

Step 9 was encouraging the patient to put his new learning into practice and to help him generate a crisis response plan with specific instructions for what to do during periods of crises.

What I Have Learned About Using REBT with Suicide

Cultural Consideration in Assessing Suicide

It is very important not to assume that other cultures think about and deal with suicide the way you do. It is important to attend to the patients' cultural differences in all phases of treatment. Dealing with cultural patterns, immigration, minority status, racism, and cultural experiences in the intervention with the patients at risk of suicide requires the therapist to demonstrate the pertinence of the intervention to the real-life problems experienced by the patients (Ponterotto, Utsey, & Pederson, 2006). REBT therapists need to be culturally competent, which means that while asking "Have you been thinking about killing yourself?", they need to pay an increased attention

to three main cultural competencies: awareness of their assumptions, values, and biases; their knowledge about the worldviews of their culturally diverse patients; and the ability to develop appropriate interventions and skill techniques specifically targeted to their patients (Grieger, 2008).

Suicide Assessment and Religious Beliefs

Most religions see suicide as an unforgivable act, but this does not mean that therapists should try to convince the patients that suicide is a sin that will cause them to go to hell. Therapists needs to integrate the patients' religiosity into their suicidal thinking patterns and try to investigate the congruence between core REBT tenets and religious beliefs (Nielsen, Johnson, & Ellis, 2001). Once I worked with a patient who held strong religious beliefs and I invited him to complete the ABC self-help form by intentionally integrating his religious beliefs in the disputation process to generate rational alternatives.

The Thus

1. **Assessing for shame**: Ask whether shame is involved in their expression of suicidality because shame is a powerful mediator of suicide risk, but therapists keep neglecting this emotion.
2. **Actively listening the suicidal narrative**: Try not to interrupt the patients at the beginning and let them give voice to their suicidal narratives in order to formulate a detailed ABC or ABBC to offer to the patients.
3. **Conceptualize suicide narratives in ABC or ABBC terms**: Try to reflect the patients' suicidal sentiments by utilizing from the beginning the ABC or ABBC models. Use ABC if the IBs are present and the ABBC model if they are not.
4. **Clarify and verify that you are working on the correct ABC or ABBC**: Make sure that your information about the ABC and the ABBC is correct by asking the patients to confirm that you have shared understanding of this material.
5. **Validate psychological pain**: Make sure to attend the pain and psychological suffering that the patients express in session.
6. **Clarify the patients' psychiatric/psychological diagnoses and their effects on suicidal thinking**: At times suicidality is activated by not taking medication regularly or sleep deprivation; in this case make sure to present the patients with this information.
7. **Formulate cases in terms of a "Wanting to live/Wanting to die" continuum**: Make sure to draw the patients' attention to their ambivalence, as evidenced by their feeling suicidal and wanting to live at the same time. I usually make a joke that reframes "50 shades of grey" as "50 shades of suicidality", which I find helps to deliver my central message about ambivalence through humor.

The Don'ts

1. **Don't assume that once suicidal, the patients are forever suicidal**: Avoid using judgmental or pathologizing language such as "once suicidal, forever suicidal."
2. **Don't assume that the patient is "kidnapped" by the A and unable to consider the B-C connection**: Avoid thinking that if you do not change the situation then it is impossible for the patients to continue working on their suicidality. Avoid focusing solely on a practical solution by implementing the B-C connection.
3. **Don't assume that it always takes two or three sessions to be able to assess for suicide/suicidality**: At times, you are unable to see the patients for a second session, particularly if you work on an inpatient unit. In such cases, I suggest asking about suicidality as soon as possible. You can make use of just one session by building on what the patients have already tried to do to solve their problems (Dryden, 2017).
4. **Don't end the session without summary or alternative ABC or ABBC**: Make sure that the patients can describe the session in ABC or ABBC terms. Make sure that they leave the session having a clear idea of how their suicidality can be seen in terms of ABC or ABBC.
5. **Don't formulate the case in categorical terms "You want to die or You want to live"**: Suicidality is better addressed by a dimensional intervention (a continuum of wanting to live/wanting to die) as opposed to a categorical intervention (I die/I live).
6. **Don't focus on meta-emotional disturbance: REBT** has always recognized the importance of addressing meta-emotional disturbances, defined by Walen, DiGiuseppe, and Dryden (1992) as problems about problems (such as patients becoming anxious about their depression). It is an accepted position in the REBT community to address the secondary emotion first in order to address this added emotional layer of the patients' suffering. In working with the patients at risk of suicide, working on the secondary emotion first is confusing and should be avoided. Indeed, the patients' cognitive constriction does not allow them to manage the presence of two emotions, and therapists and the patients should focus collaboratively on one emotion that has been agreed upon by both parties.

Aspects of REBT that Facilitate Change

1. **Utilizing a collaborative approach**: It is important to use (even if treatment lasts only a single session) a collaborative approach in therapeutic work. The Collaborative Assessment and Management of Suicidality (CAMS) (Jobes, 2006) approach stresses the importance of a relational, dynamic collaboration in working with the patients at risk of suicide in which they are seen as the expert on their own experience.

2. **The importance of instilling hope**: Even if the patients are not convinced of the possibility or value of hope at the initial stage of treatment, it is important that at least they feel some sense of it in the initial session. The main goal is to discuss hope in terms of resources of empowerment, building and sustaining connections, carving out paths toward liberation, and shoring up their terror-management resources (Scioli & Biller, 2010).
3. **Normalize and Educate the patients about their IBs**: The patients want to understand how they function cognitively and it is important that the therapist not only normalize their thoughts but also educate them about the development of these thoughts with respect to IBs and rational beliefs (RBs).
4. **Assessing the most distressing emotion**: Make sure to identify the most distressing emotions as doing so will help the patients to generate more effective ABCs or ABBCs.
5. **Addressing ambivalence**: Be sure to explain the presence of "I want to live/ I want to die" continuum and how this framework is an effective way of understanding suicide in relation to psychological pain.
6. **Patient-centered approach**: It is always about the patients' needs and desires. Avoid asking questions in a mechanical way, but do pay attention to the patients' words and actively integrate this information into your session.
7. **Be psychoeducational about the ABC/ABBC and how suicidality develops over time**: The patients like to know how they have come to be suicidal and how they can do something to help themselves the next time they are in crisis.

Aspects of REBT that Inhibit Change

1. **One size fits all approach**: Working with the patients in such a way that involves always asking the same questions and thinking that one size fits all.
2. **Dismissing the patients' psychological pain**: The patients are suffering and it is important to validate their current psychological condition. If therapists dismiss the patients' pain, that dismissive attitude will generate resistance in the patient and damage the therapeutic alliance.
3. **Unable to identify a valid ABC or ABBC**: Make sure that the patients are able to identify the ABC or ABBC in order to leave the session with something concrete that they can use in the future.
4. **Unable to provide an alternative ABC or ABBC to the patient before the end of the session**: If you are working on the ABC or ABBC, provide the patient with an alternative to their current perspective on his or her life.

Summary and Conclusion

This chapter has attempted to explain the complex topic of suicidality in REBT terms by providing therapists with the opportunity to reflect on how REBT can be modified to work effectively with the patients at risk of suicide. Indeed, the Suicidaction Potential Theory (SPT), which conceptualizes any suicide attempt as a sequence of "activation phases," offers an important contribution to the philosophical basis of REBT. Consistent with the REBT framework, a significant attempt has been made to delineate the importance of focusing on the A-C connection with complex suicidal narratives and, as a consequence, implementing a new way of utilizing the original ABC (Activating Event/Beliefs/Consequences) model in the ABBC (Activating Event/Bypassing Beliefs/Consequences) model. Although much work remains to be done to develop a comprehensive REBT framework for understanding of suicidality, a new generation of researchers are orienting their attention toward the topic of suicide to demonstrate that REBT may be tailored to successfully work with the patients at risk of suicide.

References

Ahmedani, B. K., Solberg, L. I., Copeland, L. A., Fang-Hollingsworth, Y., Stewart, C., Hu, J., ... & Lu, C. Y. (2015). Psychiatric comorbidity and 30-day readmissions after hospitalization for heart failure, AMI, and pneumonia. *Psychiatric Services, 66*(2), 134–140.

Appleby, L., Shaw, J., Amos, T., McDonnell, R., Harris, C., McCann, K., ... & Parsons, R. (1999). Suicide within 12 months of contact with mental health services: National clinical survey. *Bmj, 318*(7193), 1235–1239.

Bateman, A., & Fonagy, P. (1999). Effectiveness of partial hospitalization in the treatment of borderline personality disorder: a randomized controlled trial. *American Journal of Psychiatry, 156*(10), 1563–1569.

Brown, G. K., Beck, A. T., Steer, R. A. (2000). Risk factors for suicide in psychiatric outpatients: A 20-year prospective study. *Risk, 68*(3), 371–377.

Brown, G. K., Ten Have, T., Henriques, G. R., Xie, S. X., Hollander, J. E., & Beck, A. T. (2005). Cognitive therapy for the prevention of suicide attempts: a randomized controlled trial. *JAMA, 294*(5), 563–570.

Brown, G. K., & Jager-Hyman, S. (2014). Evidence-based psychotherapies for suicide prevention: Future directions. *American Journal of Preventive Medicine, 47*(3), S186–S194.

Chung, D. T., Ryan, C. J., Hadzi-Pavlovic, D., Singh, S. P., Stanton, C., & Large, M. M. (2017). Suicide rates after discharge from psychiatric facilities: a systematic review and meta-analysis. *JAMA Psychiatry, 74*(7), 694–702.

Cipriani, A., Pretty, H., Hawton, K., & Geddes, J. R. (2005). Lithium in the prevention of suicidal behavior and all-cause mortality in patients with mood disorders: a systematic review of randomized trials. *American Journal of Psychiatry, 162*(10), 1805–1819.

Comtois, K. A., Jobes, D. A., S. O'Connor, S., Atkins, D. C., Janis, K., E. Chessen, C., ... & Yuodelis-Flores, C. (2011). Collaborative assessment and management of suicidality (CAMS): Feasibility trial for next-day appointment services. *Depression and Anxiety, 28*(11), 963–972.

Cuffe, S. P. (2004). Suicide and SSRI medications in children and adolescents. *American Journal of Child and Adolescent Psycihiatry*.

DiGiuseppe, R. (1991). Comprehensive cognitive disputing in RET. In M. Bernard (Ed.), *Using rational-emotive therapy effectively: A practitioners guide*. New York: Plenum.
DiGiuseppe, R., Doyle, K., Dryden, W., & Backx, W. (2014). *The practitioners guide to Rational Emotive Behavior Therapy*. New York: Oxford University Press.
Dryden, W. (1998). Understanding persons in the context of their problems: A rational emotive behavior therapy perspective. In M. Bruch & F. W. Bond (Eds.), *Beyond diagnosis: Case formulation approaches in CBT*. Chichester: Wiley.
Dryden, W. (2009). *How to think and intervene like an REBT therapist*. Routledge.
Dryden, W., & Neenan, M. (2012). *Learning form mistakes in rationale emotive behavior therapy*. New York, NY: Routledge.
Dryden, W. (2013). *The ABCs of REBT revisited. Perspectives on conceptualization*. New York, NY: Springer.
Dryden, W. (2017). *Single-session integrated CBT (SSI-CBT)*. New York, NY: Routledge.
Ellis, A., & Harper, R. (1961). *A guide to rational living in an irrational world*. Englewood, 'IiIT-. NJ: Prentice-Hall.
Ellis, T. E., & Newman, C. F. (1996). *Choosing to live. How to defeat suicide through cognitive therapy*. Oakland, CA: New Harbinger Publications, Inc.
Goldblatt, M. J., Schechter, M., Maltsberger, J. T., & Ronningstam, E. (2012). Comparison of journals of suicidology. *Crisis*.
Grieger, I. (2008). *Guidelines and competencies for cross-cultural counseling research*.
Gunn, J. F., & Lester, D. (2014). *Theories of suicide. Past, present, and future*. Springfield, Illinois: Charles C. Thomas Publisher.
Hollander, M. (2008). *Helping teen who cut. Understanding and ending self-injury*. New York, NY: Guilford.
Jobes, D. A. (1995). The challenge and promise of clinical suicidology. *Suicide and Life—Threatening Behavior, 25,* 437–449.
Jobes, D. A. (2006). *Managing suicidal risk: A collaborative approach*. New York, NY: Guilford.
Joiner, T. E. (2005). *Why people die by suicide*. Cambridge, MA: Harvard University Press.
Klonsky, E. D., & May, A. M. (2015). The three-step theory (3ST): A new theory of suicide rooted in the "ideation-to-action" framework. *International Journal of Cognitive Therapy, 8*, 114–129. (Special Issue: Recent Advances in Suicide Research: Mediators and Moderators of Risk and Resilience). https://doi.org/10.1521/ijct.2015.8.2.114.
Klonsky, E. D., Saffer, B. Y., & Bryan, C. G. (2017). Ideation-to-action theories of suicide: A conceptual and empirical update. *Current Opinion in Psychology, 22,* 1–6.
Kral, M. J., Idlout, L., White, J., Marsh, I., Kral, M. J., & Morris, J. (2016). Indigenous best practices: Community-based suicide prevention in Nunavut, Canada. In *Critical suicideology: Transforming suicide research and prevention for the 21st century* (pp. 229–243). University of British Columbia Press.
Linehan, M. M., Comtois, K. A., Murray, A. M., Brown, M. Z., Gallop, R. J., Heard, H. L., ... & Lindenboim, N. (2006). Two-year randomized controlled trial and follow-up of dialectical behavior therapy vs therapy by experts for suicidal behaviors and borderline personality disorder. *Archives of General Psychiatry, 63*(7), 757–766.
National Academy of Medicine (2015). Mental Health by the Numbers.
Nock, M. K., Park, J, M., Finn, C. T., Deliberto, T. L., Dour, H. J., & Banaji, M. R. (2010). Measuring the suicidal mind: Implicit cognition predicts suicidal behavior. *Psychological Science, 21*(4), 511–517. https://doi.org/10.1177/0956797610364762.
Nolen-Hoeksema, S. (2006). *Eating, drinking, overthinking*. New York, NY: Holt Paperbacks.
Nielsen, L. N., Johnson, W. B., & Ellis, A. (2001). *Counseling and psychotherapy with religious persons. A rational emotive behavior therapy approach*. Mahwah, NJ: Lawrence Earlbaum Associates.
O'Connor, R. C. (2011). Towards and integrated motivational-volitional model of suicidal behavior. In R. C. O'Connor, S. Platt, & J. Gordon (Eds.), *International handbook of suicide prevention: Research, policy and practice* (pp. 181–198). Hoboken, NJ: Wiley-Blackwell.

Ponterotto, J. G., Utsey, S. O., & Pedersen, P., B. (2006). *Preventing prejudice: a guide for counselors, educators, and parents*. Los Angeles, CA: Sage.

Pottick, K. J., McAlpine, D. D., & Andelman, R. B. (2000). Changing patterns of psychiatric inpatient care for children and adolescents in general hospitals, 1988–1995. *American Journal of Psychiatry, 157*(8), 1267–1273.

Rudd, M. (2006). David fluid vulnerability theory: A cognitive approach to understanding the process of acute and chronic suicide risk. In T. E. Ellis (Ed.), *Cognition and suicide: Theory, research, and therapy* (pp. 355–368). Washington, DC, US: American Psychological Association.

Scioli, A., & Biller, H. (2010). *The power of hope: Overcoming your most daunting life difficulties--no matter what*. Health Communications, Inc.

Shea, S. C. (2002). *The practical art of suicide assessment*. Hoboken, New Jersey: Wiley.

Walen, S. R., DiGiuseppe, R., & Dryden, W. (1992). *A practitioner's guide to rational-emotive therapy*. Oxford University Press.

Weinberg, A., & Klonsky, E. D. (2009). Measurement of emotion dysregulation in adolescents. *Psychological Assessment, 21*(4), 616.

Weinberg, I., Ronningstam, E., Goldblatt, M. J., Schechter, M., Wheelis, J., & Maltsberger, J. T. (2009). Strategies in treatment of suicidality: Identification of common and treatment-specific interventions in empirically supported treatment manuals. *The Journal of Clinical Psychiatry, 71*(6), 699–706.

Wood, A., Barker, J. B., & Turner, M. J. (2016). Developing performance using rational emotive behavior therapy (REBT): A case study with an elite archer. *Sport Psychologist*, 1–27. https://doi.org/10.1123/tsp.2015-0083

World Health Organization. (2014). Preventing suicide: A global imperative.

REBT and Anger Disorders

Michael J. Toohey

Key REBT Theoretical Concepts in Working with Anger Disorders

Anger is a subjective, negative emotion that typically arises when one believes they are a victim of injustice or being threatened or attacked. It is associated with rigid, demanding thoughts, increased physiological agitation, and aggressive behaviors. It is considered a basic, primary emotion (Darwin, 1872/1965; Ekman, 2007). It is related to—but distinguishable from—aggression (a behavior), hostility (an attitude), irritability (a physiological mood), and hatred (a cognitively-based dislike). These are thoroughly distinguished in DiGiuseppe and Tafrate (2007). The current chapter will discuss the conceptualization and treatment of anger based on the principles of Rational Emotive Behavior Therapy (REBT).

REBT theory posits that anger is a dysfunctional, unhealthy emotion that stems from irrational beliefs. In contrast, annoyance is the paralleling functional, healthy emotion that stems from rational beliefs. For example, suppose two people, James and Ann, are being reprimanded by their boss. James thinks, "My boss should not be yelling at me! She is an A-hole!" Ann thinks, "I don't like that my boss is yelling at me, but she can do whatever she wants. I know she has done some good things in the past, but she is really acting like an A-hole right now!" James, thinking irrationally, is likely to feel dysfunctional, unhealthy anger. Ann, however, who is thinking rationally, is likely to feel functional, healthy annoyance. Consequently, James is also more likely to act in a dysfunctional, unhealthy way, while Ann is more likely to act in a functional, healthy manner.

The four irrational beliefs of REBT: demandingness, awfulizing, frustration intolerance, and globalizing (DiGiuseppe, Doyle, Dryde, & Backx, 2014) are all relevant

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to the conceptualization and treatment of anger. Some examples of each as related to anger is as follows:

Demandingness: *That absolutely should not have happened; He has to do what I say; She must behave appropriately; I need to have my coffee break today!*
Awfulizing: *That play was terrible; I was in this awful hour-long traffic jam this morning; I hate going to the dentist – it's the worst thing in the world!*
Frustration Intolerance: *I can't stand the sound of chewing; I'm not able to handle this meeting; I can't deal with this right now; I won't tolerate it!*
Globalizing: *He is such an A-hole; What a jerk; I'm such a failure; She is a lousy, rotten human being!*

Given anger's association with rigid, demanding thoughts, demandingness is typically the most salient irrational belief in those with anger difficulties. It is this author's experience that, when clients are angry, they very quickly and easily identify their belief that someone or something *absolutely should/must/needs to* be different. DiGiuseppe et al. (2014) noted that when people have their personal definition of rights and wrongs violated, they tend to first have a demanding belief and then condemn the offender with a globalization. Of course, any of the four irrational beliefs might be at the core of clients' anger. Clients might have the belief that the event that absolutely should not have happened is *the worst thing in the world*, that they *can't stand it*, and that the other person is a *complete and total jerk* because of it. It is important that REBT therapists identify and challenge any of the four irrational cognitions while paying special attention to demandingness and globalizing. While demandingness and globalizing are the most frequently associated with anger, the other irrational beliefs might be present and affecting the functioning of the client.

There are a number of common thought patterns in addition to the above irrational beliefs associated with anger (DiGiuseppe et al., 2014; DiGiuseppe, Tafrate, & Eckhardt, 1994). Three of the most common include:

Unfairness/Injustice/Self-righteousness—We tend to think we have been treated unfairly or unjustly when we are angry. We believe we are on the moral high ground and that God and everyone else is on our side regarding the offensive event.
Ego-defensive anger—We often become angry when we are criticized. Anger is not due to low self-esteem, but the contrary: we become angry when we think that others do not see us as fantastically as we see ourselves. Thus, we often become angry in defense of having a bruised ego.
External attributions of blame—We tend to blame others when we are angry. By its nature, anger narrows our focus onto the target of our anger (i.e., the offender) and we place responsibility for the offensive event on them.

In REBT, emotion episodes (including anger) are conceptualized using an ABC framework. The A stands for the activating event: the trigger or event that started the anger episode. Activating events are individualized and personal: An activating event for one person's anger episode person might be something enjoyable for someone else. However, most emotion scholars believe that frustration, being blocked from a

goal, and psychological/physical threats tend to be common (possibly even universal) triggers for anger (Ekman, 2007). Some other common activating events might involve being disrespected, cut off in traffic, or treated unfairly.

The B in ABC stands for the belief. These are the irrational and/or rational beliefs a person has about the activating event that leads them to feel anger or annoyance. As stated earlier, it is theorized that rational beliefs lead to a healthier, functional annoyance, while irrational beliefs lead to a dysfunctional, unhealthy anger. Some example of irrational beliefs for anger were described above and some specific details about rational beliefs will be described below.

The C in ABC stands for emotional and behavioral consequence of the episode. The emotional consequence refers to the physiological and emotional experience of anger and/or annoyance, and the behavioral consequence refers to the expression. For anger and annoyance, the emotional consequence includes the subjective feeling of the emotion; the somatic symptoms such as muscle tension, rapid heartbeat, shallow breathing, warmth, clammy hands, and increased blood pressure; and the frequency, intensity, and duration of these occurrences. The behavioral consequence refers to any type of expression of anger and/or annoyance such as sarcasm, yelling, insulting, punching, or kicking. This will vary depending on the individual and circumstance (and the belief). Although anger is associated with physical aggression, it is important to note that physical aggression is often preceded by anger, but feeling angry rarely leads to physical aggression. In most cases, anger is expressed in some other, less extreme manner. Other common angry expressions include screaming, pointing, impulsive movements and gestures, and fist clenching. For some people, anger is expressed through silence and withdrawal/avoidance—by bottling the anger up so that there is no confrontation. However, this tends to lead to resentment and a lack of resolution of the problem.

The above ABCs of REBT can refer to both primary and secondary disturbances. Whereas the primary disturbance is the initial ABC, the secondary disturbance is the reaction about the primary ABC (i.e., "I am anxious [C] about becoming angry again [A] because if I do I won't be able to stand it [B]!"). Although a person might feel a variety of emotions about their anger, two common ones include shame and fear. For example, a person might feel ashamed of how he or she acts when angry. Although on the surface this might be helpful for having a person reduce their anger (this would more likely be the case if the client was feeling the functional embarrassment instead of the dysfunctional shame), feeling ashamed might lead to difficulty processing or talking about anger within therapy. Similarly, a person who fears becoming angry might constantly avoid confrontation, choosing instead to bottle up his or her anger without expressing his or her concern. This might lead to building resentment instead of conflict resolution. Thus, REBT therapists typically look for and challenge any relevant secondary ABCs prior to challenging the primary anger.

Anger is a complex construct associated with a number of features that can be viewed within an REBT framework. The following sections review the literature and best practices for the conceptualization and treatment of anger. The chapter will conclude with a REBT-based case example of the treatment of someone with anger difficulties and lessons in treating anger from this author's perspective.

Key Best-Practice REBT-Based Assessment and Treatment Strategies and Techniques in Working with Anger Disorders

Although there are disorders for anxiety and depression, there is no disorder for anger in the DSM-5. Intermittent Explosive Disorder, which is based on aggression, does not require the experience of anger in order to be diagnosed. Since anger is not included in the DSM-5 as a disorder, anger has received less attention in research than other emotions that are disorders such as anxiety and depression. Consequently, there is a lack of research and information about the assessment and treatment of anger.

As of January 29, 2018 a PSYCHINFO search of the terms REBT (or RT, RET, Rational Therapy, Rational-Emotive Therapy, Rational-Emotive Behavior Therapy) and anger (or aggression) provides 20 experiments examining the effect of REBT on anger or aggression. Of these 20 experiments, 8 were dissertations, 12 used a sample greater than 30 (2 were above 60), 5 involved children or adolescents, 4 involved a population with a specific disorder, and 10 examined the effect of REBT combined with/within the context of a separate intervention (e.g., barbing). While there was mixed evidence regarding the utility of including REBT self-statements in conjunction with barbing/exposure, REBT was overall found to be effective in reducing anger and aggression.

Key Best Practice REBT-based Assessment Strategies. There are a few methods of conducting best-practice REBT-based assessment for anger. The more standardized methods of assessment include self-report measures that have been empirically validated. For anger, the most prevalent measures are the Anger Disorders Scale (DiGiuseppe & Tafrate, 2004), the Novaco Anger Scale (Novaco, 2003), and the State Trait Anger Expression Inventory 2 (STAXI; Spielberger, 1999). When reviewing the literature base for the effects of REBT on anger, the STAXI by far was the most popular measure used. There are also a few measures used to measure irrational/rational beliefs, with the most popular being the General Attitude and Belief Scale (GABS; DiGiuseppe, Leaf, Exner, & Robin, 1988) and its condensed version, the Shortened General Attitude and Belief Scale (SGABS; Lindner, Kirkby, Wertheim, & Birch, 1999). More about the measures of irrational beliefs can be found in Macavei and McMahon (2009).

The more individualized methods of assessment in REBT refer to assessing the specific ABCs of the client (see more about the process in DiGiuseppe et al., 2014). REBT utilizes a hypothesis-driven approach in which it is assumed that clients experiencing a dysfunctional emotion are thinking irrationally. The REBT therapist typically assesses first for the client's specific A and C (in either order) followed by the irrational B. In the context of treating anger (the C), client are often less focused on their own anger and more on the trigger for their anger (the A). Thus, it is this author's experience that most angry clients tend to be able to immediately identify the A of their ABCs. Once the A and C have been identified (the C being anger), REBT therapists asses for the B. When clients are asked what they think about the A that leads them to feel C, most respond with an automatic thought or inference that is not

immediately identifiable as a core belief. Many therapists in this situation would be tempted to begin to challenge and correct this automatic thought or inference. While doing so might change the client's perspective of the current problem, it will not change the client's core belief system that dictates their overarching patterns of automatic thoughts, inferences, emotions, and behaviors. Thus, REBT therapists refer to disputing a client's automatic thoughts and inferences as the inelegant solution, while disputing their core irrational belief as the elegant solution.

This author has found that, when the C is anger, clients frequently respond with a demanding belief (B) that the A *absolutely should* or *must* be different. In the case that the response is not a clear demanding belief, REBT therapists often employ inference chaining to help the client identify their core belief. Inference chaining consists of the therapist having the client assume that their automatic thought or inference (e.g., my child is disrespecting me) is true followed by questions that dig deeper (Remember: challenging whether the automatic thought or inference is true would lead to the inelegant solution). For example, the therapist might start off by saying: "For the time being, let's assume that it is true that your child was disrespecting you." The therapist might then follow up with a series of questions (depending on the response of the client) such as: "What would that mean?" or "What is the worst part about that?" Ideally, inference chaining will result in the client being able to identify his or her core belief(s) and the therapist and client would be ready to proceed with treatment.

Key Best Practice REBT-based Treatment Strategies. The best-practice REBT-based treatment strategies for anger will be similar to other emotions with a few adjustments. Similar to the treatment of other emotions, treatment will emphasize cognitive restructuring/disputation for the four irrational beliefs described above. After the ABCs have been gathered, the ABCDEs of REBT are created with the addition of the D of Disputation, and the E of finding a new Effective response. The process is described in more detail in DiGiuseppe et al. (2014), and will be described briefly here. Although there are infinite ways in which disputes can be delivered, there are three main types of disputes: Logical, Empirical, and Pragmatic. To explain each, we will use the example of a client who has the belief: "My employees must do what I say!" A logical dispute refers to the logic or semantic precision of the statement. In other words, is the statement true? An example of a logical dispute would be: "Does it logically follow that, just because you *want* them to do what you say, they *must*?" An empirical dispute refers to whether or not there is evidence or support for the belief. For example, an empirical dispute might be: "You've mentioned your employees tend to arrive late even though you've told them to arrive on time. Does the evidence show that, just because you *want* them to do what you say, they *must*?" Finally, a pragmatic dispute refers to whether it is practical or functional to have that belief. An example of a pragmatic dispute would be: "How do you feel thinking that your employees *must* do what you say, even though they don't?" In this author's experience, clients have known every time that thinking irrationally leads to feeling more upset than thinking rationally.

After, disputing (D), a new effective belief (E) is created. This process can be conducted in many ways but might look something like this: "Consider these two

ways of thinking. Option 1: Thinking that your employees *must* do what you say or Option 2: Thinking that that you *want* your employees to do what you say, but it is not true that they *must*—they can do whatever they want. Which might be the more logical, supported, and helpful way of thinking?" Similar to how the irrational belief is disputed and evaluated to find that it *does not* hold up to scrutiny, the new effective rational belief is then disputed and evaluated to find that it *does* hold up to scrutiny.

In addition to cognitive restructuring, appropriate evocative, imaginal, and behavioral techniques would be included to emphasize functional change in thoughts, feelings, and behaviors. These interventions include (but are not limited to) rational-emotive imagery, role reversals, and flooding/implosive exposure. These REBT-based techniques are similar to anger as they are for other emotions. Each will be described briefly here and are described in more detail in DiGiuseppe et al. (2014).

Rational-emotive imagery (REI) involves having clients imagine themselves in the context of a challenging situation (the A). They are asked to get in touch with their dysfunctional emotion in the moment (the C) and, once that is realized, to then imagine that—while still imagining the A—their C is now one that is functional and healthy. They are then asked to identify the beliefs (the B; i.e., the rational beliefs) that would be in accordance with the new, functional C. For example, an angry client would imagine themselves getting yelled at by his or her boss (A) and the anger felt (C) from it. He or she is then asked to imagine switching the C from feeling angry to feeling annoyed. Once the client begins to imagine feeling annoyed in the same scenario, he or she is then asked how the belief changed to make that happen (e.g., it might have switched from "My boss *must* not disrespect me!" to "I don't want my boss to disrespect me, but it is not true that he *must* not. He can do whatever he wants.").

Role reversal involves having the client and therapist switch roles: the therapist will speak the client's irrational thoughts out loud and the client will dispute them. Role reversals are best utilized after clients are familiar enough with the disputes to be able to apply them on their own. In practice, an abridged version of a role reversal might look something like this:

Therapist "Let's have you be the therapist, and I will play the role of your irrational belief. You use any disputes you have to challenge and correct me. Okay, ready? *That woman was such an A-hole when she told me to stop talking in the library!*"

Client "Well…that's not completely true."

Therapist "And why is that? She sure was being mean! I'm sure a lot of people think she is an A-hole!"

Client "Um. I guess because she has probably also done some nice things in her life, too. Like, some people might have agreed with her that people shouldn't talk in the library, even if it is quietly."

Therapist "But she has probably done more negative things in her life, so she is an A-hole!"

Client "Well still, a complete A-hole couldn't even do any nice things at all."

Therapist "I see. So how would you put it if she isn't an A-hole?"

Client "She might have been *acting* like an A-hole, but it's not true that she is a complete A-hole as a human being."
Therapist "And why is your belief more correct than mine?"
Client "Well, the evidence supports mine. And just because someone is *acting* like an A-hole doesn't mean they *are* an A-hole as a person."
Therapist "Excellent! Let's stop here for a second. What was that like for you?"

In the above role reversal, the therapist starts with explaining the role reversal idea to the client, and making sure the client understands the idea. When ready, the therapist states one of the client's irrational beliefs. The client provides an empirical dispute, and the therapist pushes it a little further with a slight comeback to the dispute. When the client continues to dispute the irrational belief, the therapist then guides the client to come up with a rational version of the belief when she states: "So how would you put it if she isn't an A-hole?" Once the client states the rational alternative, the therapist asks the client to further defend the rational alternative. The therapist then ends the exercise by asking the client to process it with her.

Flooding/implosive exposures (Stampfl & Levis, 1967) refer to exposing a client to their most triggering (i.e., in this case, angering) stimulus/activating event (A) until they habituate to it. This is due to the REBT philosophy that clients can tolerate the most triggering A (assuming it is appropriate). By not exposing them to their most triggering A, the therapist is indirectly supporting the client's irrational belief of Frustration Intolerance (i.e., that he or she would not be able to tolerate it).

As noted earlier, there are adjustments to be made to the above interventions when treating anger. Given anger's association with demandingness and globalizing/other-rating, treatment is likely to begin with identifying and challenging those two irrational beliefs—most likely starting with demandingness. It can be safely assumed that if the client is angry he or she has a strong demanding belief that is ripe for disputation.

Regarding adjustments for behavioral interventions, it is in this author's philosophy that exposures for anger are best left as imaginal until the client has shown he or she will not act aggressively toward an A in the real world. Once the client has demonstrated the ability to cope with the most angering *imaginal* A, it is more helpful to use traditional, hierarchical methods (described later in the chapter) for imaginal in vivo exposures to continue to attenuate any potential for aggression. Exposures are considered an advanced technique and, especially for anger, are best conducted further in the course of therapy, with a clear understanding and agreement from the client. Role reversals are also an incredibly helpful technique to use once the client has a solid grasp around the rational beliefs and their disputations. It allows the therapist to see whether or not the client can adequately dispute an irrational belief and, arguably more importantly, it can be incredibly empowering for client to take on the role of the therapist. It is also important for the therapist to take into consideration the current state of the client's irrational belief and anger. If the client is feeling angry in the moment, the therapist is highly encouraged to postpone behavioral—and possibly even cognitive—interventions until the client is in a better, more open-minded state.

REBT-Informed Considerations for the Treatment of Anger. There are some important considerations to be made in the general treatment of anger. For example, Ellis and Tafrate (1997) reviewed 5 myths that are to be addressed with the client. They are briefly described here. Myth 1: Actively expressing your anger reduces it. This belief has long been debunked; ventilation/catharsis (i.e., punching or yelling out your anger) leads to reduced anger in the short term but *increased* anger and aggression in the long term (Bushman, 2002). Myth 2: Take time out when you feel angry. Although this also might be helpful in the short term, overusing this technique will lead to an over-avoidance of problems with little to no conflict resolution. Myth 3: Anger pushes you to get what you want. Although anger might lead to intimidation in some people (again, in the short term), it frequently leads to long term resentment and harmed relationships. Myth 4: Insight into your past decreases your anger. Insight might help a client *understand* their anger to some extent, but it is learning and practicing new ways of thinking and behaving in the present that leads to decreased anger. Finally, Myth 5: Outside events make you angry. As described above, it is not the A (activating event) that causes our anger but the B (belief) we have that causes how we feel. Thinking irrationally will lead to dysfunctional feelings (e.g., anger), and thinking rationally will lead to more functional feelings (e.g., annoyance).

Some other general considerations for the treatment of anger are noted in DiGiuseppe, Tafrate, and Eckhardt (1994). These have been integrated throughout the chapter and primarily revolve around increased challenges with client motivation and the therapeutic alliance. When we are angry, we tend to view ourselves as the victim and we blame others. Thus, clients who struggle with anger often enter treatment less willingly or resentfully. It is the author's experience that most clients who seek anger therapy are being told to attend by someone else. Many are court-mandated or lawyer-recommended. Even those who are technically "self-referred" would most often be more appropriately referred to as "romantic partner-referred." Thus, it is important to emphasize building a strong therapeutic alliance and to work on increasing client motivation to attend therapy and to work on anger reduction. Psychotherapists often turn to the technique of Motivational Interviewing (described in the following section) to help with these ambivalent clients. REBT therapists are also well-known for their use of humor to challenge irrational beliefs and build rapport.

Overall, REBT has been found to be effective in the treatment of anger. However, there is clearly room for more empirical support. Thus, REBT therapists are encouraged to utilize findings from the broader, empirically-supported literature base to inform their psychotherapy practices. Such findings are discussed in the following section.

Treatment Guidelines from the Empirically-Supported Therapy Literature that Inform Best Practice in REBT with Anger Disorders

There have been seven meta-analyses regarding interventions for anger (Beck and Fernandez, 1998; Del Vecchio & O'Leary, 2004; DiGiuseppe & Tafrate, 2003; Edmondson & Conger, 1996; Saini, 2009; Sukhodolsky, Kassinove, & Gorman, 2004; Tafrate, 1995). Overall, treatments for anger were found to be effective for a variety of populations. Almost all meta-analyses were conducted on cognitive-behavioral interventions, and the most effective studies followed a manual and used integrity checks such as outcome assessments.

Manuals for the treatment of anger tend to follow a similar structure and use similar interventions. The most common interventions shown to be utilized in the treatment of anger include: motivational interviewing, psychoeducation, escape and avoidance, cognitive restructuring, relaxation, exposure, assertiveness, and problem solving. Although there is some flexibility to the order of interventions, most begin with an order similar to the one listed above with a strong emphasis on preparation (i.e., motivational interviewing, psychoeducation) prior to beginning interventions. This is due to the general nature of anger involving externalizing blame (i.e., not seeing one's own anger as the problem but blaming someone else) and the potential for having a tenuous therapeutic alliance with someone who frequently becomes angry with others (including the therapist). This is compounded by the above noted issue of having clients who might not be self-referred. Thus, most anger treatment protocols begin by focusing on increasing motivation towards therapy, building the therapeutic alliance, and gaining an understanding of the client's personal experience of his or her anger. This is followed by a number of specific techniques designed to reduce anger and aggression (and, ideally, increase more functional and positive emotions). Brief descriptions of the most common treatments for anger are as follows:

Motivational Interviewing. Motivational interviewing (Miller & Rollnick, 2002) involves increasing client motivation to change (i.e., reduce anger and attend therapy) by having them focus on the benefits of changing behavior towards a more functional direction and the negative consequences of sustaining dysfunctional behavior. It refers more to a spirit of communication throughout psychotherapy and less to a specific intervention that takes a certain amount of time. Thus, although it is listed first in this series of interventions, it is a therapeutic style meant to be utilized throughout psychotherapy. A main goal of motivational interviewing is for therapists to align themselves with their clients to increase client motivation while strengthening the therapeutic alliance. Motivational interviewing can inform REBT best practices in that it can be used to help build a strong therapeutic alliance and to increase client motivation for change.

Psychoeducation. Psychoeducation refers to teaching clients about their personal anger and anger in general. Discussions about personal anger involve teaching clients about the ABCs of REBT and having them explore their own ABCs by noting them each time they felt angry during the week. This is also referred to as daily monitoring,

journaling, and/or logging. More general psychoeducation would involve discussing the most common experiences of anger for the general population. For example, most people experience anger approximately once a week for about an hour, and it includes a number of potential common ABCs (such as those mentioned in the first section). Psychoeducation might also include a discussion of anger as a survival mechanism in the context of fight-or-flight. However, it is important to note that fight-or-flight best applies to immediate, physical danger in primitive times; becoming angry at a meeting with co-workers in modern times would be considered dysfunctional. For more on Psychoeducation, see Kassinove and Tafrate (2002).

Escape and Avoidance. Escape and Avoidance is a self-explanatory technique: It involves staying away from (i.e., avoiding) an anger trigger or leaving (i.e., escaping) when an anger trigger is present. The usefulness of this technique is noted to be one of the myths of anger by Ellis and Tafrate (1997), in that they lead to ignoring the problem as opposed to conflict resolution. Even so, the authors also note that escape and avoidance does have its place within anger management. It is most useful in the short term, when anger coping mechanisms are not available and attempts at conflict resolution are likely to lead to more conflict than resolution. Thus, escape and avoidance is widely taught as an effective technique for the short term. For more on escape and avoidance, see Kassinove and Tafrate (2002).

Cognitive Restructuring. Cognitive restructuring is not only used in REBT (as described above) but all types of CBT such as Beck (1976)'s Cognitive Therapy (CT). Although the process is similar, CT therapists are more likely to dispute automatic thoughts, attitudes, and assumptions (in addition to core beliefs) than REBT therapists. CT therapists and REBT therapists agree that automatic thoughts and inferences are based on core beliefs; thus, CT therapists would typically consider it more thorough to examine all types of beliefs, and REBT therapists would typically consider it unnecessary. In addition to disputing the content of beliefs, CT therapists also examine thought processes such as magnifying or minimizing certain triggers or letting our emotions determine the nature of our thoughts. Thus, it might be useful for REBT therapists to consider *how* clients are thinking in addition to *what* they are thinking. This might be especially useful for anger since anger causes us to fixate on the trigger of the anger and to magnify their/its negative qualities.

Relaxation. Relaxation exercises typically refer to Diaphragmatic Breathing (DB; Fried, 1993) and/or Progressive Muscle Relaxation (PMR; Jacobson, 1924). These interventions are especially useful if the client experiences strong physiological symptoms when angry. DB refers to breathing deeply using your stomach (technically, the diaphragm). It usually consists of taking breaths in through the nose and out through the mouth for about approximately 4 s for each inhale and exhale (8 s total) for approximately 5–10 min. PMR refers to a systematic tensing and relaxing of your muscles in groups. For example, the client is asked to tense their left arm for approximately 6 s and then to relax for 30 s, repeating for each muscle group throughout their body. For more specifics on an abbreviated version of PMR, see Bernstein and Carlson (1993). It is this author's experience that, given the high arousal and impulsivity associated with anger, clients who are feeling angry have difficulty stopping themselves to identify and challenge their cognitions in the moment.

Thus, relaxation exercises can help reduce clients' physiological arousal to make it easier for them to take time to begin to examine and challenge their own cognitions.

Exposure. Flooding/implosive exposures were described earlier in the chapter. However, the more commonly practiced CBT exposure (e.g., systematic desensitization, Wolpe, 1958) is slightly different. The more traditional CBT exposures typically introduce clients to the *least* triggering A and then gradually increase intensity based on their exposure hierarchy. This can also be paired with relaxation exercises to create an association between the trigger and relaxation. It is the same structure as exposure for anxiety but using triggers for anger. It should be done with caution and when there is a strong therapeutic alliance given the intentional increasing of anger. Specific to anger treatment, exposure is often conducted in the form of Barbing, a type of exposure using verbal statements (i.e., barbs) to evoke anger. For example, Marty McFly, in the Back to the Future movie series often becomes angry when a character calls him a coward. If he were in psychotherapy for anger, the therapist might consider conducting Barbing with Marty using a barb such as, "You are a yellow-bellied chicken!"

Assertiveness. So far, the above techniques have primarily been acceptance-based. They focus less on changing the problem and more on coping with something/someone that is unchangeable. Assertiveness and problem solving (below) are both change-based interventions. Assertiveness (Wolpe, 1990) refers to expressing one's concern honestly, directly, and appropriately, in a way that is not aggressive or passive. The specific content of phrase itself might vary, but it generally follows the format of: "When you (insert an action that was an anger trigger), I feel (insert feeling that was felt after the action). Can we talk about this?" Speaking in this manner does not guarantee that the offender will change his/her behavior, but this assertive statement is more likely to be taken well than a passive or aggressive statement. Assertiveness can help inform REBT therapy by teaching clients a functional coping behavior. Although REBT might help a client change their emotional C from dysfunctional anger to functional annoyance, clients might not necessarily know how to change their behavioral C from dysfunctional to functional. Assertiveness can help provide a behavioral coping skill for clients who might have difficulty expressing themselves.

Problem Solving. Problem solving (D'Zurilla & Goldfried, 1971) refers to generating a number of potential solutions to a problem and reviewing the pros and cons of each. This is especially helpful for clients who struggle with anger, because anger often narrows our focus and limits our ability to problem solve. For example, a client, John, is angry with his partner, Jesse, who recently told John he had an affair. John is contemplating how to proceed with their relationship, and problem solving might involve having John write down a number of potential solutions (at first, even include silly or strange ones), such as: (1) Stay in the relationship and try to work things out, (2) Stay in the relationship and stay angry, (3) Leave the relationship, (4) Have an affair to make things even, (5) Completely ignore Jesse. First, John will examine the pros and cons of each. Using the first option as an example, John might note that some of the pros of staying in the relationship might be that he is able to stay with Jesse, whom he still loves, and that they can continue to have a potential

future. Some of the cons might be that John might be wasting time with someone that might not be right for him, and that he might not be able to trust Jesse again. John would then repeat the process, considering the pros and cons of the following four (or more) potential solutions that were generated. Looking at all potential solutions and their pros and cons, John might have a less difficult time in making a decision. Similar to assertiveness, problem solving can also help inform REBT best practice by promoting another functional coping skill for clients who have difficulty considering the benefits and consequences of a number of solutions. Once clients change their feeling from anger to annoyance, they will be looking for more functional alternative behaviors such as assertiveness or problem solving instead of punching or yelling.

The above interventions are empirically-supported and are the most prevalent in protocols for the treatment of anger. All of the above interventions are considered to be cognitive behavioral interventions and, as a type of Cognitive Behavioral Therapy (CBT), REBT therapy would include these interventions. In this author's experience, and as recommended by Kassinove and Tafrate (2002), treatments for anger work best when specific interventions are utilized as needed and in an order deemed most appropriate by the particular client and therapist. Thus, not all interventions are used for all clients, and there is no set order to be followed. The following section is a brief case example of how these interventions might be utilized with a client.

Brief Case Example

This individual is fictitious and was made up for the sole purpose of this chapter. Any similarities between this case example and an actual individual are entirely coincidental.

Brittany, a 40 year-old Caucasian woman attended outpatient therapy for difficulties with her anger. She decided to attend because she had been frequently yelling at her husband, Jack, and had recently begun pushing him during arguments. Her main goals were to be able to reduce her anger towards her husband and communicate more effectively with him.

During the intake interview, her therapist, Dr. J, conducted a risk assessment regarding her and her husband's physical safety. Dr. J concluded there was no risk and began to concentrate on building a strong therapeutic alliance and increasing Brittany's motivation for psychotherapy. Dr. J purposefully used a number of reflections, validations, and affirmations to build their relationship through empathic listening. Dr. J also used humor to help create a positive environment. Dr. J additionally invoked the spirit of motivational interviewing by taking time to have Brittany discuss the negative consequences of her anger and aggression and the benefits of changing her emotions and behaviors to ones that are more functional (including attending therapy). Although this was emphasized in the beginning sessions, Dr. J considered building the therapeutic alliance and increasing client motivation throughout the entire psychotherapy process.

Anger psychotherapy with Brittany began as usual, with psychoeducation about anger in general and about Brittany's experience of anger. Dr. J gathered information about Brittany's ABCs as well as her behavioral and emotional goals for psychotherapy. Specifically, Brittany's main concern was her C: anger and aggression (specifically, yelling and pushing). Her As were primarily husband-specific: when he doesn't clean up after himself, when he doesn't look for work, and when he breathes loudly. Through the process of inference chaining, Brittany endorsed a few Bs, primarily: "Jack needs to try harder. He is a lazy pig!"

After psychoeducation, Dr. J could have begun with a number of interventions. Dr. J decided to begin with escape and avoidance (for the short term) to reduce Brittany's likelihood of encountering confrontation and responding by pushing. They discussed that, when Brittany begins to feel angry, she will leave the room until she calms down. Dr. J and Brittany also discussed relaxation to help Brittany reduce her physiological agitation.

When Dr. J and Brittany decided Brittany was able to identify her anger in the moment and take a step back before acting, they began cognitive restructuring. Cognitive restructuring began with Brittany's demand that Jack tries harder since Brittany said that belief was the most angering for her. The full irrational belief was: "I want Jack to try harder, and therefore he needs to." Dr. J used a number of disputations including: (1) "Just because you *want* Jack to try harder, does that mean that he *needs* to?" (2) "It looks like Jack has not been trying harder. So wouldn't it be false to say that he *needs* to try harder?" (3) "How do you feel when you think that Jack *needs* to try harder?" Brittany and Dr. J then created a more functional rational belief: "I want Jack to try harder, but that doesn't mean he needs to. He will do anything that he wants." They then engaged in role reversals and rational-emotive imagery to further process the disputations and rational belief. Dr. J then assigned Brittany homework to practice the disputations and rational beliefs and, eventually, to engage in behaviors consistent with the rational belief (e.g., speaking to her husband assertively rather than yelling at him).

Once Brittany had a solid grasp of cognitive restructuring, Dr. J and Brittany then discussed problem solving to help her identify other ways to resolve conflicts with her husband and assertiveness to help express herself in a way that is clear without yelling or pushing. These interventions could have also been addressed early on in therapy; however, Dr. J, like most REBT therapists, wanted to encourage acceptance of difficult events prior to changing them. This is because people tend to handle challenges better once they have accepted them.

When Brittany was ready (considering the concerns mentioned in previous chapters), Dr. J and Brittany engaged in exposure exercises. Brittany recorded Jack breathing loudly and she listened to it five times per day. Eventually, Brittany became desensitized to (and thus, less bothered by) Jack's breathing.

Finally, when Brittany's goals had been met and she was thinking, feeling, and behaving functionally around her husband, Dr. J and Brittany discussed her graduation from psychotherapy. Final sessions revolved around relapse prevention by reviewing previously learned material and considering potential future triggers (e.g., what if Jack leaves the whole entire house a mess?). Dr. J and Brittany also processed

her experience of therapy and addressed any of Brittany's remaining questions, concerns, and compliments.

What I Have Learned About Using REBT with Anger Disorders

Accommodating Individual Differences: **Client Gender, Ethnicity, Socio-Economic Status, Intelligence and Other Factors**. Individuals of all cultures think irrationally. Thus, theoretically REBT can be applied to individuals of all cultures without changing its core tenets. This has been supported in the literature showing that traditional CBT has been effective for a variety of populations.

That being said, expert REBT therapists will consider individual and contextual differences when utilizing REBT. For example, individuals who seek anger management are more likely to be involved with the criminal justice system than any other emotional disorder. It will be essential for anger therapists who are seeing clients who are court-mandated or on probation to consider the impact of court-involvement in psychotherapy. Namely, court-mandated clients will likely be less trusting of psychotherapy and will be more likely to view it as a punishment rather than treatment. Further, these clients will be less likely to disclose anger episodes given their association of anger management with the court-system.

Of course, there are a number of other individual characteristics to consider in the treatment of anger. For example, men tend to be more expressive than women when angry. Similarly, individuals from individualistic countries tend to be more expressive than those from collectivistic countries when angry. Thus, assertiveness might be especially helpful for women and those from collectivistic countries. Additionally, since cognitive restructuring is highly dependent on logic and insight into one's thoughts, it is less likely to be helpful for those with intellectual disabilities. Behavioral techniques are more likely to be helpful for these individuals.

Cultural implications are further compounded when considering the culture of the therapist and cultural differences between the therapist and client. For example, clients who are ethnic minorities are more likely to be distrusting of anger management in general. This distrust might be attenuated or increased depending upon the ethnicity of the therapist and the historical dynamic between those ethnicities. These considerations are especially important for the treatment of anger since the therapeutic alliance already has the potential for increased strain. For more on culture-specific treatments of anger, the reader is highly encouraged to review Fernandez (2013).

The do's and don'ts. This author has a number of do's and don'ts when practicing REBT based on the above information and personal experience. They are as follows:

The do's. Do emphasize building the therapeutic alliance first. A consequence of anger is that damages relationships, and it will be important to strengthen the client-therapist relationship to make the most out of therapy for the client.

Do quickly assess for the likelihood of aggression (both within and outside of therapy). Although it is rare that a client will become aggressive toward the therapist, it will be important for the therapist to assess for their own safety. This is especially important in inpatient sites. Similarly, therapists will want to assess for the likelihood of a client becoming aggressive outside of therapy to reduce the likelihood of harm toward others and the consequences of that harm (e.g., ruined relationships, jail).

Do utilize the above mentioned empirically-based Rational Emotive and Cognitive Behavior Therapy techniques as appropriate. The above techniques are empirically supported. There is no one-fits-all formula, and it is recommended that the techniques are used on an as needed basis, depending on the contextual and individual characteristics of the client.

Do emphasize the irrational beliefs of demandingness and other-rating during cognitive restructuring. As noted earlier, any of the four irrational beliefs might be present and relevant. For anger, however, demandingness and other-rating seem to be the most prominent.

Do consider individual and contextual factors in psychotherapy. Some factors to consider include the culture of the client and therapist and whether or not the client is involved with the criminal justice system. The style of therapy and emphasis on particular techniques will vary depending upon these factors.

The don'ts. Don't focus on building self-esteem to treat anger. The belief that anger is based upon low self-esteem has been shown to be inaccurate, and treatments based upon this belief have been found to potentially *increase* anger (Baumeister, Smart, & Boden, 1996).

Don't encourage catharsis/ventilation (i.e., punching or yelling out one's anger). This is based on the belief that anger is like a boiling pot and will explode if not let out. However, this belief has also been found to be inaccurate and treatments based on this belief have been found to lead to *increased* aggression (Bushman, 2002).

Don't attempt cognitive disputation with a client who is actively angry. Relaxation, grounding, empathic listening, or motivational interviewing might be the best techniques in this scenario. However, an exception to this would be if there is a strong therapeutic alliance and the client is already very familiar with (and accepting of) cognitive restructuring: In this case, this might be a good practice opportunity for the client to apply cognitive restructuring to in-the-moment anger with the therapist. Of course, the therapist would do well to proceed with caution.

Don't invalidate the client. Inherently, when therapists correct the misconception that A doesn't cause C but B causes C, they are telling the client that the client's thinking is the problem, and not the offender. This is also a consideration when disputing a client's belief, since the therapist is showing the client how their thinking has been illogical, inaccurate, and dysfunctional. Rookie therapists might end up angering clients when they do not provide enough validation for their client at these points—as one can imagine, this is particularly a concern with clients who are prone to anger. Thus, it is important for the therapist to reflect the client's discomfort, to normalize feeling unhappy with a difficult situation, and to praise the client's strengths and positive actions where possible.

Which Aspects of REBT Deliver the Most Benefit for Change and Which Don't. In this author's experience, there are some aspects of REBT that seem the most and least helpful when treating anger. They are as follows:

Which aspects of REBT deliver the most benefit for change. As noted earlier, disputing beliefs of demandingness and other-rating tend to be particularly effective. Role reversals and rational-emotive imagery are especially helpful in helping the client internalize the rational belief alternatives. Relaxation is typically helpful as an early intervention. Also, when the potential for aggression is present, behavioral interventions such as escape and avoidance (for the short term), problem solving, or assertiveness are most effective.

Which aspects of REBT deliver the least benefit for change. Conversely to the above paragraph, addressing self-rating in cognitive disputation seems to more likely address depression or anxiety than anger. Of course, it is recommended that psychotherapists always assess whether these beliefs are present, since they still might be relevant. However, it is likely most beneficial to begin with demandingness and other-rating.

Finally, although this has been mentioned many, many times already, the importance of building a strong therapeutic alliance cannot be overstated. Change is least likely to occur when the client is distrusting of (or dislikes) the therapist. When possible, have an open dialogue with the client about their potential concerns. If the client is not working well with a therapist due to the client and/or therapist's demographic (e.g., the client is female and would prefer a female therapist), consider referring the client to someone of a more appropriate demographic (i.e., in this case, the therapist—if not female—would refer the client to a female therapist). REBT has been shown to be effective, but only when performed in the appropriate context and manner.

References

Baumeister, R. F., Smart, L., & Boden, J. M. (1996). Relation of threatened egotism to violence and aggression: The dark side of high self-esteem. *Psychological Review, 103*(1), 5.

Beck, A. T. (1976). *Cognitive therapy and the emotional disorders*. New York: International University Press.

Beck, R., & Fernandez, E. (1998). Cognitive behavioral therapy in the treatment of anger: A meta-analysis. *Cognitive Therapy and Research, 22,* 63–74.

Bernstein, D. A., & Carlson, C. R. (1993). In P. M. Lehrer & R. L. Woolfolk (Eds.), *Principles and practices of stress management* (2nd ed.). New York: Guilford Press.

Bushman, B. J. (2002). Does venting anger feed or extinguish the flame? Catharsis, rumination, distraction, anger, and aggressive responding. *Personality and Social Psychology Bulletin, 28*(6), 724–731.

D'Zurilla, T. J., & Goldfried, M. R. (1971). Problem solving and behavior modification. *Journal of Abnormal Psychology, 78,* 107–126.

Darwin, C. (1872/1965). *The expression of emotions in man and animals*. Chicago: University of Chicago Press.

DiGiuseppe, R., & Tafrate, R. (2003). Anger treatment for adults: A meta-analytic review. *Clinical Psychology: Science and Practice, 10,* 70–84.
Del Vecchio, T., & O'Leary, K. D. (2004). The effectiveness of anger treatments for specific anger problems: A meta-analytic review. *Clinical Psychology Review, 24,* 15–34.
DiGiuseppe, R. A., Doyle, K. A., Dryden, W., & Backx, W. (2014). *A practitioner's guide to rational emotive behavior therapy*. Oxford: Oxford University Press.
DiGiuseppe, R., Leaf, R., Exner, T., & Robin, M. W. (1988). The development of a measure of irrational/rational thinking. In *World congress of behavior therapy*. Edinburgh, Scotland.
DiGiuseppe, R., & Tafrate, R. C. (2004). *Anger disorders scale*. Multi Health Systems: Toronto, Ontario, Canada.
DiGiuseppe, R., & Tafrate, R. C. (2007). *Understanding anger disorders*. Oxford: Oxford University Press.
DiGiuseppe, R., Tafrate, R., & Eckhardt, C. (1994). Critical issues in the treatment of anger. *Cognitive and Behavioral Practice, 1,* 111–132.
Edmondson, C. B., & Conger, J. C. (1996). A review of treatment efficacy for individuals with anger problems: Conceptual, assessment, and methodological issues. *Clinical Psychology Review, 16*(3), 251–275.
Ekman, P. (2007). *Emotions revealed: Recognizing faces and feelings to improve communication and emotional life*. London: Macmillan.
Ellis, A., & Tafrate, R. C. (1997). *How to control your anger before it controls you*. New York: Citadel Press.
Fernandez, E. (Ed.). (2013). *Treatments for anger in specific populations: Theory, application, and outcome*. Oxford: Oxford University Press.
Fried, R. (1993). The role of respiration in stress and stress control: Toward a theory of stress as a hypoxic phenomenon. In P. M. Lehrer & R. L. Woolfolk (Eds.), *Principles and practices of stress management* (2nd ed.). New York: Guilford Press.
Jacobson, E. (1924). The technic of progressive relaxation. *The Journal of Nervous and Mental Disease, 60*(6), 568–578.
Kassinove, H., & Tafrate, R. C. (2002). *Anger management: The complete treatment guidebook for practitioners*. Atascadero, CA: Impact Publishers.
Lindner, H., Kirkby, R., Wertheim, E., & Birch, P. (1999). A brief assessment of irrational thinking: The shortened general attitude and belief scale. *Cognitive Therapy and Research, 23*(6), 651–663.
Macavei, B., & McMahon, J. (2009). The assessment of rational and irrational beliefs. In D. David, S. Lynn, & A. Ellis (Eds.), *Rational and irrational beliefs: Research, theory, and clinical practice* (pp. 115–147). Oxford: Oxford University Press.
Miller, W. R., & Rollnick, S. (2002). *Motivational interviewing*. New York, NY: Guilford.
Novaco, R. W. (2003). *Novaco anger scale and provocation inventory*. Western Psychological Services: Torrance, CA.
Saini, M. (2009). A meta-analysis of psychological treatment of anger: Developing guidelines for evidence based practice. *Journal of the American Academy of Psychiatry and the Law, 37*(4), 438–441.
Spielberger, C. D. (1999). *State-trait anger expression inventory-2*. Lutz, FL: Psychological Assessment Resources Inc.
Stampfl, T. G., & Levis, D. J. (1967). Essentials of implosive therapy: A learning-theory-based psychodynamic behavioral therapy. *Journal of Abnormal Psychology, 72*(6), 496.
Sukhodolsky, D. G., Kassinove, H., & Gorman, B. S. (2004). Cognitive-behavioral therapy for anger in children and adolescents: A meta-analysis. *Aggression and Violent Behavior, 9*(3), 247–269.
Tafrate, R. (1995). Evaluation of treatment strategies for adult anger disorders. In H. Kassinove (Ed.), *Anger disorders: Definition, diagnosis, and treatment* (pp. 109–130). Washington, DC: Taylor & Francis.
Wolpe, J. (1958). *Psychotherapy by reciprocal inhibition*. Stanford, California: Stanford University Press.
Wolpe, J. (1990). *The practice of behavior therapy* (4th ed.). NY: Pergamon.

REBT and Eating Disorders

Kristene A. Doyle

While the majority of research and treatment literature addresses eating disorders from a Cognitive Behavioral perspective, there is considerable overlap in the conceptualization and treatment of eating disorders between REBT and CBT. There are numerous reasons why REBT lends itself to the treatment of eating disorders; namely, its concepts of Unconditional Self-Acceptance and Frustration Intolerance. Much of the challenge in working with clients with eating disorders lies in the over-evaluation of control of shape, weight and eating to determine one's self-worth, coupled with intolerance for discomfort or distress. Given that weight is largely under physiological control, and much of life and its circumstances are uncomfortable, REBT has the advantage of helping clients accept themselves as they are, and learn to tolerate frustration and discomfort in whatever form it presents itself. Working with clients with eating disorders is a serious responsibility for practitioners due to the associated medical complications and side effects, some of which can be life-threatening. As a result, this population, perhaps more than others, requires collaboration amongst various helping professionals. It is important for practitioners utilizing REBT in the treatment of eating disorders to understand the complexity of the therapeutic process, and to be mindful of their own irrational beliefs about the mechanisms of change.

Given that the same core psychopathology underlies the different eating disorders (with the only feature that is not a direct expression of the core psychopathology being binge eating), treatment for the most part, is similar across the disorders. However, there are special considerations for working with this population that need to be understood and addressed by practitioners.

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Key REBT Theoretical Concepts in Working with Eating Disorders

Key to working with clients with eating disorders is teaching them the concept of unconditional self-acceptance (USA). Both anorexia nervosa and bulimia nervosa are cognitive disorders (Murphy, Straebler, Cooper, & Fairburn, 2010) with an over-evaluation of shape, weight, eating, and their control to determine one's self-worth. Being that weight is largely under physiological control, helping clients achieve unconditional self-acceptance is crucial, as many of them will never achieve their goal of thinness. In addition, by self-downing and believing they are inadequate because they are unable to control their weight, shape, and/or caloric intake, clients often experience depression, guilt, anger, and/or shame. As I often explain to clients, holding onto irrational beliefs creates two problems instead of one (i.e., unable to control weight and shape, and the added component of unhealthy, dysfunctional emotions and maladaptive behaviors). It should be noted that many REBT therapists would argue that helping clients work towards achieving USA is paramount for all clinical problems. However, in the case of eating disorders, the presence of conditional self-worth and demandingess of self is striking. When discussing the concept of USA, many clients with eating disorders have said they cannot and will not accept themselves as they are today, because doing so would "be letting them off the hook" and they would become "out of control." This highlights the black and white, dichotomous thinking that is common in clients with eating disorders. It is important to explain to clients that this type of thinking tends to contribute to the self-perpetuating cycle of binging and purging in Bulimia Nervosa, and restricting food intake in Anorexia Nervosa.

Following organically from the aforementioned, utilizing the elegant solution as often as possible is important. By elegant solution, I mean identifying clients' worst case scenarios (e.g., I will become fat and that would make me worthless; People will disapprove of me and I could not stand that; I will be "just" average and therefore not good enough) and working with them to accept themselves and/or life, while simultaneously not liking the reality. Doing so does not preclude the use of the inelegant solution as well, in which we may challenge the automatic thoughts and inferences (e.g., I will become fat; People will disapprove of me; I will be "just" average). In fact, in many cases, beginning with the elegant solution and then returning to any distorted inferences helps to solidify a shift in a client's philosophy of themselves. For example, many clients with eating disorders hold an irrational belief such as "*If I eat something off my forbidden food list, I will end up binging and gaining a lot of weight, and that would be horrible*." If therapy were to proceed with addressing the inference first, there is a possibility that the client would in fact gain weight (the amount unknown), because weight fluctuates throughout days and across days (Fairburn, 2008). However, using the elegant solution first, and helping clients to decatastrophize about the possibility of weight gain and helping them to accept themselves (while not liking this possibility), allows for generalization to, and coping with, similar future activating events. Following this, returning to the inference and

testing it could be useful data for the client. Often there is no weight gain, but if there happens to be, they have acquired strategies to cope with their bad reality, due to having learned the elegant solution. It should be noted that with this particular irrational belief, there is an implicit assumption that binging will automatically occur, as opposed to a choice the client would make to binge. Emphasizing client behavioral responsibility without judging them for their choices is crucial.

Teaching the concept of the Belief-Consequence (emotional and behavioral) connection (B-C) is imperative as so many individuals with eating disorders, and individuals in general, make Activating Event-Consequence connections (A-C), irrational belief highlighted by Ellis in his revised and updated seminal book, *Reason and Emotion in Psychotherapy* (1994). However, prior to doing so, you may find that time is needed to be spent on affective education, as there is often difficulty in identifying emotions, as well as accurately labeling them. It is not uncommon to hear clients who binge report that it "happened out of nowhere" when asked what the trigger was, or they misinterpret feelings of anxiety, depression, boredom, and loneliness for that of feeling fat. Psychoeducation is necessary at this point, as well as time dedicated to expanding clients' emotional vocabulary, regardless of their age. Do not mistakenly assume that adult clients have an expansive and accurate emotional vocabulary and schema. Furthermore, REBT's conceptualization of emotions suggests that we do not aim to reduce the intensity of the unhealthy negative emotion, because the irrational belief(s) will still be present, albeit perhaps held with less vigor by the client (Dryden, 2012). It is important to elucidate to clients that if they are experiencing anxiety that is often a trigger for restricting calories, or binging and purging, reducing the intensity of the anxiety will not necessarily eliminate the consequential maladaptive behaviors. It is imperative to discuss the concept of replacing the unhealthy, dysfunctional negative emotion with a functional, albeit still negative emotion.

Another key theoretical REBT concept focused on is *Frustration Intolerance* (FI) as so many clients with eating disorders, bulimia nervosa in particular, have FI. One of the challenges with this particular irrational belief is that it tends to perpetuate itself. In other words, clients believe they can't tolerate certain emotions (e.g., anxiety, depression, or shame), and because of this belief, they engage in distraction behaviors such as restricting, binging, or purging, which temporarily relieves the emotional discomfort. As such, clients do not give themselves the opportunity to prove to themselves that while the emotion may in fact be uncomfortable, they can tolerate it. Strategies to address FI will be discussed later in this chapter.

Catastrophizing is another key concept to be addressed in working with clients with eating disorders. Regardless of the type of eating disorder, catastrophizing often occurs as a result of dietary restraint (repeated attempts to adhere to rigid rules about eating) (Fairburn, Cooper, & Shafran, 2003). When individuals break one of their arbitrary rules regarding what to eat, when to eat, or how much to eat, there is a tendency to overreact and catastrophize, followed by a temporary abandonment of the restraint, and engage in binge eating. Helping clients to decatastrophize and assisting them to view each eating episode as discrete can help in addressing the maladaptive behavior of binge eating.

Finally, assessing and addressing the presence of secondary emotional disturbance, or meta-disturbance, is important in the treatment of eating disorders. While it is common practice to do so with many types of clients with different clinical problems, it is especially necessary with eating disorders because very often there is shame as a result of binging and purging. Shame is one emotion that has the tendency to impede working on the primary behavioral disturbance of binging and subsequent purging. This is precisely why the REBT concept of Unconditional Self-Acceptance is vital with this population. Clients with bulimia nervosa or binge eating disorder are better served if they acknowledge their flaws, take accountability for their behaviors while not liking them, and not rate themselves based on their behaviors. When the secondary emotional disturbance about the primary behavioral consequence(s) (i.e., binging and purging) is addressed, it improves the probability that the therapist and client will have success addressing the eating disorder.

Key Best-Practice REBT-Based Assessment and Treatment Strategies and Techniques in Working with Eating Disorders

Assessment Strategies and Techniques

It is important to conduct a thorough assessment with a client who presents with an eating disorder. Practitioners should keep in mind that what may present as an eating disorder could in fact be masking a different clinical problem such as anxiety or depression (Fairburn, 2008). Having clients complete The Eating Disorder Examination Questionnaire (EDE-Q 6.0) (Fairburn & Beglin, 2008) assists the practitioner in assessing the nature and severity of the eating problem over the last four weeks. This particular self-report measure is only 28 items, making it a practical assessment tool. The Eating Disorder Examination interview (EDE) (Cooper & Fairburn, 1987) is considered the gold standard in assessment of core symptoms of eating disorders, with considerable reliability and validity and is considered by some to be the most precise measure of binge eating (Peterson et al., 2007). However, it is lengthier than the EDE-Q 6.0 and requires the therapist to conduct a semi-structured clinical interview. Most therapists cannot allocate the time necessary to administering the EDE. It should be noted that in studies comparing The Eating Disorder Examination and the self-report version for Anorexia Nervosa, both measures agree in the assessment of specific unambiguous behaviors (e.g., self-induced vomiting, laxative abuse) but tend to have less agreement for behaviors such as binge eating, and concern with shape and weight (Wolk, Loeb, & Walsh, 2005). When comparing the EDE and the EDE-Q with patients with Bulimia Nervosa, similar results occur. Sysko, Walsh, and Fairburn (2005) propose that binge eating and concern about shape and weight are complicated terms that lend themselves to discrepancies in measurement during assessment. Based on these findings, a combination of an easy to administer self-report questionnaire and a clinical interview is recommended, with additional

inquiry regarding binge eating and attitudinal concepts about shape and weight. It should be noted that when working with clients suffering from eating disorders, practitioners should be sensitive to the timing of when the self-report measure is administered. I have found it beneficial to start the assessment with a clinical interview, gleaning information about who the client is outside of the eating disorder, as well as establishing the nature and severity of the eating problem. Topics to be addressed in the interview include the client's perspective of the eating problem, as well as significant others' perspective (especially when working with clients who are not self-referred); the presence of any co-morbid psychiatric conditions (especially clinical depression, anxiety disorder, substance abuse, or the presence of a personality disorder); the methods the client engages into control shape and weight (i.e., self-induced vomiting, laxative or diuretic abuse, excessive exercising, chewing and spitting food, fasting); the presence of dietary restraint and/or dietary restriction; the client's outlook on shape and weight; how the eating disorder is impairing social, occupational/school, and physical functioning; any presence of binge eating (this is especially important because of the frequent presence of binges evidenced in clients with Anorexia Nervosa that are sometimes dismissed or overlooked by the clinician because they are not defined as *objective binges* but nevertheless quite distressing); checking behaviors; client and family psychiatric and medical history; and a general personal history (Fairburn, 2008). The client's attitude about treatment and any concerns or questions are also addressed in the assessment phase. Clients' height and weight are also taken at this time. Practitioners will want to simultaneously work at helping the client feel as comfortable as possible as well as gaining a clear understanding of the eating problem and the mechanisms perpetuating the eating disorder mindset during assessment to pave the way for treatment. In addition to the clinical interview and formal assessment questionnaires, utilizing the RIBS (Rational Irrational Beliefs Scale) developed for eating problems can provide insight into the particular irrational beliefs clients with eating disorders endorse, as well as the degree to which they do or do not endorse them. Examples of items include, "If I can't control my eating, it does not mean I am worthless"; "I condemn myself for not being able to control my shape/weight/or eating"; "I absolutely must not be overweight." Clients endorse the items on a 1 to 5 likert scale from Strongly Disagree to Strongly Agree. The information gleaned during the assessment can help formulate the case conceptualization and treatment plan. In addition, the RIBS can be completed each week during treatment as a means of assessing change, progress, or lack thereof.

Treatment Strategies and Techniques

Regarding treatment strategies, it is important to establish a solid therapeutic alliance before proceeding to any cognitive restructuring. Practitioners will often need to have a slower pace to develop a strong therapeutic alliance. It is imperative to show interest in the client him/herself and not simply the eating disorder. Treatment typically begins with behavioral interventions before addressing irrational beliefs and cog-

nitive distortions. From the outset of therapy, clients are weighed in session and asked to stop weighing themselves at home or at the gym. A common question asked regarding weighing is whether or not clients are informed of their weight. Weighing is collaborative, in that the therapist states aloud the client's weight and both therapist and client agree on the number and after several sessions, there will be a discussion of any trends in weight, to avoid over interpretation of any one particular number. An exception to this requirement is made only during the assessment. If the client is does not want to know his/her weight at that point, that wish is respected (Fairburn, 2008).

"In the moment" self-monitoring is also utilized from the beginning of treatment, and continues throughout the course of therapy. Depending on which maintaining mechanism is being addressed at any particular time (e.g., dietary restraint; comparison making; shape checking; performance checking; etc.), clients are asked to self-monitor as a means of becoming more aware of thoughts, feelings, or behaviors that are perpetuating the eating disorder. It is important to highlight to clients that for irrational beliefs and mood-related changes in eating to be identified, they preferably should record as close to in the moment as possible that they are engaging in the maintaining mechanism.

Clients are also asked early in treatment to begin to plan their meals and snacks. Regular patterns of eating help address clients' delayed or chaotic eating that typically results in binging as seen in Bulimia Nervosa and Binge Eating Disorder (Fairburn, Marcus, & Wilson, 1993). With clients suffering from Anorexia Nervosa, there is often a lag in the time it takes for food to move from the stomach to the intestine, resulting in a feeling of being full after consuming a small amount of food. Regular eating helps to reverse this phenomenon (Fairburn, 2008). It should be noted that for clients with Anorexia Nervosa, they will be required to consume additional calories than their usual amount in order to regain weight. Reducing or temporarily abandoning exercise may also be required during the regaining weight phase.

Once the aforementioned behavioral strategies have been implemented, cognitive interventions are introduced. Therapists will need to address core irrational beliefs such as "I *must* be a certain weight or else I am *worthless*"; "I *can't tolerate* being imperfect"; "Fat is *horrible*"; "If I eat something off my forbidden food list I will be out of control and binge and that would be *horrible,*" "*Being overweight is the worst thing that could happen to me. If I have excess body fat, I'm a total failure,*" "*If I eat at all, I will never stop. I will lose all control and that would make me a failure/worthless.*" It is important to show clients that this type of all-or-nothing thinking implies they have absolutely no self-control. Showing them by depriving themselves they are increasing the likelihood of a binge. In addition, having clients redefine "forbidden foods" as medicine to prevent future binging can prove successful. Assisting clients to accept themselves as they are today is essential to treatment.

Another key component of treatment is to have clients break their rigid rules regarding food. A helpful intervention to do in session is to have the client bring in some food on their "forbidden food list" and eat a piece of it (or as much as they would like). Breaking their rules and re-introducing "bad foods" affords them the opportunity to tolerate the discomfort and realize they don't *have* to binge and

then purge. This intervention is then utilized as an ongoing homework assignment. Finally, because so many clients with eating disorders engage in confirmatory bias, whereby they filter out evidence that does not support their irrational beliefs and cognitive distortions, it is important to assign homework that addresses their bias. For example, some clients believe, "Only thin women are happy and self-accepting" (a cognitive distortion). I have found it helpful to ask clients to purposely find women who are not thin but still are happy and self-accepting as a homework assignment.

Treatment Guidelines from the Empirically-Supported Therapy Literature that Inform Best Practice in REBT with Eating Disorders

Cognitive Behavior Therapy is the most efficacious therapeutic approach for Bulimia Nervosa in the short-term and is typically the first recommended treatment. Binge eating and purging have also been found to be more effectively treated using CBT than other approaches (Fairburn et al., 2003). Interpersonal Psychotherapy for the treatment of Bulimia Nervosa produces results equivalent to CBT in the long-term. In other words, IPT works as well but is slower to demonstrate results (Kass, Kolko, & Wilfley, 2013). Approximately 50–60% of clients with Bulimia Nervosa who are treated with CBT remit, and another 20% demonstrate a good amount of improvement. In addition, clients maintain their gains one to five years later (Agras & Apple, 2008). It has been shown that early response to CBT, specifically a reduction in in binge eating and vomiting, generally predicts outcome both at the end of treatment and at follow-up (Agras et al., 2000). It is recommended to address and reduce clients' dietary restraint early in treatment. Identifying and modifying the rigid rules clients hold about what, when, and how much to eat is beneficial. Research on the treatment for Binge Eating Disorder suggests that CBT and Interpersonal Therapy are equally as effective (Agras & Apple, 2008). Given the commonalities in the underlying mechanisms that maintain bulimia nervosa and anorexia nervosa, that is, the over-evaluation of shape, weight, and eating, coupled with the fact that approximately 25% of clients with bulimia nervosa report a history of anorexia nervosa, (Agras, Walsh, Fairburn, Wilson, & Kraemer, 2000), and the level of dietary restraint that is evidenced in clients with all types of eating disorders, a more recent transdiagnostic theory and treatment approach has been suggested (Fairburn, Cooper, & Shafran, 2003). For more information on the Enhanced Cognitive Behavior Therapy for eating disorders, the reader is referred to Fairburn (2008). It should be noted that in traditional REBT, clients are often encouraged to engage in formal behavioral experiments that are hypothesis driven. However, Fairburn suggests limiting this approach and collaborate with clients to make behavioral changes early in treatment (i.e., in-session weighing; planned meals; self-monitoring) that will attain cognitive changes. As such, one means of enhancing the practice of REBT based on research findings is to limit the use of cognitive restructuring strategies at the onset of treat-

ment. Furthermore, many REBT practitioners suggest to clients that they record their sessions and listen to them during the week to reinforce concepts discussed, interventions carried out, etc. With the eating disorder population this is not recommended as doing so tends have a negative impact of increasing rumination of irrational thinking and reinforcing the eating disorder mindset (Fairburn, 2008).

The literature on psychological treatment for Anorexia Nervosa appears inconclusive. CBT may reduce the risk for relapse in adults with Anorexia Nervosa subsequent to restoring weight. It is not known whether or not CBT is efficacious when clients are underweight (Bulik, Berkman, Brownley, Sedway, & Lohr, 2007). Overall, there is some limited support for CBT improving symptoms of Anorexia Nervosa or reducing rate of relapse when compared with "nutritional" therapies. However, results should be interpreted with caution due to limitations in the studies (Bodell & Keel, 2010).

Family therapy has the strongest efficacy in the treatment of adolescents with Anorexia Nervosa. As of 2010, of the seven randomized clinical trials conducted with adolescent populations, five utilized family therapy treatments. Results indicate that family therapy is superior when compared with other forms of psychotherapy, regardless of the format or length of treatment (Bodell & Keel, 2010). The Maudsley Method is a family-based approach which views parents' and other family members' involvement in therapy as crucial for success in treatment. Parents are temporarily put in charge to help reduce the hold the eating disorder mindset has over the adolescent. This method strongly advocates weight restoration as the primary focus in the early stages of treatment. Once successful, the parents return control to the adolescent and assist in the typical handling of adolescent developmental tasks. (Lock, Le Grange, Agras, & Dare, 2001). This research has several implications for an REBT approach to the treatment of adolescent anorexia nervosa. Given that the family therapy approach, and specifically the Maudsley Method, necessitate parents taking an active role in therapy, coupled with the fact that many adolescents are in therapy against their will and thus angry and unmotivated, REBT can be a valuable tool in helping parents with any existing frustration intolerance, feelings of guilt towards themselves and/or anger towards their child. Doing so can help improve parents' ability to carry out the crucial task of refeeding.

Brief Case Example

A 23 year old Caucasian female, Elizabeth, self-referred for treatment of Bulimia Nervosa. She reported a previous history of Anorexia Nervosa, restricting type, and had been bulimic for the past 7 years. An assessment was conducted over two sessions utilizing the Eating Disorder Examination Questionnaire (EDE-Q 6.0) (Fairburn & Beglin, 2008), as well as a semi-structured interview. Elizabeth's height and weight were taken at this time. Based on the information gleaned, a formulation was created with the client. This formulation outlined the hypothetical mechanisms maintaining Elizabeth's eating disorder mindset (i.e., dietary restraint; mood-related changes in eating as a result of frustration intolerance for anxiety, boredom, and loneliness; and

conditional self-worth). The primary goals at this stage of therapy were to understand Elizabeth's eating problem and engage her in the treatment process. I explained the process of therapy, including the rationale for self-monitoring, in-session weighing, and planned meals and snacks. While eating disorders are considered cognitive disorders (Fairburn, 2008), the beginning stages of therapy are behaviorally focused. After socializing Elizabeth to the process of treatment and what would be involved, questions and concerns were invited to be discussed. It was stressed to Elizabeth that there is no perfect ending for therapy, and the goal of therapy was to learn the skills and tools to become her own therapist. By termination, there would be a strong possibility that Elizabeth still had residual binges or mood-related changes in eating, but she would be equipped to handle them if they arose.

At the onset of therapy, one form of shape checking (i.e., weighing) was addressed by having Elizabeth agree to stop weighing herself at home or the gym, and only being weighed by me in session. Collaborative weighing involved Elizabeth wearing indoor clothing, no shoes, and when she stepped on the scale I said aloud the number and she agreed to it. We did not interpret any one particular number but rather agreed to discuss her weight after approximately four sessions. I asked Elizabeth to start self-monitoring her meals and snacks as close as possible to the time of eating, including her thoughts and feelings before and after eating, the time of day, the location, and any purging behaviors. Self-monitoring was to be done from the outset of therapy and continue throughout treatment, as it is a tool to becoming an expert on her eating problem.

Finally, the rationale for planned meals and snacks was addressed. Planned meals and snacks did not concern what Elizabeth ate, but rather that she ate whatever she planned and did not eat in between. The use of planned meals and snacks leads to a fairly rapid reduction in binge eating (and subsequent compensatory purging) (Fairburn, 2008). At the beginning of each session, Elizabeth's weight was taken and her self-monitoring records were reviewed for accuracy and discussion of any noticeable patterns. Therapy then moved to addressing other forms of shape checking and shape avoidance (feeling her bones; checking her jewelry to ensure it was loose; avoiding looking in mirrors). We discussed the motive behind each of these checking and avoidance behaviors and how they all reinforce the maintaining mechanisms of the eating disorder mindset. Elizabeth agreed to reduce these behaviors by self-monitoring. Exposure was done to address her shape avoidance by having her purchase a full-length mirror and get dressed and undressed in front of it; getting massages; and wearing fitted clothing.

Elizabeth's main irrational beliefs contributing to her bulimia consisted of the following: "*If I am unable to control my weight I am worthless;*" "*I cannot stand the feeling of anxiety*;" "*Being bored and lonely is intolerable*." The overarching collaborative goal that was agreed upon was expanding Elizabeth's concept of self-worth and helping her to work towards Unconditional Self-Acceptance (USA). At the onset of treatment, Elizabeth measured her worth as a person based on her ability to control her weight. Psychoeducation involved discussing how weight was largely under physiological control and therefore putting all of her self-worth eggs in the "ability to control her weight" basket was dangerous. Ideally, in REBT, we would

want Elizabeth to accept herself unconditionally, regardless of her weight, shape, and control, or her intelligence, friends, family, or job. However, as a starting point, we aimed to expand her concept of self-worth beyond her weight. Elizabeth gradually enhanced the significance of other domains for self-evaluation. While this lends itself more to the concept of self-esteem, it was agreed that it was a good step in the right direction towards USA.

One obstacle that presents itself with the irrational belief of frustration intolerance is that it tends to reinforce itself. When Elizabeth believed she could not stand the feeling of anxiety, she binged to escape that emotion. After binging, she made herself anxious by thinking "*I just ate all that food and now I am going to gain weight and that's the worst thing that could happen*" and would then purge by self-induced vomiting because she believed she could not tolerate feeling anxious. I utilized a strategy with Elizabeth that has been successful with many clients with frustration intolerance. We collaborated on a recurring homework assignment to simultaneous build her tolerance for anxiety as well as teach her that while she does not like the feeling of anxiety, she can in fact tolerate it. I indicated to Elizabeth that it wasn't important at this point if she binged and purged. This was strategic in that I have found that clients are more amenable to the assignment if I avoid telling them *not* to binge or purge during the week. I asked Elizabeth if she did in fact binge between sessions, if she would be willing to sit and tolerate the discomfort for 30 s and rehearse a coping statement such as "I don't like this feeling of anxiety but I can tolerate it," and then go and purge. The next time she binged she was asked to sit for one minute and rehearse the coping statement before purging. Gradually she increased the amount of time she waited in between binging and purging. This eventually led to elimination of the purging behavior. The same exercise was applied to her intolerance for other emotions that precipitated a binge. In addition, on multiple occasions Elizabeth brought into session a food of her choice that she had on her "forbidden food" list. The reasoning behind this was that she often would binge on the very foods she rigidly held as "bad foods." The goal of this intervention was for Elizabeth to break her rigid rules and see that she could eat something off her bad food list and it did not necessarily have to lead to binging and subsequent weight gain. By breaking her dichotomous thinking about food, she reduced her binging behavior. Furthermore, I asked Elizabeth to view her "forbidden foods" as medicine to prevent future binging.

As therapy was coming to an end, relapse prevention was conducted, identifying the reasons for entering treatment, possible triggers for future binge/purge episodes, how her thinking has changed, and what she would do in the future to prevent a lapse turning into a relapse. Self-monitoring and in-session weighing was phased out towards the end of therapy. We ended treatment with the understanding that she could always come in for a booster session. I explained to Elizabeth that she had acquired the necessary tools for obstacles that will present themselves. I warned her that she may hit a bump in the road, but the fall would not be as hard and she would pick herself up quicker with the use of those acquired tools.

What I Have Learned About Using REBT with Eating Disorders

Accommodating Individual Differences: Client Gender; Ethnicity; SES; Intelligence and Other Factors

It is imperative to be aware of individual differences clients with eating disorders, as well as other clinical problems, bring to therapy. One does not simply address a client's irrational beliefs ignoring context such as cultural background, religious beliefs, ethnicity, socioeconomic status, intelligence level, and gender. Such factors need to be considered in the context of treatment. However, it is not sufficient to simply be aware of these contributing factors. REBT therapists preferably should educate themselves, either on their own through research of these factors, and/or through discussion of them with their client. Exploring the role of such factors and their significance, or lack thereof, to the client's problem, can lend itself to building rapport by demonstrating interest in the client as a whole, rather than just their faulty thinking and maladaptive emotions and behaviors.

When working with a client who has a lower intelligence level, I have learned there is a need to modify my (usual) therapeutic Socratic style to more of a didactic one. The need for abstract reasoning skills to logically challenge irrational beliefs has been documented (Bernard, Ellis, & Terjesen, 2006). If a client is more of a concrete thinker, or I observe inference chaining becoming circular, it is a cue for me to adjust my approach. With such clients, I have found that doing less cognitive restructuring through challenging irrational beliefs, and more didactic teaching of the rational alternatives and emphasizing rehearsal has been effective. In addition, utilizing more behavioral strategies to accommodate lower intelligence levels has been a strategy employed.

I have found that consideration of socioeconomic status (SES) needs to be made when regular eating is being addressed with clients who have an eating disorder. Although regular eating typically does not involve *what* the client eats, but rather that the client eats what he/she has planned and does not eat in between meals, there are cases in which clients would like to eat healthier (particularly for clients with binge eating disorder). If a client comes from a lower SES, access to healthier food choices may not be reasonable. It is very important to understand this dynamic, as overlooking it can rupture the therapeutic alliance and the therapist can appear "out of touch."

Gender is an interesting factor that requires accommodation when working with eating disorders. While it has become more acknowledged in recent years that men also are afflicted, there is still a great deal of shame for many men given that eating disorders are often regarded as a female disorder (Collier, 2013). It is important to explore with male clients any messages they were given in their family regarding expressing emotions. For example, if a male client was taught that getting anxious was a sign of being weak, or that talking about how he feels was intolerable to family

members, these ideas should be discussed and addressed in therapy, as they could be contributing factors in the eating disorder. Treatment of men with eating disorders is for the most part the same as that of women; however, therapists will want to convey an understanding of the male client in the context of society which often views eating disorders as a female problem.

An important factor to consider in the treatment of eating disorders is accommodating for different cultural values. Specifically, having worked with a female with bulimia nervosa who came to New York from Honduras specifically for treatment of her eating disorder, it came to light that her culture is less individualistic and more collectivist. She reported that her father is the patriarch of the family and whom she looked up to. His rigid beliefs about what women *should* look like were passed down generationally to his children. Of note, this client requested that we have a few sessions in which we Skyped with her father in Honduras. It was important for me to understand the context of her particular culture and the importance of family involvement in her treatment. This was a striking difference from clients I have worked with born and raised in the United States who often do not want significant others involved in treatment. It is important to recognize that for some cultures, you are not simply treating the individual client's irrational beliefs, but rather the cultural irrational beliefs. For clients who have a cultural background with strong irrational beliefs, time should be spent acknowledging and working on accepting the reality of the pressure that is experienced as a result, as well as instilling the idea that while it may be difficult to overcome believing such beliefs, it is not impossible.

The Dos and Don'ts When Treating Eating Disorders

The Do's

Perhaps the most important consideration when working with a client who is struggling with an eating disorder is to ensure that a sound therapeutic relationship is established prior to doing any cognitive restructuring. It is important in the early stages of therapy that the practitioner eases the client by devoting time to exploring attitude towards treatment, validating any ambivalence that may be occurring, addressing any concerns, in addition to understanding the mechanisms that are maintaining the eating disorder. This is important because such a large amount, if not all, of their self-worth is entwined in their ability to control shape, weight, and eating. Quite often in REBT, we advocate conducting an assessment and doing therapy simultaneously with clients, and often begin therapy in the first session (DiGiuseppe, Doyle, Dryden, & Backx, 2014). However, when working with a client who has an eating disorder, one needs to take a slower pace and hold off on challenging irrational beliefs, so as to preserve the therapeutic relationship and not scare off the client. If practitioners rush to cognitive restructuring too quickly, they are at risk of having the client terminate treatment prematurely. In addition, when a foundation of a trusting therapeutic relationship is established, it paves the way for the client to carry out the

intimidating and anxiety-provoking work that is needed to be done in order to make progress. In my clinical experience, I have had numerous clients tell me that they do not want to do a particular homework assignment or in-session task because of the feared consequences (e.g., weight gain; binging; being out of control), but they agree to do it because they trust me and know that I would not ask them to do something that was not in their best long-term interest.

Another "do" when working with this population is to instill strong concern in the client about the eating disorder but avoid creating paralyzing anxiety or hopelessness. Having an eating disorder comes with very serious medical complications that are often overlooked, misunderstood, minimized, or not taken seriously by the client. In fact, many clients have such low frustration tolerance they do not consider the health risks that may manifest in the medium to longer term. There is often a need for immediate gratification, which can take the form of escaping uncomfortable emotions or activating events, without consideration of any medical or health consequences. Early in treatment, it is recommended that the practitioner explain the risks involved with the eating disorder in a serious manner, but not one that overwhelms the client with anxiety or shame and possible premature termination. Doing so often has the added benefit of motivating the client to start considering how their present beliefs are contributing to their maladaptive behaviors, and begin questioning whether or not such are sustainable in the long-term.

While it is important to convey the serious nature of the eating disorder, it also is important to simultaneously impart a sense of hope in your clients. Many have been told they will never recover, and entering treatment with this attitude leads to precisely that. By conveying your understanding of their eating problem, as well as the research that supports the efficacy of the treatment, clients will often have a sense of relief that they have come to the right therapy.

It is also important during the assessment phase to identify any co-occurring Axis I disorders, particularly the presence of clinical depression, anxiety disorders, and/or substance dependence or abuse. This is because these conditions typically interfere in the treatment of the eating disorder. If any of these conditions are present, it is generally recommended that therapists address them prior to treating the eating disorder (Agras & Apple, 2008).

Finally, it is vital for practitioners from the outset of treatment to extend Unconditional Other Acceptance (UOA), regardless of what the client shares. Many clients postpone entering therapy because of the profound shame they experience as a result of their binging (in clients with binge eating disorder), binging and purging seen (in bulimia nervosa), or because of the feared consequences of weight gain (seen in clients with anorexia nervosa). This population struggles to accept themselves unconditionally, and many assume that because they do not accept themselves and judge themselves, others will and are doing the same. Practitioners need to dispel this myth and qualify the difference between rating one's behavior and rating one's worth.

The Don'ts

It is important not to rush to cognitive restructuring early in therapy, as this could lead to a rupture in the alliance. As previously mentioned, self-evaluation is unduly influenced by the client's ability to control shape, weight, and/or calorie intake. Moving quickly to challenging their core beliefs of self-worth can be interpreted as the practitioner trying to take away their identity. This is why collaboratively establishing a set of hypotheses of what is maintaining the eating disorder and constructing a visual "flow chart" is important to do during the assessment phase. This "flow chart" assists the client in viewing the eating problem in an objective manner, and shows that there is a very clear, logical self-perpetuating sequence to the various factors contributing to the maintenance of the eating disorder, and helps address the common experience many clients have of becoming overwhelmed when talking about their problem. This is a powerful tool to help understand the eating problem and assists in breaking the over-identification many clients have with their eating problem.

Another pitfall for therapists is to avoid the appearance of being controlling, as so much of these disorders are about control. Throughout the process of therapy, it is important that a collaborative approach be taken. For example, it is helpful to invite questions from your client when conducting your assessment, obtain feedback after explaining and carrying out an intervention, and elicit any concerns your client may have about any aspect of therapy.

Due to the medical complications associated with this population, one caution is not to work in isolation. Many clients require a "team approach", with medical doctors, mental health practitioners, psychiatrists, and nutritionists involved. Often, because of the shame associated with these disorders, or the general ambivalence or avoidance evidenced, some clients will tell their therapist that they had a medical exam and all results were normal, when in fact they never went to a doctor. It is recommended that a condition of treatment is open communication between team members. Furthermore, if a therapist needs to make a referral, do not assume that a medical doctor has knowledge about eating disorders. An adolescent with anorexia nervosa I was treating told me her pediatrician told her father that she would be fine if she "just ate a cheeseburger." In addition, I have had experience with some nutritionists who indicate they treat individuals with eating disorders, but fail to understand the sensitive factors associated with them. I was working with an older woman with anorexia nervosa and wanted her to see a nutritionist. I was having difficulty finding someone who understood the nature of anorexia, so the client used a referral her medical doctor provided. Within the first ten minutes of her appointment with the nutritionist, the client was told she was going to gain weight in her thighs, stomach, and buttocks. Needless to say, the client became so anxious she terminated therapy prematurely.

Which Aspects of REBT Deliver the most Benefit for Change and Which Don't

A client's motivation to work on their eating problem is a prerequisite for change. However, many clients come to therapy either against their will and therefore unmotivated (as is often the case with adolescents), or with a high level of anxiety regarding change and as a result ambivalent about therapy. Consequently, to build and/or enhance motivation, there needs to be time in the beginning of treatment to explore the negative consequences of their eating disorder, to examine how their problem will affect areas of their life in the future (in the case of adolescents and young adults), and to dispel the myth that the clients are in control but rather their eating disorder mindset is actually controlling them. There is what many clients refer to as the "eating disorder voice", (sometimes referred to as the name Ed, or Ana) which they report as being stronger than the "healthy, rational voice", particularly in the beginning stages of treatment. When the practitioner has successfully established a sound therapeutic alliance, (the bond between practitioner and client, agreement on the goals of therapy the tasks of therapy), there is the most benefit for change. Many clients will agree to do the tasks asked of them that will affect change if they trust their therapist, despite that strong "eating disorder voice." Reinforcing clients for making steps towards change is an important task for the practitioner, as so many clients have dichotomous thinking and are perfectionistic. They view progress as either 100% or 0%, and have difficulty seeing intervals in between. Therapists can model for their clients positive reinforcement and acceptance of non-perfection.

Early in treatment, having a behavioral focus also leads to change (i.e., in-session weighing; planned meals and snacks; self-monitoring). Planned meals and snacks addresses delayed eating, and chaotic eating. This in turn results in a rapid reduction of binge eating (and consequently compensatory purging) which is often reported as the most distressing aspect of bulimia nervosa, thereby enhancing a positive mood. Research shows that clients who have not reduced the frequency of purging within the first four weeks of therapy are likely to have less success in treatment (Agras & Apple, 2008). When clients agree to stop weighing themselves and allow the therapist to do so in session, one form of shape checking (a maintaining mechanism) is addressed. This is very important because clients typically misinterpret the number on the scale; if the number is higher than what it "should" be, clients conclude it as evidence for their lack of self-control and being weak, and therefore tend to diet harder by making their rules about eating even more rigid. If the number is what it "should" be or even lower, it is evidence that the dietary restraint is working.

Perhaps the aspect of REBT that produces the most benefit for change is the concept of Unconditional Self-Acceptance. Helping clients to expand their concept of self-worth beyond control of shape, weight and eating is paramount to success. When clients begin to value other aspects of their lives beyond their shape, such as family, friends, occupation, hobbies, etc., the over-evaluation of shape and weight tends to diminish. There is an important point about this that should be highlighted. At the start of treatment, when the therapist asks a client with an eating disorder to

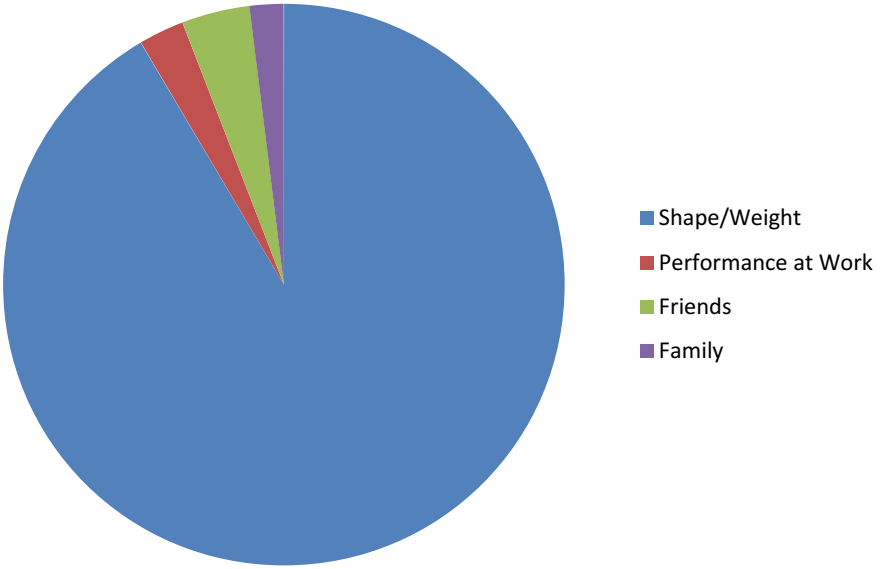

Fig. 1 Self-worth pre-treatment

draw a "self-worth" pie chart and fill in pieces of the pie, the majority of the pie comes from controlling shape, weight, and eating. As therapy progresses, the "self-worth" pie changes, with a more even distribution of other aspects of their lives contributing to their self-worth. Self-worth pre and post-treatment are presented in Figs. 1 and 2.

From an REBT perspective, we would regard this as self-esteem. In other words, clients evaluate themselves based on the fact that they have friends, family, a job, etc. Ideally, REBT therapists would want clients to accept themselves regardless of those pieces of the pie. However, sometimes the inelegant solution is elegant. I believe this is the case when working with clients with eating disorders. I have found that first having clients expand their concept of self-worth beyond control of shape, weight, and eating, and then proceeding with a philosophical discussion of accepting oneself regardless of any other factors is most effective to achieve change.

Challenging the irrational belief "*If I am fat it would be awful*" is not the most effective strategy for change. This is because a client's definition of what is awful is an arbitrary evaluation. If the therapist challenges this particular belief too quickly, the result could be, and often is, a rupture in the relationship. The therapist could be perceived as insensitive, out of touch, and invalidating. One strategy to implement is to first challenge the awfulizing about becoming fat, showing the client how continuing to think this way leads to anxiety, which often results in either binging or restricting, both self-defeating behaviors. In other words, therapists preferably should not go after whether or not becoming fat would be awful (do not challenge the client's definition of awful) initially. By doing a functional debate of the awfuliz-

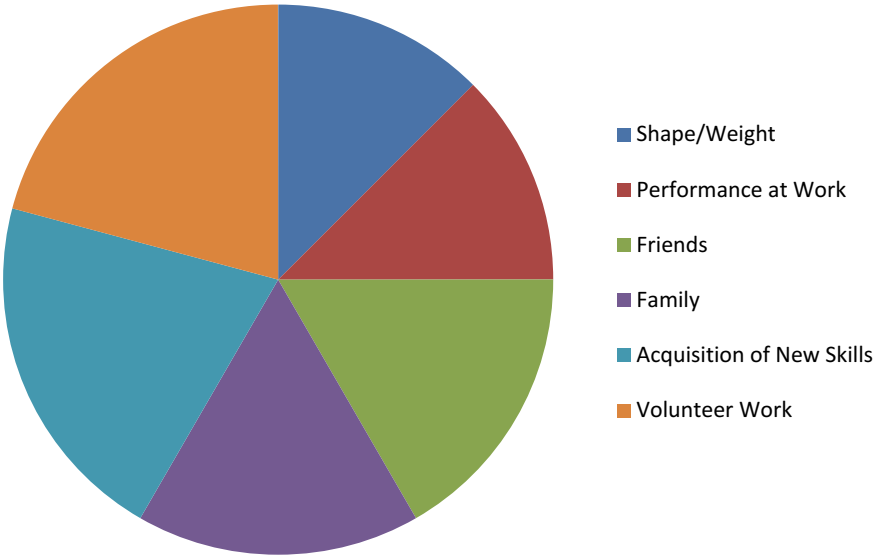

Fig. 2 Self-worth post-treatment

ing, the client may experience some symptom relief. After this occurs, it may be suggested in some cases to challenge the client's definition of awful.

Although research has shown that demandingness is primary to emotional and behavioral disturbance, the derivatives of the demand are considered proximal (DiLorenzo, David, & Montgomery, 2007; Hyland, Shevlin, Adamson, & Boduszek, 2014). When therapists insist on addressing the demands because of research findings, rather than the global evaluations of worth, there is a possibility of missing the mark, so to speak. It is important to address the irrational beliefs the client resonates with, not the beliefs the therapist hypothesizes to be central to the disturbance. Therapist rigidity in translating REBT research into practice does not benefit the client, therapist, or the therapeutic process.

Final Thoughts

It is the hope after concluding this chapter, the reader has learned some of the unique aspects of REBT that have shown to be effective in treating clients with eating disorders, as well as those nuances which are not as useful. Drawing upon over 20 years of experience in working with such clients, the paramount importance of developing and preserving a solid therapeutic alliance cannot be over emphasized. Numerous challenges arise as a result of the eating disorder itself, such as the extreme rigid thinking, the inability to concentrate, heightened obsessionality, ambivalence about getting better, and medical risks which are evidenced in many clients. An

additional obstacle for treatment with this population concerns the societal pressures and messages regarding thinness that are difficult to ignore. This is not to suggest that clients surrender to these pressures because they are pervasive; but rather it is more a caution for both the client and therapist that they will inevitably have to work harder arguing against these societal irrational beliefs and strengthen the conviction of the healthier, rational beliefs.

Working with clients with eating disorders is simultaneously challenging and rewarding. By utilizing the principles and practice of REBT and CBT, clients are taught that there is no perfect beginning, middle, or end of therapy; however, learning the strategies allows clients to end treatment and become their own therapists, accomplishing one of the primary goals of REBT.

References

Agras, W. S., & Apple, R. F. (2008). *Overcoming eating disorders*. New York, NY: Oxford University Press.

Agras, W. S., Crow, S. J., Halmi, K. A., Mitchell, J. E., Wilson, G. T., & Kraemer, H. C. (2000). Outcome predictors for the cognitive behavioral treatment of bulimia nervosa: Data from a multisite study. *American Journal of Psychiatry, 157,* 1302–1308.

Agras, W. S., Walsh, B. T., Fairburn, C. G., Wilson, G. T., & Kraemer, H. C. (2000). A multicenter comparison of cognitive-behavioral therapy and interpersonal psychotherapy for bulimia nervosa. *Archives of General Psychiatry, 57,* 459–466.

Bernard, M. E., Ellis, A., & Terjesen, M. (2006). Rational-emotive behavioral approaches to childhood disorders: History, theory, practice, and research. In A. Ellis & M. E. Bernard (Eds.), *Rational-emotive behavioral approaches to childhood disorders* (pp. 3–84). New York, NY: Springer Science + Business Media, Inc.

Bodell, L. P., & Keel, P. K. (2010). Current treatment for anorexia nervosa: Efficacy, safety, and adherence. *Psychological Research and Behavior Management, 3,* 91–108.

Bulik, C. M., Berkman, N. D., Brownley, K. A., Sedway, J. A., & Lohr, K. N. (2007). Anorexia nervosa treatment: A systematic review of randomized controlled trials. *International Journal of Eating Disorders, 40*(4), 310–320.

Collier, R. (2013). Treatment challenges for men with eating disorders. *Canadian Medical Association Journal, 185*(3), E137–E138. https://doi.org/10.1503/cmaj.109-4363.

Cooper, Z., & Fairburn, C. (1987). The eating disorder examination: A semi-structured interview for the assessment of the specific psychopathology of eating disorders. *International Journal of Eating Disorders, 6*(1), 1–8.

DiGiuseppe, R. A., Doyle, K. A., Dryden, W., & Backx, W. (2014). *A practitioner's guide to rational emotive behavior therapy*. New York, NY: Oxford University Press.

DiLorenzo, T. A., David, D., & Montgomery, G. H. (2007). The interrelations between irrational cognitive processes and distress in stressful academic settings. *Personality and Individual Differences, 42*(4), 765–776.

Dryden, W. (2012). *Dealing with emotional problems using rational-emotive cognitive behavior therapy: A practitioner's guide*. New York, NY: Routledge.

Ellis, A. (1994). *Reason and emotion in psychotherapy*. New York, NY: Carol Publishing Group.

Fairburn, C. G. (2008). *Cognitive behavior therapy and eating disorders*. New York, NY: The Guilford Press.

Fairburn, C. G., & Beglin, S. J. (2008). Eating Disorders Examination Questionnaire (EDE-Q 6.0). In C. G. Fairburn (Ed.), *Cognitive behavior therapy and eating disorders* (pp. 309–313). New York, NY: The Guilford Press.

Fairburn, C. G., Cooper, Z., & Shafran, R. (2003). Cognitive behaviour therapy for eating disorders: A "transdiagnostic" theory and treatment. *Behaviour Research and Therapy, 41*(5), 509–528.

Fairburn, C. G., Marcus, M. D., & Wilson, G. T. (1993). Cognitive-behavioral therapy for binge eating and bulimia nervosa: A comprehensive treatment manual. In C. G. Fairburn & G. T. Wilson (Eds.), *Binge eating: Nature, assessment, and treatment* (pp. 361–404). New York, NY: The Guilford Press.

Hyland, P., Shevlin, M., Adamson, G., & Boduszek, D. (2014). The organization of irrational beliefs in posttraumatic stress symptomology: Testing the predictions of REBT theory using structural equation modelling. *Journal of Clinical Psychology, 70*(1), 48–59.

Kass, E., Kolko, P., & Wilfley, D. E. (2013). Psychological treatments for eating disorders. *Current Opinion in Psychiatry, 26*(6), 549–555.

Lock, J., Le Grange, D., Agras, W. S., & Dare, C. (2001). *Treatment manual for Anorexia Nervosa*. New York, NY: The Guilford Press.

Murphy, R., Straebler, S., Cooper, Z., & Fairburn, C. G. (2010). Cognitive behavioural therapy for eating disorders. *Psychiatric Clinics of North America, 33*(3), 611–627.

Peterson, C. B., Crosby, R. D., Wonderlich, S. A., Joiner, T., Crow, S. J., Mitchell, J. E., et al. (2007). Psychometric properties of the eating disorder examination-questionnaire: Factor structure and internal consistency. *International Journal of Eating Disorders, 40,* 386–389.

Sysko, R., Walsh, B. T., & Fairburn, C. G. (2005). Eating Disorder Examination-Questionnaire as a measure of change in patients with bulimia nervosa. *International Journal of Eating Disorders, 37*(2), 100–106.

Wolk, S. L., Loeb, K. L., & Walsh, B. T. (2005). Assessment of patients with anorexia nervosa: Interview versus self-report. *International Journal of Eating Disorders, 37,* 92–99.

REBT and Addictions

F. Michler Bishop

Key REBT Theoretical Concepts in Working with Addictions

As REBT has always been a truly integrative approach, it is especially well suited for the treatment of addictions. Addictions develop over time, often inadvertently and accidently. No one sets out to be come addicted. But once in place, addictive behaviours are usually (but not always) very difficult to change, probably because of a combination of genetic predispositions and brain "re-wiring." An approach that integrates cognitive, emotive and behavioural techniques, and a non-judgemental, empathic therapeutic working relationship, appears to have the most research support as being effective.

REBT's underlying theoretical position hypothesizes that individuals are most affected by the interactive impact of their thinking, feeling and behaviour. That is, someone who one night gets in trouble with alcohol may have thought, "*I'll just have one.*" But he then wound up having not one but many and getting arrested for drunk driving. At that point, he may have thoughts and feelings about those consequences, and those thoughts and feelings may have contributed to more drinking. The therapist may also help him see that he may have been thinking something more than, *I'll just have one.* Specifically, in such situations, he is really thinking *I'll just have one, and I'll feel the way I want to feel*. It is this latter, hidden belief that is really irrational and problematic. But the first drink does not make him feel the way he wants to feel. So then he thinks *I'll just have one more, and I'll feel the way I want to feel*. But that doesn't work either. And after three drinks, so much ethanol is in his blood stream and entering his cerebral cortex, that, one could say, the whole ballgame has

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changed. His brain has changed, and with *that* brain, he should not expect himself to make the same decisions or behave the same way.

The theory also hypothesizes that the client will have feelings and thoughts about the lapse. Those feelings, perhaps shame and anger, and accompanying thoughts—*I should not have been so stupid. I am a failure. I'll always be a failure.*—may lead to other feelings—more shame and anger and possible feelings of helplessness and hopelessness, depression and/or anxiety and/or agitation—which may contribute to other sorts of behaviours, such as more drinking or, conversely, a re-commitment to abstinence.

Uncovering and identifying cycles of thoughts/beliefs, feelings and behaviours is key to conceptualizing a case. Key also to REBT is the theoretical hypothesis that humans (and clients) may make things worse as the result of the following:

Demandingness

Specifically, clients with addictive problems may make those problems worse by demanding that they feel better and/or do better. Clients may feel that other people feel better during the day, so why shouldn't they? Ample research now suggests that most people do not necessarily feel positive throughout the day. But clients, believing that they *should* feel better, may be motivated to fix the problem, pushed on by beliefs such as *It's not fair. Other people use drugs and get away with it. I can't stand feeling this way any longer. I have to change the way I feel*.

Low Frustration Tolerance

Low frustration tolerance (Ellis, 1962, 1994) (or "low distress tolerance," DBT's version of LFT) often contributes to the problem. Most people do not like to feel uncomfortable, and they may use addictive behaviours to get rid of this feeling. However, it should be remembered that people who have suffered trauma, e.g., veterans, children who have been sexually abused, may experience feelings, both emotional and physical, and envision scenes (images) which are much more troubling than most people experience. They may actually demonstrate quite high tolerance for discomfort and frustration in many other spheres of their life. They will stand the discomfort of a boring job, but later in the day, they may use drugs or alcohol to give themselves some relief from images and feelings that they have managed to keep at bay at work.

Self-downing and Self-criticism

Most people believe in the "moral model" of addictions. That is, people who have addictive problems are weak and are behaving immorally. People who are addicted have made poor choices because they are weak and demand instant gratification. Essentially, they are bad and should be punished. Nationally, in the United States, we spend far more money on jails, police officers, etc. than we do on treatment. Many countries (except Portugal) criminalize behaviours, which are really better seen as serious health issues. So it should not be surprising that most our clients agree: they are bad and weak and consistently, stubbornly self-destructive, and they should be ashamed of their continued behaviour. They should punish themselves, yell at themselves, and subject themselves to endless grilling: *Why do you behave so stupidly? Why can't you see how you are hurting yourself and the people who love you? What is wrong with you?* Of course, anyone would find any of these questions very difficult to answer from a rational, scientific standpoint. This is especially true if one is feeling beaten down already.

Awfulizing

Society also puts out the message that people with an addictive problem—with alcohol, drug (illegal or prescription), gambling, internet sex, etc.—are practically doomed. They have a "brain disease." The American Society of Addictive Medicine continues to define an addiction on its website as "a primary, chronic disease" that without treatment "is progressive" despite mounting research evidence going back over 50 years clearly indicating that many people—the majority, according to some studies—resolve their difficulties with alcohol, heroin, cocaine and marijuana on their own, without seeking professional help or going frequently to self-help meetings (e.g., Bishop, 2018; Dearing, Kitkiewitz, Connors, & Walitzer, 2013; Lopez-Quintero et al., 2011; Sobell, Ellingstad, & Sobell, 2000). Almost everyone who is addicted to nicotine quits smoking on his or her own, sometimes with help from a nicotine patch or medication. Having an addiction may be very serious, but it also may not be as awful as many forces in society—rehabs, hospitals, and pharmaceutical companies—would like people to believe.

Other Contributing Factors

In conceptualizing a case, it is generally wise to take into account other factors in addition to the interacting impact of thoughts, feelings and behaviours, e.g., genetic predispositions, conditioning, the environment, and interpersonal relations. And given the extensive evidence that adverse childhood events (cf., the ACE study, Felitti,

Anda, & Nordenberg, 1998) have a significant impact on behaviour and physical health, e.g., cardiac problems and cancer, it is important to spend some time on what may have contributed to the client's core beliefs. No doubt, insight is not curative by itself. But insight into the impact of past events on current behaviour may help a client give up self-damning beliefs and move toward a more compassionate and accepting attitude toward herself. It may also help her commit herself and re-motivate herself to the hard work often (but not always) required to change and maintain the change. She may think something like *I refuse to let what happened in my childhood rule my life*.

Key Best-Practice REBT-Based Assessment, Treatment Strategies and Techniques in Working with Addictions

Despite the fact that there are very few, if any, good studies of a specific REBT-focused approach for addictions, there are many REBT-focused studies that can help inform the way a therapist uses REBT while working with a client grappling with an addictive disorder. Moreover, a recent major systematic review and meta-analysis of half a century of REBT research establishes REBT as "a sound psychological intervention" (David, Cotet, Matu, Mogoase, & Stefan, 2017, p. 304).

There are many theories attempting to explain addictive behaviours, but no one theory yet explains why people become addicted to a substance or behaviour and why it is so difficult for some but not all to become unaddicted. The extent to which demandingness, low frustration tolerance, catastrophizing and self-depreciation may play a role in any one person's addiction has not been established yet. The problem is complicated by he fact that people vary considerably as to why and when and to what they become addicted. In addition, therapists who work with addicted clients will find that most, if not all of them, have other emotional, behavioural and relationship problems. Working on these underlying problems is crucial to helping them change their behaviour and maintain that change. They have to learn how to respond to their impulses and inhibitions, conditioning, emotional dysregulation, genetic predispositions and other contributing factors such as trauma in different ways. For those who use their addictive behaviours to manage a Major Depressive Disorder (MDD), some REBT research has clearly shown that it as effective as medication (fluoxetine); in addition, REBT (but not CT) was found significantly better at six-month follow-up over pharmacotherapy (David, Szentagotai, Lupu, & Cosman, 2008). The authors noted "a change in implicit demandingness" (Szentagotai, David, Lupu, & Cosman, 2008, p. 523) was related to reduced depression and relapse. In a more recent study, Iftene, Predescu, Stefan and David (2015) found group REBT was as effective as psychopharmacology (sertraline) and group REBT plus medication. Considering that REBT is a transdiagnostic approach, whatever a client learns in order to better manage one problem may help at managing other, interrelated and interacting problems.

Many people drink and use a variety of drugs or get in trouble with sex because they find the experience very pleasurable. Others may do the same thing to manage emotional and/or physical pain. Some people do both. For those who may drink or use drugs to manage social anxiety, an early meta-analysis of cognitive behaviour treatments, including two specifically involving RET, also found that group CBT treatment was the most cost effective (Gould, Buckminster, Pollack, Otto, & Yap, 1997). Specifically, one study found that negative functional appraisal was the "most efficient strategy" to reduce negative emotions and irrational thinking (Cristea, Tatar, Nagy, & David, 2012, p. 550).

The Kaiser-Permanante (Felitti et al., 1998) study of 17,000 people clearly established that Adverse Childhood Events (ACE) have a significant and dramatic effect of people's later psychological and physical health. Twenty-eight percent reported having been sexually abused. It is well know that trauma and substance abuse are related: Respondents who reported 4 or more adverse events were seven times as likely to suffer from "alcoholism" and 12 times as likely to commit suicide. The REBT/CBT hypothesized constructs catastrophizing, low frustration tolerance, self-depreciation and demandingness were found to contribute to PTSD symptoms in one study (Hyland, Shevlin, Adamson, & Boduszek, 2013). Moreover, rational beliefs, specifically, preferential beliefs and acceptance beliefs, moderated the impact of irrational beliefs on the level of PTSD symptoms (Hyland, Shevlin, Adamson, & Boduszek, 2014).

As noted above, some people may engage in addictive behaviors to manage a combination of anxiety and depression. Oltean, Hyland, Vallières, and David (2017), again using SEM, found that demandingness predicted catastrophizing, low frustration tolerance and global evaluations/self-downing. But perhaps of greater importance for practitioners, the study also found that catastrophizing and global evaluation/self-downing and predicted scores on the Satisfaction with Life (SWL) scale, and the "SWL demonstrated a significant, negative effect on levels of anxiety/depression" (p. 611).

Strategies and Techniques

Assessment

Similar to all CBTs, REBT practitioners do not spend the first one to three sessions doing an intake evaluation. Assessment is on going. It occurs at the beginning and during each session. It is also collaborative. The therapist and the client work together to clarify the goals of therapy: What does the client want to do? Stop? Cut down? What might help during the coming week? What has worked or not worked in the past? They then try to accurately assess and figure out what the problems are and what contributes to them and how to change them. It is critical to understand what a client is telling himself to convince himself that it is okay to drink again or use or gamble. Backing up in time, what beliefs contribute to repeating the behaviour?

The AUDIT is free and downloadable and probably the best, short assessment instrument. However, home assignments that the therapist and client agree upon may be even more helpful for assessment purposes. Evaluating the results in the next session will not only add to the initial assessment but will often move a client from being ambivalent to being genuinely motivated to take action, i.e., in terms of the Stages of Change Model, from Contemplation to Action. Home assignments that may help include:

Drinking Log

The therapist and the client agree that the client will simply note what she drinks and when and perhaps with whom. In the coming week, she will not make any effort to change. However, in most cases, bringing attention (awareness or mindfulness) back to a behaviour inevitably results in a change in the behaviour, in this case, reduced drinking.

Moderation

Many people come into my office wanting to moderate their drinking. I know from research that if they are in my office, moderation is improbable. Most people who want to moderate figure out how to do it on their own without consulting a therapist. But telling a client that may simply drive him away, and someone driven a way may not go back to a therapist for a long time. During that time he may do a lot of harm to himself and to others. So it is important to help him do what he has come to therapy to do: To figure out if he can moderate.

I often start by suggesting that a client stop for a week. That is often met with a look of dismay. To the client, that is neither possible nor desirable. So I suggest not drinking every other day. That may also be rejected. Of course, as we discuss these various options, I am getting a better sense of the extent of the problem. Let us assume that the client agrees not to drink two days out of the week, choosing Monday and Wednesday. At the beginning of the next session, after the normal pleasantries to keep the relationship in good working order, we can find out how it went. If the client was unable to not drink one single day, that is often very motivating and therefore helpful. If he has managed to abstain both days, he has probably either become aware that it is not so terrible nor so difficult not to drink (and I may have to revise my hypothesis that he cannot moderate) or he has learned that it is, in fact, very difficult and that it makes him very, very uncomfortable to not drink. This may also be illuminating and motivating.

Unlike psychodynamic therapists, most REBT and CBT therapists roughly follow a session structure:

1. Open with pleasantries to assess the "health" of the relationship and strengthen it.
2. Check the home assignment.
3. Check for lapse and/or relapse to an addictive behaviour (using Motivational Interviewing (MI) techniques, especially open-ended questions).
4. Review (and adjust, if appropriate) the goals … for therapy and/or for life.

5. Use one or more techniques, including filling out an exercise sheet in session.
6. Collaboratively decide on a home assignment that might help make the next week better than the last.
7. Summarize.

We know from research that therapists who rigidly adhere to a manualized approach or do not follow the manual at all do less well than therapists who use a manual as a guide. That may also be true for effective REBT therapists; they do not rigidly adhere to the above outline, but they do not let clients just talk.

CBAs

Doing a Cost Benefit Analysis (CBA; called a Decisional Balance exercise in MI) may be an effective, non-threatening way to start. It can be done in session, and the client will then leave with something tangible, a rarity for most people who go for therapy. A CBA may also be very effective at bringing to the surface some of the reasons people are engaging in a particular problematic behaviour. (How to do a CBA can found online in many places, e.g., smartrecovery.org).

CBAs also help re-motivate or strengthen the motivation of a client who is having difficulty. Working together collaboratively helps a client gain insight into the good things about continuing to use (or drink, avoid, procrastinate, watch porn, sext, etc.), the not-so-good things about continuing to use, the good things about stopping or cutting down, and the not-so-good things about stopping or slowing down. Doing A CBA in a group on a chalkboard works extremely well. The entire group often becomes much more focused and involved, and it increases group cohesiveness and trust.

ABC(DE)

The CBA may help segue into an ABC(DE), which remains the most popular and effective REBT/CBT exercise. It can be used effectively not only for the addictive behaviours but also for feelings and behaviours that may trigger (act as As) addictive behaviours.

Making the C the addictive behaviour that the client wants to change is the best way to begin an ABC. Often clients and therapist put the addictive behaviour as the A and a DUI or fight with someone as the C. At some point in time, that kind of ABC can be very important. But "backing up the video" to uncover the Bs that contributed to the lapse or relapse is key, so, initially, make the addictive behaviour the C. The two most common irrational beliefs are …

I can get away with it.

It won't matter.

Neither of these appear to be demands, but closer examination may reveal that underneath each are standard demands, awfulizing, etc.: *I can get away with it, as I should be allowed to get away with it. Other people do it, and I should be able to, too*.

Other common beliefs include:

I deserve it.
I'm going to eventually drink anyway, so why torture myself.
I can't stand feeling this way anymore. A drink will help.
It's really unfair. Everybody else drinks.
I should be able to do what I want to do when I want to do it.

As noted above, addictions are designed to help a person change the way she feels. If some feelings contribute to renewed drinking, those feelings need to be identified. For example, when it appears that shame about drinking or internet porn or some other addictive behaviour is a trigger, then drinking should be made the A, with shame as the C. What is the client telling herself to create those strong feelings of shame? Helping a client figure out how she might feel *instead* about addictive behaviours—irritated, aggravated, but not ashamed; determined, hopeful—may help. Rational Emotive Imagery (REI) and shame attack exercises may also be effective.

Acceptance

Acceptance is central to most modern cognitive behavioural therapies, i.e. REBT, DBT, ACT and MBCT. Unconditional self acceptance (USA, UOA, unconditional other acceptance, and ULA, unconditional life acceptance; Ellis, 1994) is key to working effectively with people grappling with addictions. However, as noted earlier, most clients come into therapy believing in a form of the moral model of addictions. The idea that a client might accept himself despite his addictive behaviours is usually difficult to sell. It is difficult enough to accept oneself with a problem like depression or panic attacks. It is quite another thing to accept oneself with a behaviour that appears to involve choice and willpower. The behaviour may also be illegal and may have already led to serious consequences, i.e., ruptured relationships, loss of employment, DUIs. The client probably believes he *should* have controlled himself better. Shame and hatred of self go hand in hand with the extent to which people feel responsible for their problems. People rarely feel shame or hate themselves for having cancer, but that is not true for addictive behaviours.

Note that the CBT/REBT model suggests that clients *are* responsible, potentially making matters worse. Teaching someone that her *behaviour* may be "bad," in the sense that it gets in the way of her achieving her goals but *she* is not "bad" is not easy. The disease model, despite all of its problems, is often helpful. It may help clients stop chronic self-damning, self-downing and self-pity. The disease model posits that the brain of a client who has been engaging in an addictive behaviour for a long period of time has become "wired," such that changing the behaviour, especially abstaining completely, is often extremely difficult. REBT-ers might prefer to think that the behaviour has become conditioned, over-learned and automatized, but that probably does include neurochemical changes and some kind of "re-wiring," perhaps even permanent. Some aspects of the disease model may help REBT therapists help clients to better accept themselves with their problems, as they would do if they had diabetes or cancer.

Treatment Guidelines from the Empirically-Supported Therapy Literature that Inform Best Practice in REBT with Addictions

Although there are very few, if any, good studies of a specific REBT-focused approach for addictions, the empirically-supported therapy research literature provides many suggestions as how an evidence-based REBT therapist should proceed. The recently developed CBT for SUDs Veterans Administration program incorporates concepts that can be traced back to Ellis's (1962, 1994) pioneering work, such as the ABC model and low frustration tolerance. This is also true of DBT and ACT, which use key concepts initially proposed by Ellis and now have research backing to show that they can successfully be used for the treatment of addictions.

As I have discussed elsewhere (Bishop, 2001), there are many research studies supporting an integrated REBT/CBT focused approach to treating addictions. Marlatt and Gordon published their ground-breaking book, *Relapse Prevention* in 1985. Beck and his associates published Cognitive Therapy for Substance Abuse in 1993. And I published my book, based primarily on REBT, in 2001. Since that time, many research studies have established that an active, structured CBT approach works effectively with clients who are engaged in various addictive behaviours.

REBT shares many techniques with CBT, DBT and ACT, and each of these broad approaches as been shown to be effective with addictions (Beck, Wright, Newman, & Liese, 1993; Dimeff & Linehan, 2008; A-tjak et al., 2015). CBT and REBT both emphasize the importance of uncovering and disputing or questioning beliefs that are unhelpful, dysfunctional or unhelpful. They also both believe in the importance of Socratic and didactic therapeutic approaches. They both share the theoretical idea that demandingness, negative evaluation (awfulizing), low frustration (discomfort) tolerance and self-downing and self-pity contribute to dysfunctional emotions and behaviours. REBT and ACT share a belief in the impact of goals and values on emotions and behaviours and the importance of an "all consuming vital interest" (REBT) and "value-guided action" (ACT). ACT practitioners believe that thoughts should not be disputed but, in contrast to CBT and REBT, should be let go to "drift down the stream on a leaf." And it may be important for someone trying not to drink or use a substance to not engage with some of the thoughts being offered up by her brain (*It's okay. One line won't hurt*.) However, other thoughts—*You're a failure. Life sucks. Poor me. No one cares about me.*—may be better dealt with by close scrutiny and active questioning/disputing. When we are trying to stick to a rule—*I am not going to drink alcohol tonight*—re-examining the rule in the moment where all sorts of environmental cues (friends, others drinking, the end of the day) may be pushing hard to resume the old behaviour will probably end in abandoning the rule. A better strategy (instead of questioning or disputing the irrational ideas popping into your client's head—*I'll just have two. You can abstain tomorrow*.) will be to put one's mind on something else (the baseball game on the TV) or to leave the environment. Cognitive "disputing" will probably fail.

REBT and CBT must be combined with MI to be effective because clients struggling with an addiction feel very ambivalent about both changing and not changing. Motivation becomes a key issue, waxing and waning as therapy progresses. The research basis of MI is well established (Miller & Rollnick, 2012). Considerable research also exists supporting the idea that a structured session is more effective than the traditional format in which clients come in and just talk about their issues, and there is some research supporting the importance of doing homework assignments between sessions (Decker et al., 2016). Homework becomes especially relevant when a client is trying to manage and change a behaviour, not just a mood disorder; psychoeducation, a good working alliance and insight may be important, but practice between sessions is essential. The effectiveness of self-talk while practicing has also been well established, even in sports (Hardy, Comoutos, & Hatzigeorgiadis, 2018). In addition, the importance of acceptance (what Rogers called "unconditional regard") no matter what a client does, especially with regard to lapses and relapses, is also well established.

In 1985, it was also quite common to treat an addictive behaviour such as alcohol abuse completely separately from a mental health disorder, such as depression or anxiety or bi-polar disorder. Such an approach is slowly dying out and being replaced with a transdiagnostic approach, for which REBT is particularly well suited. The evidence for the effectiveness of REBT/CBT with various mood disorders and populations, i.e., social drinkers, is continuing to grow (Miller, Wilbourne, & Hettema, 2003; Olthus, Watt, Mackinnnon, & Stewart, 2015; Rawson et al., 2013; Scott, 2007) and the evidence of the effectiveness of approaches using REBT/CBT concepts in combination with other techniques, e.g. mindfulness, is also increasing (Hsu, Collins, & Marlatt, 2013; Stasiewicz et al., 2013).

The most popular current scientific model (in contrast to the moral model) is the brain disease/medical model. Besides some form of REBT/CBT, medications may be very helpful. Ellis (1962, 1994) encouraged the use of medication when he thought it would be helpful, and it might be better if the medications that have been shown to be effective for various addictive behaviours were used more widely, e.g., Antabuse, Naltrexone, Suboxone; even the SSRI medications have been shown to be associated with less drinking episodes and fewer drinks per episode.

Brief Case Example

When I first met A, he was 37 and a highly successful asset manager at a hedge fund in New York. He was using cocaine, drinking heavily, and hooking up with random women, despite the fact that he was engaged to get married. He was also profoundly troubled by his lifestyle. Although he liked being successful and being very well paid, he did not respect what he was doing. He felt that he was like his dad, who always hated his work in advertising.

We quickly developed a good working relationship. Research indicates that most people with addictive problems do not think they need professional treatment nor

think it will be helpful. Consequently, the objective of the first session was to get a second session. He needed to feel that I was listening nonjudgmentally and understanding his issues and his goals for therapy. I did not use a written assessment instrument. However, by asking a series of questions about his use of alcohol and cocaine, I fairly easily understood his pattern of alcohol misuse ("Misuse" is the term currently used in the DSMV; "abuse" and "dependence" have been fazed out.), cocaine misuse, and sporadic and impulsive sex with random partners. Given his professional success—he is well known in the industry and the City—and his confident, "I can do anything" style, it took me longer to realize that anxiety played a key role in his behaviour.

I introduced him to the ABC way of looking at his thinking and his behaviours. Like many clients, he was ambivalent. He liked some aspects of his high-powered job, partying, and hanging out late, and many of his peers drank hard and used drugs and womanized. We identified some of the triggers, including (1) over-working, which fed into beliefs such as, *A real man (a man you can be proud of) works hard, and knows how to cope (not feel or show what he is feeling). I have worked so hard and am so good at my job, I should be able to do what I want when I want. I deserve it*. (2) self-pity, a feeling that was incompatible with the belief that he was a "real man." Alcohol, cocaine and women helped cover up that feeling. (3) anxiety; many of the behaviours that he engaged in were designed to avoid feeling anxious. It was initially difficult for him to acknowledge that he was anxious often during the day—*A real man does not feel anxious.*—but the fact that he had not been to a dentist for ten years, despite dental problems, helped open the door.

He identified his goals for therapy as follows: (1) moderate his alcohol use; (2) stop using cocaine; (3) stop sleeping with random women. Later, (4) change his career, (5) experience less anxiety, and (6) stop sexting were added to the list. Because he travelled a lot for week, he came for therapy at most once per week and frequently less. As a result, it took a few years to work toward achieving each of these goals.

In the third session, we did a CBA for his cocaine use. (In later sessions, we did CBAs for his drinking, for sexting and hooking up.) The CBA helped him realize that he used cocaine to manage his anxiety as he worked and socialized. We did ABCs and REI for the anxiety. I suggested, with a smile, that he was a "dopamine addict." We talked about how cocaine dramatically increases dopamine, how aspects of his fast paced, competitive job were dopamine boosters, and how novelty (random women) also increased dopamine.

As is typical with many clients, he had good weeks when he did not drink too much or use cocaine and bad weeks, when he misused both. When his behaviours were not in line with his goals, we "backed up the video" to try to uncover and understand what he was thinking to himself at the time and how his feelings and the environment had had an impact. It was difficult for him to accept that once he started drinking, it was very difficult for him to moderate; in fact, over the first two years of therapy, he almost never drank moderately. However, he slowly began to recognize that being around certain people and in certain settings led heavy drinking and, later, to cocaine use and random sex. His cocaine use gradually decreased over the first six months and stopped after a year. He became more mindful of with whom he was

drinking and where they were proposing to go next. He learned that saying, "No, thanks. I don't do that anymore" did not lead to the end of the world, the end of most of his friendships or the end of having fun. He learned that he could, at times, not behave like a "Southern gentlemen"; he stopped offering women a ride to their hotel on his way home, because, in fact, he almost never went home. He gave up some old friends and partying habits and he did not die. Getting married helped. Much of his old lifestyle ceased, and he made new friends and went out in a very different way.

Standard REBT "disputing" helped: *Where is the evidence that you have to say "yes" to all friendly offers to go some other place to "party"?* How has thinking, *I'll just go have a drink in her room* worked in the past? *To what extent is using cocaine compatible with your long-term goals?* Continually demonstrating unconditional acceptance no matter what he reported doing undoubtedly was key. He also started to meditate each day, and that—in addition to REBT's stress on the important role in lapses and relapses of "Low Frustration Tolerance" (I tend to call it "low discomfort tolerance")—helped him a lot to learn to sit with the discomfort of saying "no, thanks" to a friend or to sit in a dental chair. (Finding him a dentist who specialized in "gentle dentistry" and in working with dental phobic patients helped, too.)

Over the course of five years, he stopped using cocaine. He continues to drink alcohol but rarely overdrinks. His womanizing continued and eventually led to the end of his marriage, a marriage that might not have worked for many other reasons. He found and likes his new career, which is intellectually exciting and challenging. He is currently looking for a new partner, and occasionally spends the night with someone, but always with someone from his network of friends, i.e., never random women he has met that night. He is not using any medication.

What I Have Learned About Using REBT with Addiction

Accommodating Individual Differences: Client Gender, Ethnicity, Socio-economic Status, Intelligence and Other Factors

People react differently to different chemicals and repetitive behaviours. People differ significantly regarding which foods they like and dislike is obvious. And some people love alcohol, but others can take it or leave it. Some people love marijuana; others do not. Some people prefer Tylenol; others Advil. Some people do well on Lexapro; others do not. Pharmaceutical companies and doctors have a vested interest in ignoring or explicitly hiding the fact that people are very different chemical factories and have very different reactions to different chemicals. One client is not like another, psychologically or neurochemically. Clients need to understand and often accept that fact. For example, some people cannot drink alcohol. After two martinis they want a third more than the first and the second. That is not true for most people. Helping clients who are having problems with chemical or behavioural

addictions acknowledge and accept that people are very different is a critical part of compassionate REBT. To do better, some clients have to give up their demand that they can behave like a lot of other people.

Helping clients accept themselves and the fact that they have a serious, difficult-to-change problem, while at the same time holding out hope, is challenging. Educating clients about the genetic factors that are often a significant contributing factor to addictive behaviours may help. Often it will turn out that other people in their family, parents and grandparents, have had similar problems, as is also true, of course, for other disorders, e.g., bi-polar disorder, mood disorders. Educating clients regarding the results from the ACE study can also be effective. They may have heard and subscribe to the belief that REBT therapists do not believe what happened in the past matters. But the fact is that adverse childhood events have a dramatic and significant impact. People are not doomed by their childhood, but they may want to (and have to) worker harder to offset the impact of those events.

Moreover, some diseases like malaria and diabetes never totally go away. People remain vulnerable for their entire life. For that reason, some people join AA and continue to go to meetings for life. They will do better by remaining continually vigilant and having on-going support to help them manage life.

A therapist may also want to keep in mind other idiographic factors and share that information with clients. For example, research suggests that females tend to me more successful at moderating drinking behaviour than males. And drinking is far more prevalent in some cultures than in others. Moreover, the very under-studied factor, socioeconomic class, may have an impact, as well. In the only long-term study (Vaillant, 2003), on one measure (abstinence) the cohort made up of non-delinquent, inner city youth (primarily lower class men of Irish descent in Boston) when the study started, have done better than the Harvard, undergraduate co-hort. However, individuals differ in so many different ways with regard to so many different chemical and behavioural addictions, that, on an individual basis, none of this data may be very helpful to a therapist working with a specific client.

The Do's and Don'ts

The Do's

1. **Do Offer Both Short-term, Periodic, As-needed Therapy and Long-term Therapy Most** people with addictive problems do not think they need treatment or that it would be helpful. Those who realize they need some help often do not or cannot make a commitment to weekly therapy and/or group therapy, let alone intensive outpatient therapy (IOP), i.e. 4–8 h of group and individual therapy, 3–5 times per week while the client lives at home. So I often suggest that people come in for a consultation, not necessarily for therapy. There is considerable research evidence that brief interventions are as effective as longer forms of therapy. Eventually, depending on the severity of the addiction and the presence

of co-occurring problems, e.g., persistent depressive disorder, major depression, social anxiety, the client may begin more traditional, once per week therapy. But he may not. And periodic sessions over the year—"check-ins" or "booster shots"—may work just as well as consistent, once per week therapy. On the other hand, I have seen some bi-polar, occasionally alcohol misusing clients periodically for over twenty years. REBT has helped them stay out of hospitals and get off the fastest acting, readily available (short-term) antidepressant on the market, alcohol. More severe cases, of course, will benefit from more intensive therapy, perhaps including IOP and inpatient stays.

2. **Do Initially Focus on the Addictive Behaviour** Ellis (1962, 1994) was perhaps one of the first to argue that it was important to address the problem about the problem before focusing on the problem itself. He correctly noted that depression about depression can bring about the depression that is so arduously being avoided and that saying to oneself upon awakening, *OMG, I'm getting depressed again. I can't stand it. This is the end. I'll never change.* can quickly contribute to someone getting depressed again.

   However, starting in 1990, Ellis and I did many workshops together focused on the treatment on addictions. Early on I asked him what he thought should be addressed first, the feelings about the addictive behaviour(s) or the addictive behaviours(s). He was very clear. It was important to focus first on the behaviour, e.g., the drinking, and second on the consequent feelings, thoughts and behaviours. Many drinkers feel intense shame and remorse after having relapsed. It is certainly important to address those feelings as they may contribute to more addictive behaviour. But initially the focus of REBT should be on changing the behaviour, i.e., what may contribute to the behaviour and how to change the behaviour.
3. **Do Teach How to Rate Behaviour without Self-downing** As is well known, many clients rate themselves equal to their behaviour. If they overdrink, they are failures, or worse. So it is very important to consistently help clients learn to rate their behaviour as in line with their goals and values or not. But, as noted above, considering that so many clients have accepted the moral model as correct, they are very quick to condemn themselves along with their behaviour.
4. **Do Treat the Brain as a Separate Organ** In line with not rating oneself based on one's behaviour, it is often helpful to suggest to clients that they treat their brain as a separate organ that sometimes misfires. We may use our brains at times intentionally and purposively to think about something, but working with psychotic clients (and looking at our dreams) suggests that the brain does its own thing sometimes (much as a heart may start beating irregularly or too fast in some people). Old, chronic "irrational beliefs," e.g., *I can't stand this. I have to have a drink.* may be best seen as the brain tossing up some old ideas based on old wiring. That does not mean, however, as ACT suggests, that we will necessarily do better by just letting such ideas drift away and not question their validity. That may work for some people and for some ideas. But questioning the validity a la the ABC model may work better for other people and other ideas.

5. **Do Focus on the Goal(s) of Therapy on an On-going Basis** When clients who come into the office just start talking and/or venting—having perhaps been "trained" by other psychotherapists or having learned about traditional therapy in some other way—it is helpful to make a time-out sign with your hands, smile, and ask, "Yes, but what is your goal in therapy?" Or if a client who has said she wants to get along better with her teenage daughter reports that she is still drinking too much, asking, "Yes, but what are your goals? Moderation? Stopping? I'm not very clear" can be very important and helpful.
6. **Do Focus on a Client's Long-term Goals and Values** Ellis frequently emphasized the importance of "an all consuming vital interest." Without some value-guided goal out in the future that is incompatible with an addictive behaviour, change is unlikely. This is a philosophical and existential issue. Addictions often significantly affect changes in the brain, and those changes are often very challenging. However, it is quite common for humans to do very challenging things, once they become convinced that those things are worth doing.
   To work successfully with clients trying to change an addictive behaviour—-moderate it or cut it out entirely—REBT practitioners need to help them become clearer about why they want to make such a difficult change. Few people change a difficult-to-change behaviour—and one that often makes them feel better and that, on one level, they enjoy—without a very good reason for doing so.
7. **Do Add "Wonderfulizing" to the Toolkit** "Wonderfulizing" must be added to the toolkit. Clients with addictive problems may awfulize and catastrophize about things in life, including how they might feel if they did not smoke a joint or have a drink, but they also wonderfulize the impact, as well. In fact, in folklore about drug use, people talk about "chasing the high" that they (believe they) had the first time they used. Clients addicted to sex wonderfulize what it will be like to hook up with someone, even though repeated experiences prove to be much less wonderful in reality. Gamblers get high on "the action," wonderfulizing how it feels.
8. **Do Be Gently, Compassionately Confrontive** Given the ambivalence that most addicted clients feel about changing, the research suggests that both strong confrontation and low empathy therapists (Miller & Rollnick, 2012; Moyers & Miller, 2013) drive clients out of therapy and contribute to lapses and relapses. Being open and direct with clients—some would use the word "confrontive"—is very important and can be done in a less strong, non-judgmental manner. It is an essential part of MI. Careful observation of Ellis reveals that he was confrontive but always in a very sympathetic and encouraging manner. *You can do it*, he would say emphatically with a big smile and without a trace of doubt in his voice. No therapist is famous as Ellis, so a less direct, confrontive approach may work better at times, especially in the initial sessions and because clients grappling with an addiction are usually ambivalent. On the other hand, therapists who avoid directly discussing the addictive behaviour(s) and focus on the feelings about the behaviour can do just as much or more harm as being too confrontive.

9. **Do Encourage Involvement in SMART Recovery®** REBT continues to be the backbone of SMART Recovery, so it can be very helpful for clients to attend SMART Recovery meetings while they are in therapy. SMART Recovery's Four Point program includes: (1) building and maintaining motivation; (2) coping with urges; (3) managing thoughts, feelings and behaviours; and (4) living a balanced life. REBT exercises and philosophy are central to every meeting. Good meetings are a combination of a skills-building workshop and a supportive group. There are now over 2500 meetings in 24 countries, both face-to-face but also online. Both recovering individuals and therapists run SMART Recovery meetings. Helping start a SMART Recovery meeting in your community will not only increase your exposure but also provide a service to your community.
10. **Do Find Out about the Client's "Theory" of Addictions** REBT therapists may find it helpful to explore the (probably unconscious) models that their clients believe in. The use of the term "war" in the "War on Drugs," encourages people to think that there is an "enemy" and that the enemy should be treated as enemies have always been treated. The medical/"brain disease" model has been seen by some as destigmatizing alcohol and drug misuse, and that may be the case. But the belief that one's brain disease determines the rest of one's life, while perhaps true for some people, is probably not correct for the vast majority. As noted earlier, most people appear to overcome addictive problems on their own without treatment. This strongly suggests that if people are suffering from a "brain disease," it is not always permanent.
11. **Do Treat People Who Are Still Using** We do not tell people who are depressed to first get over their depression, and then we will see them. Unfortunately, many therapists will not see clients who are still using. "How can they get anything out of therapy when they are still using?" I have been asked. That is like saying that someone who is depressed or manic cannot get anything out of therapy. Just because someone is still using does not mean they are dysfunctional. For over twenty-five years, I have seen clients who are still using. I have two rules: You have to treat the receptionist with respect, and you cannot create problems in the waiting room. Neither of those rules has been broken once yet.

The Don'ts

1. **Don't Be Too Confrontive** As noted above, being too confrontive may simply drive a client out of your office, and if someone finally goes to a therapist and the therapy does not go well, he may not go back to a therapist for a very long time. Ideally, when a client leaves your office, he will feel that he was heard, and he will have something practical to do as a home assignment with the goal of making things better in the future, sooner than later.
2. **Don't "Dispute" with Your Client** In contrast to the psychoanalytic and psychodynamic therapist in the mid-1950s, Ellis strongly believed that people could and should work on themselves. As a result, he created a number of self-help tools that people could remember easily and do on their own, the ABC(DE)

model being the most powerful, popular and long lasting. Ellis was also a master at selling new ideas, and he knew he needed a catchy, memorable acronym, so it was only natural that after the A and the B and the C, a word starting with D should be included. Ellis chose "disputing." But for many people, "disputing" goes with an argumentative, in-your-face kind of approach. I prefer to encourage clients to question the rationality, helpfulness, etc. of their beliefs, but, of course, "question" does not start with a D. Nevertheless, questioning allows us to go beyond just questioning the usefulness or rationality of a belief; we can easily segue into questioning why someone would do something difficult like giving up an addictive behaviour. Why would you want to make such a change? Why would you put so much effort and energy into changing?

3. **Don't Discourage Clients from Going to AA or "Working the Steps"** AA, which has strongly embraced the disease model, unequivocally asserts that one is "powerless" to solve one's problems without help from a higher power. However, REBT therapists can work with most of what AA teaches because most of those teachings are, in fact, compatible with REBT's philosophy, e.g. many traditional AA sayings are quite REBT-like. "Get your feet to a meeting and your mind will follow" is quite similar to "Do, don't stew." Even "Let go, let god," suggests that people will often feel and do better by practicing USA, UOA, ULA.
4. **Don't Subscribe to the "Moral Model" Yourself** Some REBT therapists unfortunately also agree with the moral model. And many practitioners continue to avoid treating addictions because of their own irrational beliefs about "addicts" and "alcoholics," as a result of the powerful proponents of the moral model. Much evidence suggests that addictions are similar to other disorders that therapists routinely treat and that shaming and damning are not effective; they were the predominant techniques used for many years. Fortunately, partly because of the work of Marlatt (Marlatt & Gordon, 1985) and Miller et al. (2003), these "techniques" have been shown to be ineffective.
5. **Don't Let Your Own IBs Cause Professional Burn-out** Addictions are a confusing mix of choice and "disorder," and they are very difficult to change. It is easy to succumb to our own irrational beliefs: *This client will never change. This is a waste of my time.* Or tell ourselves: *I should know how to do this (help the client change). His friends and family will think I'm a failure and a terrible psychotherapist.* It is important to do an ABC on your own beliefs. This is especially true if you are working with a very difficult population, e.g., homeless, traumatized veterans. Why "should" or "must" you succeed? And what do you mean by "succeed"? Perhaps you are helping people who are grappling with serious, chronic problems more than you think.
6. **Don't Give Up** One study suggests that the number of times people try to quit cigarettes varies from 1 to 140, but what is more relevant for clinicians is that there appears to be no correlation with the number quit attempts and success or failure. In other words, it is just as likely for someone to succeed (or fail) on attempt #3 and attempt #103. So practitioners should never give up encouraging (but that does not mean nagging) clients to quit.

Which Aspects of REBT Deliver the Most Benefit for Change and Which Don't Aspects of REBT that Deliver the most Change

1. **REBT Is Goal-focused**. Gently stopping someone who has been "trained" by other therapists to come into an office and talk, asking, "Yes, but I am not clear. What is your goal—or are your goals—for therapy?" has a tremendous impact. I often ask my students to watch a portion of the very popular HBO series "*In Treatment*." Even after a half an hour it is not clear what the goal is. What does the client want to work on? What does the client want to gain out of therapy? REBT is goal-focused and more effective because of it.
2. **REBT Is Integrative**: Good REBT therapists quickly try to figure out which techniques might work best for each particular, individual client: Teaching and doing ABC(DE)s? Inference Chaining? REI? Shame Attacks? Risk-taking Exercises? Socratic, Didactic or Humorous "Disputing"? More than once I heard Ellis grumble that therapists only used the ABCs. When I was in training, I asked him specifically was there any technique I could not try and he quickly answered—again, with a smile—"No, as long as you don't encourage them to WHINE!" I have asked Adler's first memories questions and even used free association for a while when I thought it would be useful.
3. **REBT Includes the "Emotive"** Unlike many CBTs, REBT includes a focus on the E, on feelings and emotions. Addictive behaviours are designed to change the way a person feels. Addictions develop partly because people want to change the way they feel. Research indicates that the idea that all addictions are *not* a form of self-medication. Many people want to party. They feel good and they want to feel better. They like getting drunk, using cocaine, etc. REBT therapists will be more effective when they acknowledge that many addictive behaviours are very pleasurable. If that were not the case, addictive behaviours would probably not exist.
4. **REBT Emphasizes Self-Guided Change** Along with other prominent psychologists, e.g., Glasser and Bandura, it is clear from any videotape of Ellis working with a client or doing a demonstration, that he continually pushed the client to believe in his or her own ability to change. Often while teaching REI, if the client said, "I cannot do it"—Ellis would say in a very confident voice (and with a big smile), *Yes, you can. Come on, PYA* (push your ass), and each time, the client did, in fact, find a way to complete the exercise. Ellis consistently argued that it was not our past that determined our future. We, ourselves, could take responsibility for change. And many studies have shown that increasing self-efficacy leads to better outcomes in the treatment of addictions.
5. **REBT Emphasizes the Importance of Acceptance in Therapy and in Life** As already discussed, acceptance of oneself, others, life and especially one's own peculiarities, e.g. inability to interact with cocaine or gamble without getting into trouble, is key to helping someone moderate or stop addictive behaviours.

6. **REBT Is Future-oriented** Most traditional therapies focused on the past. Clients (and therapists) believed that gaining insight into their past would help them do better in the future. And with some highly insightful, motivated clients that may have been sufficient. While good REBT therapists do exercises with their clients in session (in the present) and pay special attention to nonverbal and verbal behaviours in the session (in the present), the focus of REBT therapy is on how to make the future, maybe just the coming week, better.
7. **Most REBT Sessions Have a Structure** In working with Veterans Administration therapists who were training to become CBT therapists for SUDs, one of the most difficult things to do was to follow some sort of structure for their sessions. Their habit was to let clients come in and just talk. Their faith in the effectiveness of just talking was difficult to overcome; their resistance (the therapist's) to change was strong. Some kind of structure—outlined previously—helps make therapy sessions more effective and the time spent in therapy more efficient.
8. **REBT Encourages Homework** Some clients think that if they come to therapy once per week and talk about their problems—especially the roots of their problems, things that happened in the past—their behaviour will change. But changing an addictive behaviour is difficult. It requires practice. Clients who do nothing between sessions rarely get better. Insight into their "issues" may grow, but their addictive behaviour will remain the same. Home assignments—keep a drinking log; only drinking wine; cutting the prescription medication in half; drinking half-caff; taking your wife out on a date; saying something nice to your teenager; making a list of ten things you like about yourself; making a list of ten things you like about yourself; doing something risk-taking; doing a shame attack—help people change faster.
9. **REBT Shows that Short-term Therapy (even Very Short-term Therapy) Can Be Effective** This was another significant break from the past, and the idea that brief interventions might be effective with addictive disorders is still strongly resisted by practitioners despite the mounting evidence that longer term therapy may not work and is often much less effective than it is advertised to be.
10. **REBT Is Direct** I wonder sometimes whether REBT's direct nature is a reflection of it founder's birthplace. New Yorkers are famous for being direct; some people would call it rude. Whatever its roots, REBT is known for being direct and my experience suggests that for many, it is a breath of fresh air compared to the style of other therapists clients have worked with.
11. **REBT Is Client-Centered** Psychoanalytic and psychodynamic theory hypothesizes that the causes of the problems are repressed and well defended against. Consequently, it is impossible for a client to know and say what the real problem is. Therapy has to be a very indirect, sneaking-up-on process, focused on slips of the tongue, dream interpretation, etc. Rogers and Ellis turned that theoretical position on its head. A client was encouraged to say what he wanted to work on and therapists were encouraged to help the client work on it, thus making

therapy "client-centered," and collaborative, not top down, i.e.. only the doctor can know what the real problems are.

12. **REBT Encourages Working Collaboratively with Clients** Although REBT is sometimes criticized for being too didactic and too forcefully "teaching" people, it encourages the therapist and the client to work together collaboratively to figure out how and what Bs contribute to the C (in this case, the problematic addictive behaviour), and then, moving back in time, what As tend to be the more potent, troublesome "triggers." The therapist, by virtue of having done more ABCs, may be very helpful in this process as a guide or coach, but ultimately the client will be the one to identify the Bs that are most problematic.

Aspects of REBT that Deliver the Least Change

1. **The Emphasis on Short-term Therapy When It May Not Be Effective** For some people, additive problems are a life-ling issue, as is true for some other psychological disorders, e.g. bi-polar disorders. So suggesting that one can "overcome" such a severe problem with short-term therapy probably amounts to a form of cruelty.
2. **When the Philosophy of Rating a Behaviour but Not Oneself Is Misapplied** Unfortunately, not all clients can correctly understand the idea that "you may do something bad but you are not a bad person." They may get drunk, yell at their family, and then say something like, "But REBT says I just behaved badly. But I am not a sh_t." For most of us, if someone abuses us, we do not forget. We may not want to "boil them in oil" (as Ellis used to say), but we will also not want to be around them, work with them, etc. That is, we are not interested in judging their totality or damning them to hell, but we may also, for shorthand purposes, tell someone else that they are a "sh_t." Unfortunately, I have heard some REBT clients (and REBT therapists) engage in this kind of mental gymnastics and gotten the impression that they think that it is perfectly "okay."
3. **When the Value of the Therapeutic Relationship is De-emphasized** As is well known, Ellis actively disparaged and dismissed the importance of the relationship in therapy. However, as anyone can easily observe in the many demonstration videos, although Ellis may not have taken a gentle, Rogerian-like approach with his clients, he quickly developed an empathetic, working relationship, sharing stories about himself, joking and smiling broadly. And because people had observed his demonstrations either live or on video, they already, to some extent, *had* a working alliance with Ellis; they believed he could help them and wanted to work with him.

   Many research studies (Greenberg, Watson, Elliot, & Bohart, 2001; Moyers & Miller, 2013) indicate that developing an empathic, non-judgmental relationship contributes significantly to better outcomes in therapy. Regarding the treatment of addictions, many studies demonstrate the effectiveness of Motivational Interviewing (MI) (Miller & Rollnick, 2012), which relies heavily on Rogerian princi-

ples of active listening and unconditional regard, similar to Ellis's unconditional self-acceptance (USA).

4. **When "Confrontation" and "Disputing" Are Too Active** People suffering from addictions are not as motivated to change as people suffering from depression, anxiety, ocd or many other mental health issues. In the initial stages of treatment, using a too direct REBT/CBT approach may not work. That is why it is important to integrate many of the evidence-supported techniques used in MI.
5. **When the Impact of Past Events is Downplayed** Ellis stressed that it was what people were currently thinking and feeling about past events that was significant, and focusing too much on past events and not enough on the coming week was an error. But ignoring—never discussing, even for twenty minutes—what has happened in the past, which may have contributed to an addiction is also an error. Respecting the impact of the past may help clients forgive and accept themselves and take stronger, more motivated action going forward.

Summary

Ellis (1962, 1994) emphasized using an integrative, transdiagnostic approach for the treatment of a wide variety of disorders, including addictions. He also believed that it is very important to use many different cognitive, emotive and behavioural techniques, and medications when he thought they would help. The existential piece is also critically important; a client will *do* better (not just *feel* better) when he or she finds and aspires to meaningful, value-guided goals. When an addictive behaviour is incompatible with what a client really wants—to do better at work, to keep a relationship from ending, to be a better parent—then change occurs. On the other hand, irrational beliefs held by both clients and by therapists may impede treatment. As a result, both clients and therapists may effectively use REBT to help themselves work more effectively when addictive behaviours are involved.

Unfortunately, in the United States, despite many evidence-based techniques available to REBT therapists, "You have to stop" and "You have to go to AA," continue to be the two main "treatment" options offered by many professionals. Given this unfortunate situation, REBT therapists have a significant opportunity to make effective therapy more available to the people in their communities.

References

A-tjak, J. G., Davis, M. L., Morina, N., Powers, M. B., Smits, J. A., & Emmelkamp, P. M. (2015). A meta-analysis of the efficacy of acceptance and commitment therapy for clinically relevant mental and physical health problems. *Psychotherapy and Psychosomatics, 84*(1), 30–36.

Beck, A. T., Wright, F. D., Newman, C. F., & Liese, B. S. (1993). *Cognitive therapy of substance abuse*. New York: Guilford.

Bishop, F. M. (2001). *Managing addictions: Cognitive, emotive and behavioral techniques*. Northvale, NJ: Jason Aronson.

Bishop, F. M. (2018). Self-guided change: The most common form of long-term, maintained health behavior change. *Health Psychology Open.*

Cristea, I. A., Tatar, A. S., Nagy, D., & David, D. (2012). The bottle is half empty and that's bad, but not tragic: Differential effects of negative functional reappraisal. *Motivation and Emotion, 36*(4), 550–563.

David, D., Cotet, C., Matu, S., Mogoase, C., & Stefan, S. (2017). 50 years of rational-emotive and cognitive-behavioral therapy: A systematic review and meta-analysis. *Journal of Clinical Psychology*. https://doi.org/10.1002/jclp.22514.

David, D., Szentagotai, A., Lupu, V., & Cosman, D. (2008). Rational emotive behavior therapy, cognitive therapy, and medication in the treatment of major depressive disorder: A randomized clinical trial, posttreatment outcomes, and six-month follow-up. *Journal of Clinical Psychology, 64*(6), 728–746.

Dearing, R. L., Kitkiewitz, K., Connors, G. J., & Walitzer, K. S. (2013). Prospective changes in alcohol use among hazardous drinkers in the absence of treatment. *Psychology of Addictive Behaviors, 27,* 52–61.

Decker, S. E., Kiluk, B. D., Frankforter, T., Babuscio, T., Nich, C., & Carroll, K. M. (2016). Just showing up is not enough: Homework adherence and outcome in cognitive–behavioral therapy for cocaine dependence. *Journal of Consulting and Clinical Psychology, 84*(10), 907–912.

Dimeff, L. A., & Linehan, M. M. (2008). Dialectical behavior therapy for substance abusers. *Addiction Science & Clinical Practice, 4*(2), 39–47.

Ellis, A. (1962, 1994). *Reason and emotion in psychotherapy.* Secaucus, NJ: Citadel. Rev. ed., Secaucus, NJ: Carol Publishing Group; Revised 1994, New York: Birch Lane Press.

Felitti, V. J., Anda, R. F., Nordenberg, D., et al. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The adverse childhood experiences (ACE) study. *American Journal of Preventive Medicine, 14,* 245–258.

Gould, R. A., Buckminster, S., Pollack, M. H., & Otto, M. W. (1997). Cognitive-behavioral and pharmacological treatment for social phobia: A meta-analysis. *Clinical Psychology: Science and Practice, 4*(4), 291–306.

Greenberg, L. S., Watson, J. C., Elliot, R., & Bohart, A. C. (2001). *Psychotherapy: Theory, Research, Practice, Training, 38,* 380–384.

Hardy, J., Comoutos, N., & Hatzigeorgiadis, A. (2018). Reflections on the maturing research literature of self-talk in sport: Contextualizing the special issue. *The Sports Psychologist,* 1–8.

Hsu, S. H., Collins, S. E., & Marlatt, G. A. (2013). Examining psychometric properties of distress tolerance and its moderation of mindfulness-based relapse prevention effects on alcohol and other drug use outcomes. *Addictive Behaviors, 38,* 1852–1858.

Hyland, P., Shevlin, M., Adamson, G., & Boduszek, D. (2013). The role of trauma-specific irrational beliefs and sociodemographic risk factors in posttraumatic stress responses. *Journal of Rational-Emotive & Cognitive-Behavior Therapy, 31*(3), 152–166.

Hyland, P., Shevlin, M., Adamson, G., & Boduszek, D. (2014). The moderating role of rational beliefs in the relationship between irrational beliefs and posttraumatic stress symptomology. *Behavioural and Cognitive Psychotherapy, 42*(3), 312–326.

Iftene, F., Predescu, E., Stefan, S., & David, D. (2015). Rational-emotive and cognitive-behavior therapy (REBT/CBT) versus pharmacotherapy versus REBT/CBT plus pharmacotherapy in the treatment of major depressive disorder in youth; A randomized clinical trial. *Psychiatry Research, 225*(3), 687–694.

Lopez-Quintero, C., Hasin, D. S., de los Cobos, J. P., Pines, A., Wang, S., Grant, B. F., & Blanco, C. (2011). Probability and predictors of remission from lifetime nicotine, alcohol, cannabis, or cocaine dependence: Results from the National Epidemiologic Survey on Alcohol and Related Conditions. *Addiction*, *106,* 657–669.

Marlatt, G. A., & Gordon, J. R. (1985). *Relapse prevention: Maintenance strategies in the treatment of addictive behaviors*. New York: Guilford Press.

Miller, W. R., & Rollnick, S. (2012). Motivational interviewing: Preparing people to change addictive behavior. New York: Guilford.

Miller, W. R., Wilbourne, P. L., & Hettema, J. E. (2003). What works? A summary of alcohol treatment outcome research. In R. K. Hester & W. R. Miller (Eds.), *Handbook of alcoholism treatment approaches: Effective alternatives* (3rd ed., pp. 13–64). Boston: Allyn & Bacon.

Moyers, T. B., & Miller, W. R. (2013). Is low therapist empathy toxic? *Psychology of Addictive Behaviors, 27,* 878–884.

Oltean, H. R., Hyland, P., Vallières, F., & David, D. O. (2017). An empirical assessment of REBT models of psychopathology and psychological health in the prediction of anxiety and depression symptoms. *Behavioural and Cognitive Psychotherapy, 45*(6), 600–615.

Olthus, J. V., Watt, M. C., Mackinnnon, S. O., & Stewart, S. H. (2015). CBT for high anxiety sensitivity: Alcohol outcomes. *Addictions, 46,* 19–24.

Rawson, R. A., Rataemane, S., Rataemane, L., Ntlhe, N., Fox, R. S., McCuller, J., & Brecht, M. L. (2013). Dissemination and implementation of cognitive behaviour therapy for stimulant dependence: A randomized trial comparison of 3 approaches. *Substance Abuse, 34,* 108–117.

Scott, J. (2007). The effect of perfectionism and unconditional self-acceptance on depression. *Journal of Rational-Emotive & Cognitive-Behavior Therapy, 25,* 35–64.

Sobell, L. C., Ellingstad, T. P., & Sobell, M. B. (2000). Natural recovery from alcohol and drug problems: Methodological review of the research with suggestions for future directions. *Addiction, 95*(5), 749–764.

Stasiewicz, P. R., Bradizza, C. M., Schlauch, R. C., Coffey, S. F., Gulliver, S. B., Gudleski, G. D., & Bole, C. W. (2013). Affect regulation training (ART) for alcohol use disorders: Development of a novel intervention for negative affect drinkers. *Journal of Substance Abuse Treatment, 45*(5), 433–443.

Szentagotai, A., David, D., Lupu, V., & Cosman, D. (2008). Rational emotive behavior therapy versus cognitive therapy versus pharmacotherapy in the treatment of major depressive disorder: Mechanisms of change analysis. *Psychotherapy Theory, Research, Practice, Training, 45*(4), 523–538.

Vaillant, G. E. (2003). A 60-year follow-up of alcoholic men. *Addiction, 98,* 1043–1051.

REBT and Sexual Problems

Mike Abrams

Key REBT Theoretical Concepts in Working with Sexual Problems

Sex and its close relation to love has been the inspiration for artists, poets and musicians throughout the history. As such, it has been idealized or romanticized to the extent that many people suffer for failing to attain sexual performance that is both unrealistic and arbitrary. Consequently, when falling short of the ideals portrayed by social and cultural mores, a person can often become prone to self-depreciation, and not just in matters of sexuality but also in overall personal self-assessment as a human being. Indeed, there is no other bodily function that is so frequently used to measure self-worth. With the great cultural, historical and personal importance placed on sex, many suffer from sexually related distress that is entirely unnecessary. A common result of this overemphasis of sex as a measure of personal worth, happiness, and gender fulfillment, is distorted or irrational thinking.

The distorted thinking about sexual matters often centers around the arbitrary link between love and sex. People commonly, and falsely, believe that love and interpersonal intimacy must harmoniously interlock. Unfortunately, the ideal of the synchrony of love and sex is not as common as one may hope. Moreover, even when love and sex do cleave, the bond between the two is often short-lived. Since humans are very social beings, the rigid linking of sex with love and intimacy results in a significantly increased potential for distress in many domains of life. To understand both the failures in sexual performance and the failure of sexual relationships, I have found it best to turn to the founder of modern psychotherapy and pioneering sex therapist, Albert Ellis. Both Ellis and Beck (1989) a contemporary and co-founder of cognitively based therapies, observed that romantic passions which often begin

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with the intensity of drug intoxication tend to attenuate as rapidly as they began. This observation has been supported by the work of evolutionary researchers like Fisher (2004) and Buss (2003), who noted that the tempering of love and sexual attraction leads to distinct changes in the perception of one's lover. As romance begins to fade, the infatuated individual will gradually see his or her partner in a new and less exciting light. This quintessential aspect of intimacy makes a strong argument for Rational Emotive Behavior Therapy (REBT) as a treatment for most sex-related problems. The intense and ephemeral nature of passion in both love and sex tend to foster irrationality during the course of relationships. This tendency seems to be a result of evolutionarily developed processes, making our sexual irrationality innate, intense, and nearly universal (Buss, 2003; Buss & Abrams, 2016). Sex and its partner love both arise from native drives that are highly likely to lead to irrational and self-defeating thinking, and there are no better means to help people who have become locked into dysfunctional thinking than with a system that is designed to help them think more clearly, effectively, and with fewer demands. When REBT is applied to sexual problems, the therapist must first identify the beliefs, personal philosophies, and perceptions about love and intimacy that are leading to distress or conflict.

Problems with sexual functioning are critically interwoven with personal judgments. It is common for someone losing sexual attraction to a lover to perceive it as an undesirable change in their lover rather than a change in him or herself (Abrams, 2016). This type of cognitive distortion arises in most people suffering from difficulties in love and sex. As such, a therapeutic intervention that is based on attenuating these distortions will be the most logical recourse. And if one chooses such an intervention from among the growing array of therapies that fall under the rubric of cognitive behavior therapy, REBT offers the most specific advantages in that it:

(1) Is constructivist, as it acknowledges that each person constructs his/her world representation, consisting of explanatory models of human behavior (including his/her own), rational or irrational beliefs, and subjectively constructed memories (Ellis, 1998).
(2) Advocates unconditional acceptance of the self (Ellis & Dryden, 2007).
(3) Advocates unconditional acceptance of the other (Ellis & Dryden, 2007).
(4) Posits that all problems that can be addressed by psychotherapy can be addressed by altering perceptions, beliefs, and personal philosophies (Ellis & Abrams, 2008).
(5) Predicates all interventions on the premise that cognitions, emotions, and behaviors are dynamically interactive and functionally inseparable attributes of humanity (Ellis, 1962).

These particular and unique qualities of REBT make it the treatment of choice for problems relating to sex and intimacy. REBT's constructivism also makes it inherently responsive to the broad scope of sexual and gender expressions that therapists encounter. The rejection of all judgments and measures of personal worth facilitates its capacity to engender trust and comfort within people seeking help with problems that are frequently associated with shame and guilt. Its emphasis on philosophical

change adds to its efficacy by fostering enduring change. And its recognition that emotions, thoughts, and actions must be approached as three parts of an interactive whole is particularly effective for the complexity often observed in disorders relating to sex.

In addition to its philosophical advantages, REBT has a unique historical benefit in the field of human sexuality. Before founding what would become the first CBT, Albert Ellis was among the nation's first sex therapists and the first of those to publish specific therapeutic methods for sexual problems (e.g., Ellis, 1954a, b, 1957a). As a result, Ellis' cognitively oriented therapy always included techniques for treating sexual problems. As far back as the early 1940's Albert Ellis recognized that a significant portion of relationship conflicts had to do with a waning in sexual interest or capacity. Importantly, he noted that sexuality was driven by evolutionary and biological systems (Ellis, 1957b) that take many forms throughout the lifespan. Consequently, he counseled therapists to treat sexual issues with an understanding of psychology, sexology, and anthropology (Ellis, 1954a). During the origins of sex therapy, Ellis recognized that sexual desire and partner choice are both malleable and transient. As a result of the subjective nature of sexual perception, Ellis concluded sexual commitment would be challenged by the temptation of outside sources of stimulation (Ellis, 1972). His understanding of the many forces impacting sexual attraction, performance, or commitment led to a range of interventions that are as relevant today as they were half a century ago.

Ellis understood that a particularly vexing aspect of our evolutionary sexual heritage is the tendency to develop irrational beliefs when confronting challenges to one's sexual standing. As evolutionary psychologists have compellingly argued, innate urges will invariably lead to irrational thinking. The original insight that many human drives are evolutionary adaptions was first set forth by psychologist John Bowlby (1982) who coined the term environment of evolutionary adaptation (EEA). Despite his association with psychoanalytic theory, Bowlby was an evolutionary psychologist who noted that our love, bonding, and sexual behaviors are influenced by the ancient environments in which they evolved. Like Bowlby, Ellis in his earliest Rational Therapy (Ellis & Abrams, 2008) conceptualized irrational behaviors relating to sexuality as evolutionarily innate.

Consequently, people who are rational in many aspects of their lives often become quite dysfunctional as a result of primordial brain circuits that alter perception when sexually stimulated. Rational and defensive behaviors tend to become attenuated when an individual is sexually activated. For example, a stranger's saliva is most often sickening, when noticed on a rim of an offered bottle of soda—usually the bottle is handed back with haste and a grimace. Yet, when sexually aroused, we greedily suck the saliva of our paramour—in the act of French kissing. Or, in an even more dramatic example, the most sociopathic outlaw may appear caring and loving when he is strongly attracted to a woman.

These biological predicates of love and sex need to be understood by therapists treating people with problems concerning sex or sexual intimacy. Too often sexual problems are viewed as purely and primarily social, cultural, or vicarious learning. In contrast, the overwhelming evidence evinced by sex researchers indicates that love

is a biological event that bonds people only long enough to mate and nurture a child (Fisher, 2004). Studies have shown that romantic love is a result of activation of brain reward circuits such as right ventral tegmental area, the right postero-dorsal body and the medial caudate nucleus (Aron et al., 2005), primitive brain regions that regulate motivation and pleasure. Importantly, romantic or sexual love is a cross-cultural universal constant that can be explained by innate neuropsychological systems. These systems evolved to produce intense sexual yearnings and subsequent bonding. The cravings emanate from the reward centers of the brain and lead to intense withdrawal in the case of cravings for the absent lover. Also, they tend to attenuate all negative judgments about the lover. Sadly, this intense love and attraction tend to fade in a year or two (Fisher, 2004). The intrinsic nature of sexuality-related irrationality is important as, unlike irrational thoughts that are more socially and culturally based, sexual ones tend to be more resistant to disputing and psychoeducation, as they are deeply immersed in our neural circuits. For example, morbid jealousy will resist most interventions as it is likely an imperative that at one time was advantageous (Buss & Abrams, 2016). As a result, the therapist must first embrace the apparent legitimacy of the client's feelings before helping him work on attenuating them.

Recently, Buss and Abrams (2016) and Abrams (2016) have advocated adding evolutionary psychological principles to traditional REBT/CBT techniques. Ellis had also discussed the influence of biologically innate tendencies on sexuality and relationship, including their role in therapy. He stressed the importance of informing clients on biological determinants of human sexuality to better assist them with solving intimacy troubles. As a result, effective REBT includes helping individuals better understand both the personal and universal origins of their irrational or self-defeating thinking about sexuality. This understanding will enhance the client's commitment to contesting and altering beliefs leading to his or her sexual distress.

Key Best-Practice REBT-Based Assessment and Treatment Strategies and Techniques in Working with Sexual Problems

Identifying and Classifying Sexuality Problems

The complex nature of love, passion, and sexual attraction discussed above is made more vexing for the sex therapist by the definitional problems of sexual disorders. Most sex researchers (e.g., Abrams, 2016) argue that no sexual expression or desire is inherently pathological unless it meets some very precise criteria. The most important diagnostic criterion is distress in the affected individual or impaired functioning in his or her life. Both the International Classification of Diseases by the World Health Organization (ICD-10) and the Diagnostic and Statistical Manual of Mental Disorders by the American Psychiatric Association (DSM-5), categorize a substantial number of sexually related inclinations or behaviors as pathologies. The DSM requires that before assigning a diagnosis all medical conditions and situational factors that could

lead to misdiagnosis have been ruled out. DSM-5 acknowledges the possibility of multiple etiologies, advocating the diagnostic subtype "due to combined factors." In contrast, the basic feature of the ICD-10 classification is the definition of sexual function as the individual's ability to participate in sexual relationships according to his or her wishes. ICD categories include purely organic dysfunctions, nonorganic dysfunctions, and disorders that have both etiologies. For the most part, psychological explanations are indispensable for the understanding of sexual disorders, even if a biological basis of a sexual problem can be identified, as its experience will invariably be psychological. A Cartesian dualism in which mind and body are viewed as distinct entities fails to capture the complex interplay of the organism. The brain is a bodily organ, the function of which is continually mediated by bodily functions.

For the proper assessment of sexuality issues, the REBT therapist should be familiar with the classifications offered by ICD and DSM, but also with possible medical, physical conditions that may cause the problem. The REBT therapist should be familiar with research in psychology, but also biology, physiology and evolutionary psychology. Only by understanding the complex interplay of factors that can influence sexuality—arousal, desire, performance—can a therapist successfully discover the true nature of the presented problem. A therapist must also be familiar with social mores, norms, and traditions of the cultural groups to which his/her client belongs. This familiarity is particularly critical with sex, as distress that arises from socially induced shame, guilt or stigma, can be conflated with pathology. Of unique relevance for the REBT therapist making a clinical assessment is evaluating the client's cognitive style, beliefs regarding herself, his/her attitudes towards people, relationships, and sexuality. The therapist must also assess how these beliefs have influenced person's relationships, sexual identity and performance (Abrams, 2016).

Presented below are some paradigmatic sexual disorders and the recommended REBT approach for each. As discussed earlier, the scope of sexual problems is as expansive as that of sexual expressions. Despite this, there are sexual problems particularly prone to educing anguish, some because they impede intimacy and others because they evoke shame or guilt.

Sexual dysfunction covers a range of experiences—from lack of sexual arousal to hypersexuality. Therapists working with sexual problems need to understand that sexual arousal activates many of the same motivational centers of the brain as addictive drugs. Despite the anatomical commonalities the motivation for sex differs from most other drives in many ways. For example, while narcotics will cause addiction in everyone after a certain period, most people engaging in frequent sex or repeated exposure to pornography won't develop an addiction. "Sex addiction" tends not to be correlated with high sex drive or numerous sexual encounters. Importantly, arguably the foremost organization of sex therapists and educators, the American Association of Sex Educators, Counselors and Therapists (AASECT) rejects the diagnosis of sex or pornography addiction (AASECT, 2017). The REBT therapist, when treating someone who feels a loss of control over their sexuality, needs to respect the client's goals in seeking control. Although the therapist needs to be conversant with normative data, these norms are not necessarily the standards that a client needs to strive

to. Very often, a person will seek help for behaviors that have been defined by others as pathological, yet are not otherwise impairing.

In contrast to feeling distressed by excessive sexual drives or acts, a problem more commonly encountered is difficulty with sexual arousal. Like most difficulties related to sex, arousal problems are often related to comparative judgments, which often are ill-informed and prone to produce irrational thinking. REBT therapists helping people cope with problems associated with waning sexual interest, reduced ability to perform with a partner, or requiring different types of stimulation must first have some familiarity with the processes of sexual arousal.

The most common source of failure of sexual arousal in men is based on an essential difference in arousal between the sexes, which is shaped by evolution and therefore not likely to change (Buss, 2003). Men are visually aroused and when aroused often tend to be less sexually selective in who arouses them. Women typically require displays of emotional commitment, affection, stability, and status from those who arouse them, before engaging sexually. Both of these general rules have exceptions, but they are important starting points for inquiry in counseling people who have difficulties with arousal.

One arousal problem that is particularly feared, yet easy to treat, is erectile dysfunction. Recent studies have shown that it is more common than most afflicted men may think. And this fact is something that needs to be conveyed in sexual counseling. Occasional difficulty in obtaining an erection is among the most common sexual problems a man may face. Erectile dysfunction increases with age, but there is a high prevalence in all age groups; studies report that 12–25% of men suffer from some degree of erectile dysfunction (McCabe et al., 2016). Before the advent of the phosphodiesterase inhibitor (PDE5) medications, which include Viagra, Levitra, and Cialis, the predominant problem addressed in sex therapy for men was erectile dysfunction. This is no longer the case. However, the capacity to more easily induce an erection should not be considered, ipso facto, a cure for erectile dysfunction. Many men do lose their ability to get an erection exclusively due to deficient penile blood flow. In others, an erection will assist in sexual performance, but the act is no longer desired. For the latter case the REBT therapist must investigate any beliefs or attitudes that have made sex less desirable.

Among the most frequent problems observed in women is lack of sexual interest and desire, with reported frequencies involving as many as 55% of women (McCabe et al., 2016). Moreover, orgasmic dysfunction is present in 11–37% of women, and some mild and occasional issues with orgasm are registered in as many as 80% of women. Cognitive schemas and irrational beliefs appear to have a strong correlation with sexual dysfunction in both males and females. According to Peixoto and Nobre (2015), men with sexual problems tend to activate five common schemas—beliefs in their undesirability, fears of sexual incompetence, tendency towards self-depreciation, beliefs in an undesirable differentiation, or feelings of helplessness. In contrast, women with sexual issues tend to primarily be troubled by concerns about undesirability, observing themselves as different, and helplessness. Many other cognitive and affective influences are associated with sexual disorders, some of them stemming from the cultural factors. For example, conservative attitudes about sexual-

ity tend to be related to reduced sexual desire and to arousal difficulties. Body-image beliefs are associated with women's difficulty achieving orgasm. Reduced sexual desire tends to be connected with beliefs centered on sadness, guilt, and disillusionment. Interestingly, sexual fearfulness is one of the best predictors of vaginismus. These examples make clear that the REBT therapist must explore the many values and beliefs associated with the client's sexual worldview.

When working with couples, sexual problems naturally become more complex. Many couples seek help regarding loss of sexual interest with each other or on the part of one of the partners. This problem needs to be addressed by finding source of the client's anger or other negative beliefs that may present barriers to finding new ways for the couple to excite each other again. The therapist must be careful to determine the level of commitment of each partner. If the seeking of sexual help is proforma, as in the case of a partner who is having extra-relationship sex, sexual therapy will be futile. As noted earlier, the waning of romantic love is usually linked to a decline in sexual arousal. Of course, with all sexual problems, especially those with recent onset, organic bases must be ruled out. These can include endocrine problems—especially reduced free testosterone levels in men. Thus, it is useful to be able to rule out organic bases for the problem before proceeding with psychotherapeutic interventions.

REBT for Loss of Arousal

Any therapeutic intervention must be cognizant of the natural tendency to become inured to one's lover. As suggested above, men tend to habituate to lovers relatively rapidly and women, although a bit slower in losing interest, will do so with fading romance. When romantic love fades arguments increase, and the idiosyncrasies of one's lover become more vexing, and a partner begins to attend to other possibilities. These tendencies conspire to make sex with one's mate less exciting. It is important that a couple's counselor ascertain whether problems like erectile dysfunction or anorgasmia result from a loss of sexual attraction rather than organic problems. If the attraction has indeed faded, the REBT therapist then needs to determine if the individual soliciting help is truly committed to his partner. Sexuality can survive a diminution of passion if there is conjugal love and friendship between partners. If the therapist concludes that the sexual difficulty has arisen from habituation, but there is a bond between partners, then the counselor can help by exploring the irrational beliefs that will invariably make the problem worse. These include beliefs like: "It is a terrible affront that my lover does not get excited by me!" "I can't stand that she doesn't excite me anymore," "I am a terrible person for fantasizing about other men," or "This relationship is a complete failure because he/she doesn't want sex."

The investigation of disturbing beliefs and their consequent emotions is essential for treating this sexual problem. The client needs to be helped to see the tacit rigidity, demandingness, and the damning nature of irrational beliefs that have arisen from diminutions in sexual response or interest, and then guided through the process of challenging them persistently and committedly.

When working with couples, each partner can be guided to find and then disavow these beliefs in front of the other partner. Openly rejecting the irrational beliefs will help reduce the anxiety, hurt, and guilt associated with changes in sexual response, frequency, or functioning. Also, the therapist can educate their clients on facts of sexual desire including its tendency to vary over time and in response to relationship changes (Ellis & Dryden, 2007). Helping people understand that the obstacles they are facing are natural will help them avoid catastrophizing over changes in sexual functioning or feeling.

REBT for Paraphilias

Paraphilias represent a statistically normal aspect of sexuality, but also one that is frequently associated with distress or conflict. Paraphilias are sexual fantasies, urges, or behaviors that are considered culturally irregular (Abrams, 2016), characterized by persistence over time, and resistance to change in therapy. It is for this reason that paraphilic researcher Moser (2009) has long argued that paraphilias need to be addressed the same way as other sexualities, i.e., gay or straight. He argues that much of the motivation that leads to paraphiles seeking treatment is societal shame or situational humiliation. Despite this perspective, paraphilias remain as disorders in both the DSM and ICD and are often addressed during therapy.

The desire to inflict harm in sexual contact is quite common and almost exclusively a male propensity. Sexually sadistic acts typically lead to shame, guilt, and troubled relationships. Men with sadistic or other paraphilias often cannot be physically aroused by their partner alone. Instead, the lover of the paraphile can be relegated to being an accessory necessary for sexual arousal. It is imperative for the counselor to be aware that paraphilias are as refractory to change as a person's sexual identity. For example, it is no easier for a man with a hair fetish to learn to be aroused by an entire person, than it is for a straight man to become visually aroused by male genitals.

An REBT therapist helping someone troubled with a paraphilia needs to be cognizant of their estimated prevalence, which is as high as 80% (Abrams, 2016); thus, a therapist must exercise caution before treating paraphilia as a sexual pathology. A reasonable standard for paraphilic treatment is the criteria set by the DSM and ICD in which it becomes a disorder when it impairs functioning, leads to distress or becomes a danger. Since most paraphiles have learned to keep their propensities secret, they will typically be accidentally exposed in a relationship, after they let their guard down. Examples of this include man who gets caught masturbating to fetishistic pornography; or his partner discovers sexual implements, women's undergarments, or finds him viewing a fetish website. Even if the paraphilia does not rise to the level of pathology, it commonly leads to fear and shame when exposed. The person whose paraphilic sexuality is discovered by a partner will often respond with denial, excuses of experimentation, or if undeniable, vows to change. But a paraphilia is a part of one's sexuality—it is not likely to change, even if a paraphile

wants to change. Counseling both, couples and individuals with this problem must include an assessment of the severity, focus, and duration of the paraphilia. In the more severe forms it tends to exclude all traditional sexual intimacy and can be obsessively consuming of sexuality and even career functioning. In such cases, an intimate relationship becomes almost impossible, except if the non-paraphilic partner is extraordinarily accommodating and flexible. In less severe forms, the paraphilic individual needs to build a sex life that includes the paraphilia in such a way that his partner doesn't experience any suffering whether physical or emotional. Common (irrational) beliefs among women who discover their mate is a paraphile are "he is a pervert and a terrible person for having these desires," "he completely deceived me about his love, and our relationship is a total lie," "he should be able to be turned on by me without his fetishes," or "if he really loved me, he would be attracted to me without needing his sex games."

The response of the male lover when his mate discovers his predilection is often shame, guilt, and denial. Men "outed" as paraphiles will suffer beliefs like: "I am a pervert and a terrible person for having these desires," "I am not a real man if I need to be aroused in such a sick way," or "I can never be happy with these desires." The counselor must help the client challenge these irrational beliefs. It is often helpful to introduce the individual or couple to data demonstrating the high prevalence of paraphilias in the population—understanding that paraphilias are far from unusual helps their "normalization" and diminishes shame and inadequacy (Abrams, 2016; Ellis & Dryden, 2007). Individuals with paraphilias must be helped to accept them as enduring aspects of their sexuality. They need to be helped to acknowledge their paraphilic desires and channel them in ways that allow for enduring relationships. Counseling for the couple with a paraphilic partner must focus on changing the irrational beliefs of both partners, especially those regarding shame, rebuke, and betrayal (Abrams, 2016). The woman needs to be helped to challenge beliefs that the paraphilia is a volitional betrayal of the relationship or that her lover's sexual desires denote a lack of love. This is not always possible, and only if this stage is successfully established should the therapy continue to the next phase.

This second phase of the counseling must involve strategies to help the individual or couple develop a sexual compromise that permits limited expression of the paraphilia. For example, if the man has lingerie fetish such that he is aroused by wearing women's undergarments his partner is invited to find her comfort range with his dressing this way prior to or during sex. The therapist can facilitate the process by helping the paraphile's spouse explore the basis for her aversion to his arousal cues. The therapist can then assist the paraphile in understanding the very cognitions his lover might have about his arousal cues. In this process, his irrational beliefs and demands are elicited and challenged. For example, beliefs like the following must be strongly challenged "if she really loved me she would accept what arouses me," "she is a terrible spouse for reacting badly to what turns me on," or "I am a sick degenerate for liking this stuff".

Facing Infidelity

When one is emotionally and sexually committed to another person, there are few life traumas that approach the one of discovering that a committed sexual partner has been intimate with someone else. This intimacy is usually sexual or it could be purely romantic, which to some is more traumatizing than a superficial sexual encounter. Finding romantic infidelity more hurtful than sexual is more common with women. This type of infidelity is also more common among women who might develop a deep romantic bond with a man (on occasion with a woman) without ever having sex. Although husbands and lovers tend to find this disturbing, it does not approach the emotional firestorm in many men that ensues when the relationship is indeed sexual (Buss & Abrams, 2016). Evolutionary psychology explains the different responses of males and females to infidelity—while fear of cuckolding makes men especially sensitive to sexual infidelity, females are endangered by possibility of losing love, dedication and protection of their partners, and therefore they get more upset in case of the partner's emotional infidelity (Buss, 2003).

REBT treatment of a couple suffering infidelity should begin with both partners attending individual sessions. This is because in this case one or both members of the dyad may use couples therapy as an exit strategy. It is painful to leave a relationship for reasons that include guilt, inertia, social responsibility, or feelings of obligation. Thus, the participation in couples' therapy is not based on a sincere desire to preserve and enhance the relationship. In this case, the counselor is placed in a no-win situation in which the partner who secretly desires a way out can claim that he or she has tried everything to make it work, or even blame the therapist's intervention for the failure. A requisite of being a couple's counselor is being thick skinned; but the job does not include billing for wasted time. Thus, it is essential that the counselor makes a determination of whether both partners are really committed to continuing the relationship. The research presented earlier is of particular importance in that it denotes that a great deal of sexual motivation is innate, evolutionarily old, and not immediately accessible to the individual. As Beck (1989) emphasized, couples radically change their judgments when romantic passion attenuates. The role of the couples' counselor is to accurately assess the factors that led one partner to seek sexual satisfaction outside of the relationship.

A brief history of the sexual trajectory of the relationship needs to be compiled. This is to ascertain whether the infidelity is a result of problems such as:

- Diminished attraction on the part of one or both partners
- Pairing for reasons other than sexual attraction such that one or both were never compellingly sexually attracted to each other
- Succumbing to a brief intense temptation
- Anger at the partner and seeking retribution through infidelity
- Undisclosed sexual orientation
- Undisclosed sexual performance issues
- Undisclosed sexual pathology

It is also important for the therapist to understand the evolutionary factors related to infidelity. While long-term, monogamous relationship is a goal for many, it has only recently become the ideal, and not in all societies. In fact, sexual monogamy in nature is quite rare. This stands even for the birds and prairie voles—species that were believed to create pair bonds for life, yet often engage in extra pair copulations or what married couples would denote as adultery. Research from humans' close relatives—apes—supports these claims. Bonobos and chimpanzees also tend to be sexually promiscuous, with only some resemblances to pair bonds (Fisher, 2004). Similar stands for humans. According to the researchers, we are greatly overestimating the importance of romantic love, mutual attraction and desire that last forever, as they tend to diminish over time, and only small number of relationships "survive" this. While none of this justifies adultery, it changes perspective, and improves understanding of the infidelity (Abrams, 2016).

Once the counselor has a reasonable sense of the basis of the infidelity and whether the unfaithful partner is earnest about his/her commitment to remaining faithful, he/she should take the next step, which requires that the couple explores the beliefs and emotions that led the unfaithful partner to stray. It is important to be aware that a sincere desire to be faithful does not erase the flaws in the person or the relationship that led to the infidelity.

Irrational beliefs typical for a lover with an unfaithful partner

- "I have been completely humiliated and must retaliate to save my honor."
- "He/she is completely worthless, and I must punish him/her."
- "I can never trust any lover again."
- "I must punish him/her by fighting for the kids."
- "I cannot stand the idea that people will know that I was cheated on."
- "I am a worthless lover and cannot satisfy any woman."
- "The infidelity tainted him/her and I cannot be with this person."
- "My marriage is a total failure."
- "She/he deceived me and I everything she/he ever said must be a lie."

Common beliefs of the unfaithful partner

- "I have an absolute right to pursue sexual gratification if he/she refuses to meet my needs."
- "It is completely his/her fault that he/she aged. I was forced into arms of someone else."
- "My new lover completely understands me and loves me far more than he/she did, so I am doing absolutely nothing wrong in seeking his/her affections."
- "He/she is not the person I fell in love with, so I had to find someone like my lover used to be."
- "I shouldn't have to be with a man this bad, when there are nice men who like me."
- "My lover should understand that I needed to do this."
- "He/she made me lonely and dissatisfied, and I have an absolute right to be happy."
- "It is very common to have an affair; he should understand and accept it."

Even though these irrational or demanding beliefs are likely to arise in part due to innate factors, they can be addressed through REBT. After each irrational belief is identified through therapeutic dialogue, they can be diminished using one of the many disputation techniques. Each partner has to be helped to see that his/her alienation from his loved one is in part a result of a change in his/her perception of a partner. This applies to both the unfaithful partner who blames his/her partner's deficiencies for infidelity and the aggrieved partner who blames the infidelity for all negative feelings. This can be accomplished by encouraging each partner to specify the exact nature of the partner's change that is troubling and to explore the reality of change.

A significant percentage of those suffering infidelity will never forgive the offense (Shackelford, Buss, & Bennett, 2002). This needs to be assessed early in treatment. If indeed it seems that infidelity represents an unforgivable transgression, then the couple needs to be counseled accordingly. Specifically, the unfaithful partner needs to be warned that staying in the relationship will tend to be associated with ongoing hostility and resentment. However, if the partner of someone unfaithful is able to recognize infidelity as something unacceptable, but not catastrophic and unforgivable, therapy can help couples completely overcome the situation (Abrams, 2016). Importantly, the essential REBT principles used for this acute source of sexual conflict can be applied to almost any sexual conflict.

The vast preponderance of clinical research in REBT and other CBT variants has been focused on emotional and personality disorders, but the pool of studies focusing on sexuality issues is increasing. CBT becomes a treatment of choice for many sexuality issues. Studies demonstrate that CBT is successful in treating sexual pain in females, and also that its effects are persistent over time (LoFrisco, 2011). CBT is also the gold standard therapy for paraphilias in sexual offenders—it is aimed at decreasing inappropriate arousal and instead supporting appropriate sexual responding and behavior. Research shows that CBT indeed helps prevent recidivism in these cases, although its success depends on the type of paraphilia (Kaplan & Krueger, 2012).

A distinctive aspect of sexual disorders is that what may seem like a secondary problem is actually the issue of concern. Therefore, the REBT therapist must keep in mind that most sexual problems overlie sexual predilections that are not amenable to change (sexuality, gender, preferences)—and some of them are even unethical to treat as pathological conditions. The initial distortions that must be addressed are often related to shame and guilt about one's sexuality. Having addressed these, the problems that seem secondary are immediately elevated to the primary.

The preceding examples of REBT for several common sexual problems are certainly not comprehensive, but should provide a conceptual framework for applying REBT to many sexual problems. Focusing on the client's beliefs that both result in problems, or arise due to life challenges, is the main approach in all CBT based therapies. Understanding how these beliefs cause suffering, and working on replacing irrational beliefs with more adaptive and flexible ones is the most effective means by which therapy achieves efficacy.

Treatment Guidelines from the Empirically Supported Therapy Literature that Inform Best Practice in REBT with Sexual Problems

Cognitive-based therapies are becoming a treatment of choice for sexuality disorders (Stephenson, Rellini, & Meston, 2013). As a comprehensive therapeutic system, REBT has a firm theoretical basis, set of assessment and treatment procedures for a whole spectrum of psychological issues (including issues regarding intimacy and sexuality) and growing empirical support. However, the REBT therapist should be familiar with all relevant, evidence-based data regarding sexuality issues, and efficacy of various treatments offered for particular problems. Psychotherapists must view their field as a dynamically changing science that provides new methods and demotes less effective ones. Thus, the REBT practitioner needs to be aware of changing methods and be ready to apply the approach that has the best chance of success. Additionally, he/she should incorporate his/her knowledge and experience into every therapeutic plan such that each client and each presenting problem is tackled with the best evidence supported technique.

The REBT therapist needs to be conversant in the four essential approaches to sexual disorders even if he/she practices only psychotherapy. Ethical treatment requires at least some knowledge of other modalities including those involving surgical/medical interventions, medications, and hormonal adjustments. For example a common problem faced by men—erectile dysfunction—is usually (and mostly successfully) treated with medications and lifestyle changes like weight loss, dietary change or exercise. Similarly, most common women's sexual problems: vaginismus or pain during intercourse, are often effectively treated with topical medications, and in some cases surgery. Still, while the efficacy of medicaments is proved by numerous studies, for some issues (e.g. low sexual desire in females) psychotherapy (especially CBT) is a treatment of choice (Brotto et al., 2017). Comparing effects of pharmacological and psychological interventions is challenging; medication therapy has a narrow influence, in comparison to psychological treatment, and it affects only primary symptom—often successfully. However, some findings suggest that psychotherapy can be at least as effective as pharmacotherapy (Günzler & Berner, 2012). Furthermore, outcomes of psychotherapy are generally wider, by targeting possible comorbid issues and enhancing quality of life and relationship outcomes, with no side effects. Interestingly, treating clients with both, medical procedures and psychotherapy appears to be less effective than applying cognitive therapy alone (Brotto et al., 2017). Apparently, medications leave the client as a passive actor in the treatment process and do not provide the psychological tools and sense of control obtained by someone given only REBT. When applied alone, REBT provides clients with coping techniques that help reduce catastrophizing and sex-related distress

Sexuality disorders are often followed with a variety of psychiatric comorbidities. In order to address particular problem from the most appropriate perspective, it is valuable to understand cognitive and emotional symptoms that might underline or accompany it, and understand these interconnections. Different therapies may be

suitable based on the characteristic of the problem, but also different techniques from one approach. In their article, Hallberg and associates (2017) explored the efficacy of one modality of cognitive therapy (with emphasis on acceptance) in treating hypersexual disorder—the therapy proved to be effective in decreasing symptoms, while high satisfaction and attendance were also registered. Authors propose how different techniques employed were believed to affect the complexity of hypersexuality disorder—combination of acceptance-based and self-monitoring techniques are aimed at experiencing undesirable urges, but not acting on them; problem-solving strategies were expected to affect stress and social interactions; and exposure techniques help with anxiety symptoms. For a therapist, it is useful to know that acceptance and commitment therapy shows good effects in compulsive and addictive disorders, and to understand the similarities between these disorders and hypersexuality. Similarly, arousal issues are found to be connected with cognitive distraction during sexual activity (Newcombe & Weaver, 2016)—mindfulness-based techniques are helpful in staying in present, regarding cognitions, emotions, and bodily sensations, and prove to be effective in addressing sexual desire and arousal issues (Newcombe & Weaver, 2016; Paterson, Handy, & Brotto, 2017). In one study (Paterson et al., 2017) mindfulness also appears to improve desire by decreasing depression and anxiety that are in many females comorbid with lack of sexual desire. Indeed, mindfulness appears to have more than one effect on sexuality—through reducing sex-related distress, depression, cognitive distractions, and improving focus on bodily sensations and sexual stimuli. On the other hand, cognitive analytic therapy appears to be more effective for high-risk sexual behavior, where old (non-adaptive, and dangerous) behavior patterns need to be exchanged with more appropriate ones (Sacks, Jagielska-Hall, & Jeffery, 2016). Psychoeducation is also often included in therapy of sexuality disorders, as it can help client focus and understand bodily sensations, and also feel more in control (Brotto et al., 2017).

In the case of couple therapy, the REBT therapist should not succumb to the idea that increasing the quality of an intimate relationship will necessarily resolve sexuality issues. It is, actually, one of the strongly embedded irrational beliefs in our culture—that if love is strong, sex will always be good and easy. More often, sexual life of a couple requires work, communication and compromise. Other issues in the relationship can also affect the intimacy of a couple—unresolved problems, anger, resentment, and more. Therefore, it is useful for a therapist to understand relationship dynamics, their patterns of functioning, and implicit rules (Capuzzi & Stauffer, 2016) to determine the source(s) of problems. Studies also show that relationship quality can moderate the effect of CBT on sexuality (even when individual therapy is employed)—more precisely, greater relationship satisfaction correlates with better effects of therapy on sexual satisfaction and levels of sex-related distress, but not on sexual functioning (Stephenson et al., 2013). This finding strongly emphasizes the need for a comprehensive understanding of client's sexual and romantic life while exploring and treating sexual disorder.

The case below is written with permission of the client and took place prior to this writing. The problems and interventions described instantiate many of the principles I have discussed.

Brief REBT Case Example: Carol

Carol sought psychotherapy as a result of intimacy problems, life dissatisfaction, career setbacks and conflicts with her family. Her therapy was intermittent, lasting three years during which she exhibited a pattern of self-defeating sexual and life behaviors. This woman exhibited a very similar profile to clients who had been sexually abused, but in fact she had suffered no remarkable trauma at any point in her life. Carol's parents divorced when she was in her teens, leading to a distressing break-up of the family. Carol, her younger brother and sister, lived in the family home with their mother until all had graduated college. Carol had done reasonably well in college but had few friends. When she sought treatment as an adult, she was continuing to live with her mother and siblings. In fact, her primary presenting problem was frustration with her family. She was in a continual state of conflict: fighting, often physically, with both her mother and siblings. At the workplace, she was continually in passive aggressive conflicts with co-workers. Indeed, her avocation seemed to be plotting revenge for perceived slights.

When Carol was not around, her family never seemed to have any conflict. When this would be pointed out to Carol she was refractory to its implications and she instead chose to see it as evidence of her being victimized. Professionally, she was a paradigm of underachievement, typically earning less than half the salary of similarly educated peers. In addition, in all jobs requiring any degree of socializing she would typically be discharged in under a year. Here too she failed to find herself as the common denominator blaming it instead on unfairness, victimization, or her own benign nature. Despite her perception, each job was marked with a few key adversaries whom she predetermined were hostile to her, and to whom she would react with hostility or outright rage. Notably, rage was her primary expressed emotion followed by grief typically resulting from the failures that grew out of her rages. Carol's romantic life was denoted by a series of turbulent and short-lived relationships. She would react to any perceived slight by her numerous lovers with ad hominem vitriol. This usually involved attacks on their sexual adequacy, genital size, or overall worth as humans. At the end of her typically brief relationships she would spend a great deal of time contriving maximally damaging modes of revenge. She would rarely have anything positive to say about the men in her life, or men in general. In fact, she seemed clearly delighted in disparaging or humiliating them. Her sexual fantasies involved doing violence to men. Despite the common conceptions about women involved with sexual violence, she was never abused. This was verified with a family session with her mother and her sister.

As with all REBT clients, Carol and this writer established a therapeutic relationship in which her expressions of distress were patiently and non-judgmentally heard. In this phase, lasting about three sessions, almost no interventions were offered unless requested by Carol. After this period behavioral interventions were suggested only in direct response to a problem she would present. Suggestions relating to change of self-defeating behaviors were often perceived as rebukes. Thus, all interventions had to be suggested with caution and subtlety. This was also the case when she was offered

more rational ways to view social interactions or her own beliefs. With Carol, there was always a very fine line between a constructive criticism and a condescending rebuke.

Over many sessions her recriminations and complaints were distilled into a number of self-defeating or irrational beliefs:

"Everyone close to me will conspire to hurt me."
"Men are sexually attractive, but all are terrible people."
"If someone hurts me, I must plan revenge to completely shame and humiliate him."
"I absolutely cannot bear the discourtesy of others – especially as they are always intentional."
"It is completely humiliating if people get to know the real me."
"I must hurt or humiliate a man before having sex with him, otherwise in submitting to him, I will be humiliated."
"Sex is an act of impulse that can't be enjoyed because it is inherently exploitive and shameful."

The therapy emphasized examining the logic and practicality of her destructive behaviors in relationships, and her sadistic and suspicious sexuality. She was helped to examine her beliefs and develop compromises in her most strongly held beliefs. Using REBT in this way emulates many of the features of the derivative therapy Dialectical Behavior Therapy. Specifically, REBT can help clients to diminish irrational or destructive beliefs by engaging in model conflicts with the therapists. Consequently, her therapy required this REBT therapist to remain steadfast in the face of her anger at being challenged and disputed. By remaining stable while facing her anger she was tacitly taught that not all significant people are adversaries and not all relationships are exploitive. Frequently telephone contact was made available to her, especially during periods marked by anger that impelled her to potentially damaging acts. One therapy call was made prior to her execution of a plan to mail nude photos of herself to the wife of a paramour. She was helped to see that her vengeful act would not punish the perceived slights of her married suitor, but hurt an uninvolved third party. Such interventions were quite frequent.

Her paraphilic sadism was also addressed by challenging the belief that a women's role in sex was inherently shameful, and helping her understand that her delights in humiliating men only led to short term benefits. She was helped to see that her behavior illogically violated her own ethical beliefs and resulted in enduring guilt, shame, and fear of reprisal. Enlisting her to pursue more traditional and rational relationships was met with a great deal of conflict but over time she largely abandoned sadistic behaviors. Eventually, she moved away from relationships with men, to intimate non-sexual relationships with women. She was able to sustain a long-term professional job, by avoiding those beliefs that created conflicts in the workplace.

Carol is paradigmatic of people seeking help with sexual problems in that these problems are just one aspect of a person's life. They do not exist in a vacuum and typically have adverse effects in many domains. People with sexual problems, like those presenting with many other nominally circumscribed problems, need to be

understood as complete human beings. And sexual problem needs to be treated in the context of the many interlocking features of their life.

What I Have Learned About Using REBT with Sexual Problems

Accommodating Individual Differences

Through my work with people from different groups and social milieus I have found that a therapeutic bond requires a deep understanding of the client's worldview. This understanding has typically fallen under the rubric of diversity understanding. In sex therapy this term is typically applied in three ways. The first refers to a mindset in which people of many cultural and racial backgrounds are engaged in the REBT process or at least made welcome to it. The second denotes creating a conviction in which the practitioner is open to the numerous worldviews and behaviors that diverge widely among human groups. The third is founded on the premise that each person is unique, and is best understood and approached from that perspective. This last one is most important for mental health professionals, especially those dealing with sexual concerns.

Because people with sexual difficulties often are, or at least feel, marginalized, it is particularly important that the therapist be aware of the diversity in sexual identity, sexual values and sexual behavior. However, rather than engage in formal diversity training, the REBT therapist need only be open to learning the client's world view and his or her own sexual culture. I have found that many diversity awareness protocols merely substitute one set of stereotypes with others. There is little evidence that utilizing formulaic models of diversity enhances the efficacy of REBT. I found little help from normative data about sexual behavior or attitudes, as there is too much individual variance to effectively apply it to any individual. Indeed, had I begun treating any person with sexual problems constrained by rigid beliefs about their cultures or sexualities, I would have risked failing to develop an effective therapeutic relationship. It was being open to each client as a unique individual that was most effective in fostering a rapport that supported help and change.

Gender roles, and society's perception of them, have been evolving during the last few decades. However, our gender schemas are still heavily influenced by culture, and these cultural foundations are established in early life (Capuzzi & Stauffer, 2016). Gender schemas heavily influence the sexuality of both, males and females, and set the boundaries of what is allowed and acceptable—boundaries that are often quite arbitrary in nature. It is important to understand each client's beliefs regarding gender, and their influence on the client's sexuality and intimate relationship. Similarly, understanding a client's sexuality—whether it is heterosexual, homosexual, asexual, or somewhere in between, requires not only to ask about behavior, but also to inquire about client's perception of his/her sexuality (Morgan, 2013). This is important as

the client's sexual role and his/her identity often diverge. Since REBT focuses on both, thoughts and feelings, and behaviors, understanding how they are integrated within an individual is of particular importance.

The Dos and Don'ts of REBT Sex Therapy

Since sexual problems are typically highly sensitive and stigmatized, the REBT therapist needs to be aware that he or she is not treating a member of a class, but an individual. Of course, a person's attributes will be partially a product of his or her social group, but to rely on this affiliation in order to gain deeper understanding of an individual presents more problems than solutions. Rather than overly relying on published models of gay, minority, transgender, or marginalized sexual groups, it is far more rational and efficient to work hard in order to understand the individual.

Moreover, the REBT therapist must focus on the person, not the disorder. People with sexual problems—however outlying, atypical, or even offensive—are still people. The therapist must avoid seeing her client as an exemplar of pathology, but rather as a human being whose sexual problem is just one attribute among many others. REBT therapists should be aware of their own prejudices that may arise when working with people with sexual problems. The REBT clinician must first acknowledge these biases and then learn how to control and tolerate feelings of perplexity or repulsion. The therapist must always keep in mind that people coming to therapy are usually good people having a bad time. And this bad time does not represent the sum of who they are.

Which Aspects of REBT Sex Therapy Deliver the Most Benefit for Change and Which Don't

In 32 years of helping people with problems related to sex, I have become confident that the dynamically evolving REBT is equal or superior to any other method. Among the qualities that make REBT so effective are its principles of unconditional acceptance of the client's lifestyle, his/her values and behavior. The REBT philosophical approach both encouraging a stoic acceptance of life's adversities and also providing means to change the negative emotions adds profound strength to its ability to help people with sexual and other problems. REBT's emphasis on unconditional acceptance of oneself and others is remarkably important, especially in the context of sex therapy. Since sexuality and its many manifestations often engender stigma and shame, unconditional acceptance is liberating to most clients. Indeed, when I have made it clear that I would not judge **any** sexual behavior as shameful or bad, and instead accept all variants of sexual behavior as equally legitimate, I have had the best outcomes (Abrams, 2016). When I both worked to understand client's sexual and

social views, and demonstrated acceptance even in cases when they do not conform to common mores, my REBT was maximally effective. My avoidance of yielding to the temptation to seek to verify the legitimacy of a client's beliefs, such as in the case of a client reporting that his family despises him due to his homosexuality, greatly helped minimize the client's emotional distress. In essence, REBT has the specific feature of helping eliminate irrational thinking without judging the beliefs.

REBT therapists are not immune to the mistakes of all therapists, the foremost of which is the sine qua non of psychoanalysts—spending more than a minimum time on seeking historical explanations. If therapists learn anything from the work of forensic psychologists, they need to attend to the evidence that autobiographical memory is unreliable, malleable, and subject to the tacit expectations of the therapists. REBT is foremost among therapies in eschewing extensive histories. Each therapist should ask him/herself "how will this line of questioning about the client's past alter my treatment?" It should not change the formulation of distorted beliefs, irrational thinking, dysfunctional life philosophy, or diagnosis. All of these can be derived by the client's depiction of his current mental state, relationships, and beliefs about himself and his life.

A second caution for REBT therapists working with clients with sexual problems is strict avoidance of moral judgments. One client I treated had been released from a prison exclusively for recidivist sex offenders. His offenses included raping an 18-month-old toddler and two other children. At no point was it necessary for me to tell him that what he had done was offensive to me, or to society; fifteen years in prison had made that clear to him. My only role was to help him with his reasoning and emotional functioning so that he would function more appropriately in the future. If I had judged him for his crime there could have been no alliance, no trust, and no effective therapy. Even people deemed reprobates by society have a right to a non-judgmental therapeutic alliance. If the reader cannot achieve this, then he should eschew morally or socially distasteful clients. A final caution for the REBT therapist is to avoid literalizing the diagnosis. Of course diagnoses are necessary for ethical and effective treatment, but they are no more than abstractions of the client. A client is not merely a paraphiliac, a borderline, a schizophrenic, or any other diagnosis classification. Instead, he/she is a person with many attributes, who also happens to have some of the features of that diagnosis. REBT is a humanistic therapy that obligates the therapist to accept all humans as unique striving beings. Categorizing a person as a diagnosis is at odds with the humanistic side of REBT that strives to perceive the person as a unique entity.

References

Abrams, M. (2016). *Sexuality and its disorders: Development, cases, and treatment*. SAGE Publications.

American Association of Sex Educators Counselors and Therapists. (2017). https://www.aasect.org/position-sex-addiction.

Aron, A., Fisher, H., Mashek, D. J., Strong, G., Li, H., & Brown, L. L. (2005). Reward, motivation, and emotion systems associated with early-stage intense romantic love. *Journal of Neurophysiology, 94*(1), 327–337.

Beck, A. T. (1989). *Love is never enough: How couples can overcome misunderstandings, resolve conflicts, and solve relationship problems through cognitive therapy*. New York: Harper Perennial.

Bowlby, J. (1982). *Attachment* (2nd ed., Vol. 1). New York: Basic Books.

Buss, D. M. (2003). *The evolution of desire: Strategies of human mating*. New York, NY: Basic Books.

Buss, D. M., & Abrams, M. (2016). Jealousy, infidelity, and the difficulty of diagnosing pathology: A CBT approach to coping with sexual betrayal and the green-eyed monster. *Journal of Rational-Emotive & Cognitive-Behavior Therapy, 35*(2), 150–172.

Brotto, L. A., Basson, R., Chivers, M. L., Graham, C. A., Pollock, P., & Stephenson, K. R. (2017). Challenges in designing psychological treatment studies for sexual dysfunction. *Journal of Sex and Marital Therapy, 43*(3), 191–200.

Capuzzi, D., & Stauffer, M. D. (2016). *Counseling and psychotherapy: Theories and interventions.* Wiley.

Ellis, A. (1954a). Psychosexual and marital problems. In L. A. Pennington, I. A. Berg, L. A. Pennington, & I. A. Berg (Eds.), *An introduction to clinical psychology* (2nd ed., pp. 264–283). New York, NY US: Ronald Press Company.

Ellis, A. (1954b). *The American sexual tragedy*. New York: Twayne.

Ellis, A. (1957a). Rational psychotherapy and individual psychology. *Journal of Individual Psychology, 13,* 38–44.

Ellis, A. (1957b). How do I love thee? *Let me count the ways. Psyccritiques, 2*(7), 188–189.

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

Ellis, A. (1972). *The civilized couples guide to extramarital adventure*. New York, NY: David McKay.

Ellis, A. (1998). How rational emotive behavior therapy belongs in the constructivist camp. In M. F. Hoyt (Ed.), *The handbook of constructive therapies: Innovative approaches from leading practitioners* (pp. 83–99). San Francisco: Jossey-Bass.

Ellis, A., & Abrams, M. (2008). *Personality theories: Critical perspectives*. Thousand Oaks, CA: Sage Publications.

Ellis, A., & Dryden, W. (2007). *The practice of rational emotive behavior therapy*. Springer Publishing Company.

Fisher, H. (2004). *Why we love: The nature and chemistry of romantic love*. New York: St. Martins Griffin.

Günzler, C., & Berner, M. M. (2012). Efficacy of psychosocial interventions in men and women with sexual dysfunctions—a systematic review of controlled clinical trials. *The Journal of Sexual Medicine, 9*(12), 3108–3125.

Hallberg, J., Kaldo, V., Arver, S., Dhejne, C., & Öberg, K. G. (2017). A cognitive-behavioral therapy group intervention for hypersexual disorder: A feasibility study. *The Journal of Sexual Medicine, 14*(7), 950–958.

Kaplan, M. S., & Krueger, R. B. (2012). Cognitive-behavioral treatment of the paraphilias. *The Israel Journal of Psychiatry and Related Sciences, 49*(4), 291–296.

LoFrisco, B. M. (2011). Female sexual pain disorders and cognitive behavioral therapy. *Journal of Sex Research, 48*(6), 573–579.

McCabe, M. P., Sharlip, I. D., Lewis, R., Atalla, E., Balon, R., Fisher, A. D., … & Segraves, R. T. (2016). Incidence and prevalence of sexual dysfunction in women and men: a consensus statement from the Fourth International Consultation on Sexual Medicine 2015. *The Journal of Sexual Medicine*, *13*(2), 144–152.

Morgan, E. M. (2013). Contemporary issues in sexual orientation and identity development in emerging adulthood. *Emerging Adulthood, 1*(1), 52–66.

Moser, C. (2009). When is an unusual sexual interest a mental disorder? *Archives of Sexual Behavior, 38*(3), 323–325.

Newcombe, B. C., & Weaver, A. D. (2016). Mindfulness, cognitive distraction, and sexual well-being in women. *The Canadian Journal of Human Sexuality, 25*(2), 99–108.

Paterson, L. Q., Handy, A. B., & Brotto, L. A. (2017). A pilot study of eight-session mindfulness-based cognitive therapy adapted for women's sexual interest/arousal disorder. *The Journal of Sex Research, 54*(7), 850–861.

Peixoto, M. M., & Nobre, P. (2015). Cognitive schemas activated in sexual context: A comparative study with homosexual and heterosexual men and women, with and without sexual problems. *Cognitive Therapy and Research, 39*(3), 390–402.

Sacks, M., Jagielska-Hall, D., & Jeffery, S. (2016). Cognitive analytic therapy for high-risk sexual behaviour. *Sexual and Relationship Therapy, 31*(1), 20–31.

Shackelford, T. K., Buss, D. M., & Bennett, K. (2002). Forgiveness or breakup: Sex differences in responses to a partner's infidelity. *Cognition and Emotion, 16*(2), 299–307.

Stephenson, K. R., Rellini, A. H., & Meston, C. M. (2013). Relationship satisfaction as a predictor of treatment response during cognitive behavioral sex therapy. *Archives of Sexual Behavior, 42*(1), 143–152.

REBT and PTSD

Candice R. S. Woo and Komal Sharma-Patel

Experiencing some psychological difficulties in the aftermath of a traumatic event is a common response; one-third of trauma survivors experience symptoms of posttraumatic stress disorder (PTSD) that remit by one month post-trauma (Committee on Treatment of Posttraumtic Stress Disorder & Institute of Medicine, 2008). However, 10–20% of individuals experience prolonged and debilitating symptoms of PTSD that interfere with their daily lives (Norris & Sloane, 2007). Identifying key components in the psychological adjustment to trauma is important to help individuals recover. In this chapter, Rational Emotive Behavior Therapy (REBT) in the context of other evidence-based treatments is presented. A trauma-focused REBT treatment of PTSD and trauma-related symptoms is described.

Key Rational Emotive Behavior Therapy Theoretical Concepts in Working with PTSD

REBT's Constructivist View of PTSD

REBT (Ellis, 1962, 1992) is helpful in understanding how a healthy and normal reaction to trauma becomes a debilitating and protracted course. Consistent with the constructivist theory (e.g., Hollon & Garber, 1988; Neimeyer, 1998; Resick & Schnicke, 1992), Ellis proposed that the experience of negative emotions in relation

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to negative life events is a healthy response, and only a protracted course of symptoms that interferes with daily life is maladaptive. The distinction between these emotional responses stems from one's beliefs, which may be 'rational' (resulting in healthy negative emotions) or 'irrational' (unhealthy negative emotions), as well as one's understanding of symptom occurrence (Ellis, 1962, 1992). This is founded on Ellis's conjecture that pre-conceived beliefs of the world, developed from life experiences, are the basis of one's perception of the world, which can be modified to incorporate new information.

In the same vein, the constructivists propose that trauma initiates a meaning-making process to elucidate information that is often inconsistent with pre-existing beliefs (e.g., Hollon & Garber, 1988). Specifically, most people view the world as "just," "benevolent," or "meaningful" (Janoff-Bulman, 1992); traumatic experiences lead one to challenge the validity of these schemas. According to Ellis (1962, 1992), individuals who have protracted PTSD symptoms hold 'irrational beliefs' consisting of 'demands' that their pre-existing worldviews be true (i.e., 'demandingness'; Ellis, 1962). They further place undue judgment on their (others' or the world's) worth, ability to cope, or severity of the traumatic event. For example, victims of domestic violence who hold the 'demand' that "the world must absolutely be just," may conclude that (1) people "are worthless because they can hurt you" (i.e., 'ratings of worth'); (2) they "cannot stand that the world is unjust" (i.e., 'frustration intolerance); or that (3) it is "awful to live in an unjust world" (i.e., 'awfulizing). Ellis (1994) proposed that only by changing these 'secondary irrational beliefs' can the symptoms be changed (i.e., "I would like to see events play out justly, but I accept that things do not work out in ways that I deem just.").

REBT's ABC Model and Cognitive Restructuring

REBT's theory of emotional disturbance proposes that it is not trauma or attributions about the trauma (i.e., 'antecedent'; "A") itself that determines whether one develops PTSD. Rather, it is the 'B'; (i.e., 'belief') that one has about the event that leads to emotional disturbance or PTSD (i.e., 'consequence'; 'C'). REBT's ABC (i.e., 'antecedent', 'belief', 'consequence') model posits that faulty beliefs are to be challenged and replaced by empirically-based, realistic, and flexible cognitions. Specifically, 'acceptance' of one's beliefs as preferences rather than 'absolute demands' allows for the adoption of more accurate, rational and flexible beliefs that lend to healthy emotions. Further, identifying and changing 'secondary irrational beliefs' of (1) 'ratings of worth' (i.e., that oneself, others, or the world is not worthy), (2) 'frustration intolerance' (i.e., that one cannot withstand a certain feeling or behavior etc.), and (3) 'awfulizing' (i.e., that referential behavior, event, emotion is "awful"), are necessary for symptom reduction.

As mentioned earlier, REBT (Ellis, 1994) highlights the role of secondary disturbance or 'symptom stress' in the perpetuation of PTSD symptoms (Clark, 1986). These individuals have 'demands' that they not experience physiological symptoms

relating to the trauma, and hold 'secondary irrational beliefs' of 'awfulizing' (e.g., "It is awful that I have to cope with these physical symptoms after what I have already been through"), 'frustration intolerance' (e.g., "I cannot stand having to feel this way anymore"), and 'global ratings of worth' (e.g., "I am such a loser for having these symptoms). Secondary disturbance interferes with emotional processing (Foa and Kozak, 1986), as one is not able to engage with the emotions of fear. Specifically, Jaycox and Foa (1996) discussed the role of negative emotions such as anger or shame as barriers to habituation during therapy. Thus, if identified, secondary disturbance is to be addressed first and can serve to reduce barriers to exposure therapy. For example, in challenging 'awfulizing' beliefs, one might adopt the belief, "It is unfortunate to have to cope with these symptoms of PTSD, especially after what I have been through, but it is not the worst thing possible." Instead of 'frustration intolerance', one might adopt the belief, "I do not like to feel this way but I can tolerate the symptoms." Finally, replacing 'global ratings of worth' beliefs with more realistic evaluations, such as "I am only human for having these symptoms" will be the first steps before 'core irrational beliefs' contributing to PTSD will be addressed.

Current Empirical Evidence for the Effectiveness of REBT in the Treatment of PTSD

Empirical evidence for REBT's conceptualization of PTSD is offered by Hyland, Shevlin, Adamson and Boduszek (2014). They found that 'irrational beliefs' explained 67% of the variance in symptons of intrusion, 50% of the variance in avoidance, 67% of variance in dysphoria, and 56% of the variance in hyperarousal. These results suggest that 'irrational beliefs' about cognitive distortions predict PTSD symptomatology. Further, it was found that 'demandingness' predicted symptoms of intrusion, hyperarousal, avoidance, and dysphoria through 'secondary irrational beliefs' of 'ratings of worth', 'frustration intolerance' and 'awfulizing.' Specifically, 'demandingness' predicted intrusion and hyperarousal through all three 'secondary irrational beliefs', avoidance symptoms through 'awfulizing' and 'ratings of worth' beliefs, and dysphoria symptoms through 'low frustration tolerance' and 'ratings of worth' beliefs. Hyland et al. (2014) concluded that targeting 'demandingness' and 'secondary irrational beliefs' are necessary in the amelioration of PTSD symptoms.

REBT's Unique Contribution to the Conceptualization of PTSD

REBT has unique theoretical and clinical aspects that can serve to bridge the gap in the current evidence-based treatments. This is pertinent as the two most researched evidence-based cognitive-behavioral treatments of PTSD, Prolonged Exposure (PE; Foa, Hembree, & Rothbaum, 2007) and Cognitive Processing Therapy (CPT), are not effective for all survivors of trauma. However, there is robust treatment effectiveness

for PTSD symptoms and depression, despite differences in the theoretical models from which they stem. As the two therapies are both effective in reducing symptoms of PTSD and depression, each individual model may not be sufficient in capturing the complete symptom profile of PTSD. Constructing a unified model of PTSD is warranted. REBT's approach can add to the treatment efficacy in the following ways.

REBT's Focus on Emotions

The range of emotions that are targeted in REBT lends support to the conceptualisation of PTSD. Individuals rarely present with PTSD alone (Sareen, 2014). Comorbid symptoms include unhealthy levels of anger (at oneself, others or the world; e.g., Whiting & Bryant, 2007), shame and guilt (e.g., Lee, Scragg, & Turner, 2001). In fact, Jaycox et al. (1995) proposed that anger mediated client's response to exposure therapy. REBT's approach allows for treatment of these emotions, which are barriers to treatment success in PE. This is done through identifying and disputing 'imperative/schematic cognitions' and 'secondary irrational beliefs' related to the unhealthy negative emotions.

Level of Cognitions Targeted in REBT

REBT adds to the current cognitive conceptualization of PTSD by potentially preventing re-traumatization. 'Irrational beliefs' about cognitive distortions targeted in REBT are specific and systematic; REBT aims for a complete philosophical change about one's core beliefs. PE and CPT challenge automatic thoughts; although this has been shown to be effective in reducing symptoms of PTSD and depression, lasting and fundamental changes may lie in challenging and replacing distorted belief systems.

One of REBT's criticisms of other cognitive therapies is that the targeted level of cognitive distortions are not always false. For example, victims of trauma may think that "I will never be safe on the subway again" after being assaulted on a subway platform. Although this is an overgeneralization from one attack to all future encounters, this individual may very well experience further negative incidents in a similar environment. Thus, if this victim is led to believe that future incidents are unlikely, being subjected to another assault may lead to exacerbation of symptoms or a vulnerability to experiencing future unhealthy negative emotions (DiGiuseppe, Doyle, Dryden, & Backx, 2014). As per REBT, individuals would be guided to explore their 'irrational beliefs' about the 'A' that future attacks are "unlikely but possible."

Thus, REBT proposes that one's processing of an event be subdivided into three levels of cognitions: (1) 'inferential cognitions, (2) 'imperative/ schematic cognitions', and (3) 'second-level' or 'evaluative cognitions' (DiGiuseppe et al., 2014). Commonly challenged in cognitive therapies (Beck et al., 1996), 'inferential cognitions' (or automatic thoughts) refer to interpretations of events. Oftentimes, these

inferences are faulty in that they have a very low likelihood of being true if surveyed empirically or socially; yet, the inferences may sometimes hold true. REBT proposes that inferences contribute to one's unhealthy negative emotions, but are not the central cognitions. An example of an inference relating to someone's child who was involved in a serious accident at school may be, "Caregivers other than myself cannot be trusted" Although disputing whether caregivers can be trusted may help to reduce the experienced negative emotions (e.g., sensible and physically capable grandparents are likely to be trusted), it is always possible for a child to get hurt even under the most vigilant supervision of trusted caregivers.

'Imperative' or 'schematic cognitions' are core 'irrational beliefs' thought to be central to one's perception of the world, and thus, emotional disturbance (e.g., "Life must be fair," "People must be trustworthy," "Family members should absolutely not hurt each other"). Distinguishing cognitions in this way serves to (1) better identify and correct the core 'irrational beliefs' that lead to PTSD and (2) create a better therapeutic alliance with clients.

Second-level cognitions evaluate inferences in terms of whether (1) one is able to cope with them ('low frustration tolerance'; "I am not going to be able to stand it if the world were a dangerous place"), (2) one's/others'/the world's value ('global ratings of worth'; "I am worthless for not having done more to save my colleague") and (3) the severity of the inferences ('awfulizing;' "I am never going to be able to get into another vehicle and that is awful").

REBT's View on Secondary Disturbance

Ellis (1992) proposed that secondary disturbance or 'symptom stress' perpetuate PTSD symptoms (Clark, 1986). Individuals who experience symptoms in relation to a traumatic experience 'demand' that they not do so and place judgement on their worth ("I am a loser for having these symptoms"), ability to cope ("I cannot stand to live through these symptoms"), or severity of the symptoms ("It is awful that I am having these symptoms"). Secondary disturbance prevents individuals from engaging with the emotions that are necessary for symptom reduction according to the emotional processing theory and the re-organization of trauma memory.

REBT's Trauma-Specific Irrational Beliefs

Trauma-specific 'irrational beliefs' include 'demands' such as regarding the world ("This world must be just", "other people must be benevolent", "loved ones should absolutely be trustworthy"), and self ("I should absolutely have done more", "I absolutely should have known better"). These 'demands' are associated with guilt, shame, anxiety, depression, but also maintain symptoms of PTSD as individuals ruminate. The act of ruminating may also act as avoidance of emotional processing

of fear, allowing one to avoid experiencing the negative emotions necessary to the natural process of recovery.

In terms of 'ratings of worth', there are 'ratings of self-worth' and 'ratings of other's worth' that are common amongst trauma victims. Specifically, for child sexual abuse victims, an adult survivor might believe that they are no longer "loveable/worthy of others' love" (i.e., "Because I was raped, I am now damaged goods and thus, worthless"). These thoughts are often associated with the emotions of depression, disgust and shame. In terms of other's worth ratings, individuals may adopt the belief "If somebody I knew could do this to me, everyone is worthless."

Trauma-specific 'irrational beliefs' related to 'frustration intolerance' include the belief that one cannot handle the emotions associated with the trauma. Clients may avoid thinking/talking about the trauma because it would be "too hard" to process or that "they would not be able to handle the overwhelming emotions of sadness, anger and fear." Some report that they are "cascaded with emotions" and are thus no longer safe despite evidence to the contrary.

Trauma is life-changing, and often, life-threatening. As a result, many trauma survivors often believe that their life is "ruined"/"horrible" (i.e., 'awfulizing') for the remainder of life. For example, individuals believe that "I have been through so many traumas. This means that I will continue to experience traumatic events in the future and this is horrible."

Key Best-Practice REBT-Based Assessment/Treatment Strategies in Working with PTSD

REBT does not propose a comprehensive assessment of background information or detailed psychiatric history as these are not pertinent to the modification of core 'irrational beliefs' (DiGiuseppe et al., 2014). Lengthy clinical interviews sometimes account for early treatment drop-out. Still, assessment of barriers to treatment of PTSD is necessary (e.g., substance abuse, suicidal/homicidal ideation, self-injurious behaviors; Sareen, 2014). Cognitive functioning and behavioral analysis of current difficulties are pertinent to treatment and are assessed in relation to client's therapy goals. In terms REBT-based assessment, a thorough assessment of client's ABCs relating to PTSD, will be central to treatment success.

General REBT Assessment and Treatment Strategies

A number of REBT strategies are useful in assessment and treatment. REBT emphasizes the use of Socratic questions in examining assumptions and implications of beliefs. Frequent questions for clarification can be helpful to discussing trauma-related core beliefs or emotions.

Assessment of A

The A encompasses the event (e.g., car accident), perceived activating event (e.g., getting injured by a drunk driver), and the inferences made about A (e.g., "I was not driving carefully enough"). Clients usually have little difficulty providing details about the A, and are encouraged to limit such details because A is not central to the amelioration of C, given that the identification and modification of B is the ultimate pathway to change. Further, this minimizes clients' belief that A caused their unhealthy negative emotions or behaviors (i.e., C). Limiting details of A also prevents clients from being retraumatized by retelling their traumatic experience.

Assessment of C

C is readily reported by clients as therapy is usually sought to relieve negative emotions and problematic behaviors. For example, clients may report symptoms of avoidance, nightmares, or other concerns such as interpersonal difficulties. When assessing for C, identifying possible secondary disturbance is necessary, as these become barriers to the treatment. Example of a secondary disturbance would be feeling guilty for experiencing depression (C) in relation to one's mother's traumatic death (A), or feelings of shame (secondary disturbance) about one's avoidance of the workplace (C) relating to a sexual assault (A).

Assessment of B

The assessment of B is the most difficult as clients' beliefs are usually well-rehearsed and automatically guiding clients' emotions and behaviors. Becoming aware of core beliefs and their role in determining emotional reactions (i.e., the B–C connection) is a new skill for clients. A number of strategies are available for eliciting the IBs—'Inference chaining' is done by having the client assume that his inference (A) is true to draw out the next set of inferences until the core IBs are revealed. Therapists may ask "what if that were true?" to elicit inferences about inferences until an IB is identified. More active and directive strategies can also be used when IB are not elicited through 'inference chaining'. 'Deductive hypotheses driven assessment' is a method in which the therapist offers hypotheses about the clients' IB based on their given As, Cs, clients' history, clinical experience and knowledge of psychology/REBT. These hypotheses require the clients' acknowledgement and modifications.

When working with clients with PTSD, it may serve well to first address 'irrational beliefs' that are not central to their current difficulties. Further psychoeducation is important to orient client to the treatment model and the reasons for which Bs are assessed. Clients who have been through life-threatening traumas may have difficulty accepting the B–C connection, rendering attempts to find an IB invalidating. Clients who feel guilty about having survived a traumatic experience may find the assessment of B to be another reason for self-blame.

The Use of Behavioral Strategies

Behavioral strategies are thought to be part of the philosophical change in beliefs. Clients' change in behaviors are a measure of internationalization of new 'rational beliefs.' Although not specifically outlined for the treatment of PTSD, behavioral strategies serve to reduce the veracity of 'irrational beliefs' and to strengthen new 'rational beliefs.' Specific strategies such as 'risk-taking exercises,' 'shame-attacking' exercises, 'act against the irrational belief—opposite action', the use of imagery and 'writing assignments' are outlined in the section on TF-REBT.

Empirically-Validated Assessment Measures

These Offer a Comprehensive, Systematic, Standardized Assessment of Symptoms and Progress Throughout Treatment.

Interviews

The CAPS-5 (Weathers, Blake, Schnurr, Kaloupek, Marx, Keane, 2013) is a 30-item structured interview. Individuals are assessed for PTSD symptoms as well as the onset and duration of symptoms, level of distress, and the impact of symptoms on one's social and occupational functioning. Further, response validity, severity of PTSD and dissociative specification are offered. The PTSD Symptom Scale-Interview (PSS-I; Foa, Riggs, Dancu, & Rothbaum) assesses the presence and severity of PTSD symptoms and the Structured Interview for DSM-5 (SCID-5) allows for the diagnosis of all major diagnoses.

Self-Report Measures

There are a number of measures assessing trauma exposure in adults. The Life Events Checklist for DSM-5 (LEC-5, Weathers et al., 2013) is a 16-item self-report measure to assess for exposure to potentially traumatic life events and is often used in conjunction with CAPS-5. The Impact of Event Scale—Revised (IES-R) is a 22-item self-report measure assessing for subjective distress in relation to traumatic events. In terms of symptoms, the Posttraumatic Stress Disorder Symptom Scale-Self Report and Interview for DSM-5 (PSS-SRP and I-5; Foa et al., 2016) is available for free and is comprised of 20 items to assess the presence, frequency and severity of PTSD symptoms for the "past two weeks", and two items to gauge distress and impairment.

Treatment Guidelines from the Empirically-Supported Therapy Literature that Inform Best Practice in REBT with PTSD

Reviewing literature on the evidence-based treatment of PTSD serves to inform REBT treatment of PTSD. First, the effectiveness of active treatment components from the empirically-supported treatments, namely, PE and CPT, will be reviewed. Then, active treatment components that will enhance the use of REBT in the treatment of PTSD will be proposed. All current guidelines recommend cognitive behavioral therapies as effective treatments for PTSD (e.g., Institute of Medicine, 2008). In terms of cognitive behavioral treatments, trauma-focused cognitive behavioral therapies that include psychoeducation, anxiety management, as well as exposure and cognitive restructuring, are shown to be more effective than non-specific cognitive behavioral treatments (Sareen, 2014). With the most empirical support, PE (Foa & Kozak, 1986) and CPT (Resick, Nishith, Weaver, Austin, & Feuer, 2002) have been shown to be effective in reducing PTSD symptoms and depression. However, 20–50% of the treatment completers continue to meet criteria for PTSD (Gallagher & Resick, 2012). Thus, components unique to REBT are recommended to address non-responders to PE and CPT.

Theories and Effectiveness of PE and CPT

Given that PE and CPT are based on different theories of PTSD, namely, the emotional processing theory of fear (Foa & Kozak, 1986) and the information processing theory/ constructivists' model of PTSD (e.g., Hollon & Garber, 1988; Resick & Schnike, 1992), it is possible that each therapy operates on different mechanisms in the amelioration PTSD and depression.

PE and the Emotional Processing Theory of Fear (Foa & Kozak, 1986)

PE is based on the emotional processing theory of fear (Foa & Kozak, 1986), which conceptualizes symptoms of PTSD in relation to classical and operant conditioning of fear. It offers robust empirical evidence on the behavioral treatment of PTSD, consistent with REBT's behavioral treatment strategies and an empirically-based framework of the role of cognitions and meaning associated with fear, to support REBT's treatment of core 'irrational beliefs' and 'secondary disturbance.'

According to the emotional processing theory, individuals who are exposed to a dangerous or life-threatening event learn to fear and avoid stimuli that are paired with danger, such as vehicles if they were in a car accident, or people in general if they were

assaulted. In turn, the fear responses associated with these stimuli are strengthened through operant conditioning when individuals experience relief upon avoiding these stimuli (i.e., negative reinforcement). Further, Foa and Kozak (1986) proposed that a fear network exists to store information relating to fear, which includes stimuli, response and meaning of the threat, and fear. A pathological fear network is one that contains neutral stimuli *not* relating to danger, physiological fear responses or escape behavior that are evoked by neutral stimuli, and fear responses that impede natural processing of fear. Thus, in addition to fearing external neutral stimuli, individuals may also have erroneous beliefs about their anxiety, such as the thought that they would "go crazy" if they were to experience anxiety by facing the feared stimuli. In terms of meaning, individuals tend to perceive the world as dangerous and themselves as incompetent as a result of the large number of stimuli associated with danger and negative evaluations of their actions during the trauma and their interpretation of their symptoms. These cognitions maintain PTSD symptoms.

Thus, recovery requires the fear network to be activated, and for new, correct, and incompatible information to replace erroneous information in the fear network (i.e., emotional processing). Habituation, or the experience that increased anxiety can be tolerated and reduced, is necessary. Emotional processing and habituation are impeded in individuals with PTSD because of their tendency to have an unusally large number of stimuli associated with danger, and to avoid trauma reminders. In other words, temporary relief of anxiety or negative reinforcement from avoidance of trauma cues prevents habituation, thereby perpetuating erroneous beliefs. This in turn encourages the individual to further avoid trauma cues in the future. During treatment, individuals participate in in vivo and imaginal exposure to avoided situations or other trauma reminders including thoughts and feelings to facilitate habituation. Cognitive processing is used to challenge and replace faulty cognitions, particularly those about self-incompetence and dangerous world, with empirically based and realistic cognitions.

The emotional processing theory of fear and PE are consistent with REBT's conjecture that 'core irrational beliefs' need to be identified and replaced with 'rational' and logical beliefs about the traumatic event. Further, REBT's stance on behavioral change in addition to cognitive change agrees with the use of exposure and for habituation to be a behavioral goal. The theory is particularly helpful in enhancing the REBT model of PTSD. It places REBT's theory or 'irrational beliefs' as a determinant of unhealthy negative emotions within a framework for understanding fear and its constituents. It also provides a clear model of fear and PTSD to inform clients about their symptoms, particularly physical ones and their disorganized trauma memory, during psychoeducation. It lends support to the use of exposure therapy to fear in order to attain habituation, consistent with REBT's theory on using behavioral strategies. REBT, on the other hand, addresses the barriers to the incorporation of fear-disconfirming beliefs, by first addressing secondary disturbance and unhealthy negative emotions (e.g., shame, guilt, anger).

CPT and the Information Processing Theory/ Constructivists' Model of PTSD

Constructivists propose that fear conditioning is only a partial explanation of PTSD (Resick & Schnicke, 1992). Information processing theory (e.g., Hollon & Garber, 1988) is based on the notion that one's view of the world stems from pre-existing schemas, and these schemas largely view the world and people as "just" and "benevolent" (Resick & Schnicke, 1992). After a traumatic event, a meaning-making process takes place in which trauma-related information must either be changed to be incorporated into pre-existing schemas (assimilation) or the schemas must be modified to accommodate new and incompatible information (Hollon & Garber, 1988). Resick and Schnike (1992) further proposed over-accommodation as an outcome of trauma-exposure, in which self- or other-blame thoughts are coupled with guilt or shame. Individuals who have lasting difficulties after a traumatic event cannot organize new information relating to (1) safety, (2) trust, (3) power/control, (4) esteem and (5) intimacy into pre-existing schemas. The goal for therapy is accommodation, in which individuals modify their pre-existing schemas to incorporate trauma-related information. This theory/ constructivists' model is consistent with REBT's ABC model, which proposes changes in 'core beliefs.' CPT contributes to REBT's model of PTSD by offering specific trauma-related themes that are empirically-based.

Combining the Three Therapies for Treatment Effectiveness

Proposing a Trauma-Focused REBT Treatment of PTSD

Although treatment effectiveness is established for both CPT and PE, about 20–50% of individuals who have completed treatment continue to meet diagnostic criteria for PTSD (Resick et al., 2002), underscoring necessity for treatment modifications; as such, a trauma-focused REBT treatment is proposed that integrates core elements of these approaches within the framework of REBT's emphasis on examination and correction of core beliefs.

Components from other approaches to be included are drawn from research on the active components. First, preliminary evidence indicates that cognitive therapy without any exposure is effective in treating PTSD, providing initial support to using REBT's cognitive approach. Resick et al.'s (2008) dismantling study of CPT, showed that cognitive restructuring alone was more effective than exposure therapy or combined exposure therapy and cognitive restructuring. However, in studies that examined exposure therapy with or without cognitive restructuring in PE, results suggested that cognitive restructuring did not have added benefits to exposure therapy in the amelioration of PTSD and comorbid depression, suggesting that exposure is necessary to incorporate in a trauma-focused REBT. A follow-up on the dismantling study showed that different mechanisms of change were responsible for treatment effec-

tiveness, suggesting that elements from both treatments are important (Gallagher & Resick, 2012). Thus, it appears that the inclusion of active treatment components from both PE and CPT is warranted in a trauma-focused REBT treatment.

A trauma-focused REBT treatment of PTSD is proposed, incorporating traditionally included components (relaxation, psychoeducation, exposure, cognitive restructuring) imbedded in an REBT framework that aims to address unhealthy negative emotions associated with trauma and core beliefs. Key REBT strategies for ameliorating unhealthy negative emotions—challenging 'demands' and 'secondary irrational beliefs' (cognitively, behaviorally and emotively) will be used to eliminate unhealthy negative emotions and any secondary disturbance. The core philosophical components of REBT can add to the cognitive restructuring piece by (a) disputing core beliefs of 'demands' versus inferences, (b) types of emotions to be targeted, (c) unconditional self-, others-, world-acceptance, and (d) philosophical change to prevent future traumatization. REBT in a significant way, can help reduce secondary trauma symptoms, such as anger, which has been shown to impede with exposure therapy. A sample Trauma-Focused REBT will be examined in the next section.

Format of Trauma-Focused REBT

Basic REBT Therapist Skills

Empathy about client's history of trauma and validating their emotions are essential in the initial stages of therapy. REBT's philosophy of unconditional self-, other, and world-acceptance is applied throughout therapy. Doing so, the therapist demonstrates respect for the client's perspectives (i.e., 'inferences' about the trauma), without necessarily agreeing with the underlying philosophy (i.e., 'irrational beliefs). This is the key contribution of REBT, as it serves to validate client's thoughts, emotions, and experiences, and also offers them self-agency to change their beliefs that might be activated by the traumatice experience, thereby helping themselves to experience relief from the unhealthy negative emotions. For example, "I hear that you think it is your fault that the accident happened. I can think of many other reasons why the accident might have happened. But let's play devil's advocate and assume that you are right, what does it then mean to you if it were your fault?"

Psychoeducation

Psychoeducation is important in helping clients become active participants in their therapy. It serves to normalize their symptoms and provide a theoretical understanding of their difficulties and treatment. Information about their treatment helps to reduce attrition as therapy is intensive; clients experience negative emotions that they have avoided. The information to be included are (1) natural and biological

responses to a traumatic event, (2) the theoretical underpinnings and strategies for addressing 'irrational beliefs,' (3) the rationale for and process of exposure and habituation, and (4) the 'new effective response (i.e., 'E') or new effective trauma narrative. Trauma-specific REBT psychoeducation on emotions (labeling, descriptive deficits, dichotomous thinking, mislabeling of emotions, minimization or intense expression of emotion in session) is particularly important as traumatized individuals often have these difficulties in daily life as well as when discussing trauma. REBT framework proposes the 'belief-consequences' (i.e., B–C) connection, allowing client's to be empowered to change their maladapative behaviors and unhealthy negative emotions through ameliorating their 'irrational beliefs' (this will be further discussed in the subsequent sections). REBT's emphasis on emotions offers language for discussing emotional avoidance; the idea that avoidance (of physical or cognitive trauma reminders) might be a coping strategy helps the clients to label their thoughts and emotions, as well as to increase the clients' willingness to participate in exposure therapy. Additionally, REBT offers the rationale for confronting painful emotions as they relate to low frustration tolerance (e.g., "I cannot stand feeling all these emotions").

In terms of the sequence of active treatment components, the identification and replacing of core 'irrational beliefs' will take place after exposure therapy, as clients may continue to bring up daily problems in order to avoid the exposure component. Further, individuals who have had a long history of traumatic experiences may genuinely have multiple daily problems that will interfere with completing exposure therapy. DiGiuseppe et al. (2014) suggested that cognitive changes are usually more likely when preceded by behavioral changes. Regarding the use of exposure therapy, the concept of habituation will be discussed in the context of REBT's behavioral change strategies as well as the emotional processing theory.

Relaxation and Emotion Regulation

Although clients are directed not to use relaxation techniques during exposure, experiencing an increase in symptoms of anxiety or coping difficulties is common. During the initial sessions, breathing retraining is introduced as a means to cope with unhealthy negative emotions on a day-to-day basis. Clients are instructed to take slow normal breaths and to focus on a long exhalation (Foa et al., 2007). A cue word, such as "calm" or "relax" can also be used to be associated with relaxation.

Emotion regulation skills are helpful for individuals who have difficulty coping with intense emotions, and are at risk of engaging in maladaptive coping strategies. They can address deficits in emotion management (e.g., self-soothe, distraction), thereby allowing the client to focus on changing 'core irrational beliefs'. Providing psychoeducation on how disturbed negative emotions can interfere with behavioral change is important.

Exposure

Following the introduction of relaxation and emotion regulation, the next major component is exposure therapy/'behavioral disputes'. Individuals re-experience the trauma in a hierarchical fashion both through verbal narratives and in actual contact with feared stimuli (in vivo). Borrowing from PE's thorough outline on conducting exposure therapy, individuals participate in in-session imaginal exposure and between-sessions in vivo exposures.

In vivo exposure. The in vivo exposures are conducted independently outside of therapy sessions. Individuals are assisted in creating a list of avoided situations; a hierarchy of their corresponding anxiety levels is constructed. The client is to confront each situation by experiencing anxiety without escaping. The commonly avoided situations are those associated with the meaning of fear (i.e., trauma cues), as well as those avoided due to a loss of interest after the traumatic experience (Foa et al., 2007). Using REBT's behavioral framework, these targets of in vivo exposures are elicited and targeted using the following strategies (1) 'shame-attacking' (for situations relating to 'ratings of worth;' i.e. a first-responder failing to rescue all victims of a fire, he is encouraged to attend the funeral of the victim or to offer condolences to a family member); (2) 'risk-taking' (for situations relating to 'low frustration tolerance;' i.e., driving to the same intersection where the accident occurred); (3) 'acting opposite' to one's unhealthy negative emotions such as returning to the place of assault (provided that it is a safe location) because one feels anxious about returning to the place.

During the in vivo exposure, clients are instructed to measure the Subjective Units of Discomfort (SUDS), or the level of anxiety associated with the situation and throughout the exposure, starting with a situation associated with moderate levels of anxiety (SUDS = 50), and gradually to the highest level of anxiety. The goal is to remain in the exposure for 30–45 min, or until the SUDS have reduced by about 50%, until habituation is attained.

Imaginal exposure. REBT is based on the belief that imagination contributes to one's narrative of life experiences and the meaning associated with them. This is important in the treatment of PTSD as the meaning (or 'core beliefs') of the trauma is faulty, and the trauma memory is disjointed. Borrowing from imaginal exposure strategies from PE (Foa et al., 2007), clients are assisted in recounting different aspects of the trauma memory, including thoughts, feelings, and physiological responses. The clients are given the opportunity to re-experience the trauma memory emotionally with habituation being one of the goals of imaginal exposure. Further, clients are assisted in re-organzing details of the trauma. During the imaginal exposure, the clients are to describe the incident in the present tense, to enhance engagement with the memory for 45–60 min. SUDS are collected every 5 min. For homework, individuals listen to the taped imaginal exposure session between sessions and measure their SUDs.

At the end of imaginal exposure, the therapist facilitates the processing the trauma memory by providing positive feedback, highlighting habituation, and helping the client gain new and realistic perspectives on the trauma. Problematic thoughts or themes that are contributing to the perpetuation of PTSD symptoms are to be

addressed. Clients are guided to address negative or incorrect thoughts about the trauma and to incorporate new information.

Cognitive Restructuring

Negative thoughts about oneself, others, the world (i.e., "self-blame' and "dangerous world" in particular) or one's ability to cope with the trauma, are addressed during this phase, as they have been shown to be related to chronic PTSD (Foa et al., 2007). Clients are facilitated in identifying and evaluating faulty beliefs, and constructing new effective beliefs. The focus on establishing and rehearsing a new rational 'effective response' (i.e., 'E') is unique to REBT, and may be particularly helpful in treating PTSD symptoms given that trauma narratives are fragmented and include maladaptive beliefs.

REBT makes explicit the core beliefs of 'demands', and secondary inferences such as 'awfulizing', 'global ratings of worth', and 'frustration intolerance', that contribute to unhealthy negative emotions and behaviors. Borrowing from CPT (Resick et al., 2017), five core themes of safety, trust, power/control, esteem, and intimacy also are highlighted. The 'irrational beliefs' are elicited using the previously outlined ABC model. However, the sequence for which this is attained can be any of the following strategies: (1) Identifying A-B–C followed by disputation and the construction of a new 'effective belief.', (2) Teaching IBs versus RB, followed by D and the construction of E, or (3) Teaching IBs versus RBs, followed by E. Once clients are able to identify the irrational beliefs, the validity of these beliefs are evaluated through 'disputation' (i.e., 'D'), an exercise in which the client is asked to scrutinize his/her beliefs through logic, empiricism, philosophy as well as the utility of the beliefs. Disputations should lead to a replacement of the 'irrational beliefs' with valid, logical and flexible beliefs. The goal is to attain philosophical change in one's beliefs in these areas, rather than a perspective change on one situation. Clients can achieve this through examining the empirical evidence for their beliefs, determining whether they serve them well in changing their negative emotions, whether the beliefs have logical bases, and whether they resonate with their philosophical values. Clients are to rehearse these new beliefs to attain automaticity. In terns of cognitive disputations, clients are asked to evaluate their beliefs socratically and didactically. Schemas held by individuals are usually developed over time and have served the purpose of understanding the world. Thus, persuasion to see its 'irrationality' will take sufficient (1) logical, (2) empirical, and (3) functional evidence, particularly in the case of trauma, when one's life was potentially threatened.

Logical Disputation. This type of disputation challenges the logical reasoning of the client's 'irrational beliefs'. For example, "Why must family members protect each other?" challenges the client's 'demand' rather than desire for family members to protect each other from harm. It is also encouraged to challenge client's inconsistent logic within the same belief. For example, a client who minimizes one's worth ("I am worthless for not knowing that father was in pain before committing suicide")

could be asked whether she would judge her brother to be 'worthless' for not having predicted the suicide.

Empirical Disputation. This type of disputation challenges the data or empirical evidence of the 'irrational belief'. For example, survivors of multiple traumas may state that "the world should be fair" may be asked whether demanding the world to be fair over the years has made the world so. The same client may also state that s/he "cannot stand having to deal with another tragedy" and be shown that s/he has actually "withstood" multiple tragedies and has a better history of being able to "stand" another tragedy compared with his or her peers.

Functional/ Pragmatic Disputation. This disputation challenges the utility of the belief, and whether it provides any practical value in believing it. This may include impediements in attaining a goal, experiencing relief from an unhealthy negative emotion, or time expended. For example, a client whose mother was killed in a motor vehicle accident may 'demand' that "the driver must pay for my mother's death" can be asked whether this 'demand' will help resurrect his mother, or help him to accept his mother's death.

Additionally, REBT propose the use of imagery. Using 'negative rational emotive imagery' (e.g., Maultsby and Ellis, 1974), clients can be asked to imagine once again that they are in the targeted situation (A) until they experience the unhealthy negative emotion (C). Once this is attained, they are asked to focus on the thought (B) that is leading to C, and to try to change C to one that is less severe. Clients are then asked to state the strategy for doing so, and a rational belief (B) is usually elicited. Further in 'positive rational emotive imagery' (e.g., Maultsby and Ellis, 1974), clients imagine themselves in the same A but to experience the target emotion or behavior. After doing so, the client is prompted to discuss the thought that was used to change the C, thereby eliciting a new and more adaptive B.

The New Effective Response

REBT is unique in highlighting the replacement of 'irrational beliefs' with a 'new effective response' (E). This is particularly important in treating PTSD due to the fragmented nature of the trauma memory and core belief systems about oneself and the world. The strengthening of one's conviction of the RB is important in attaining a philosophical change as well as its automaticity in making attributions about events. DiGiuseppe et al. (2014) discuss the use of writing in REBT, consistent with the written exposure used in CPT. Clients are instructed to re-write their trauma narrative using the new RBs and to retell it to the therapist in session to re-organize the trauma memory.

Safety Planning

Prior to termination, clients are assisted in planning for and problem-solving for stressful periods that may be associated with increased unhealthy negative emotions.

Ensuring that clients are physically safe, particularly for individuals who have experienced continuous abuse, is warranted. Further, anniversaries relating to the traumatic events can trigger increased negative emotions. Psychoeducation and normalization of this occurrence is important. Use of relaxation, emotion regulation skills, and cognitive restructuring should be practised.

Termination

A coherent narrative of the trauma with "corrected" beliefs demonstrates the reorganization of trauma memory and change in faulty cognitions. In terms of REBT, a narrative with rational beliefs about the five trauma-focused schemas should be constructed.

Brief Case Example

Jenny sought therapy due to behavioral and emotional difficulties after her mother's fatal car accident. Results from the brief clinical interview and self-report measures showed symptoms of PTSD, depression and anxiety. Client also reported a history domestic violence, school bullying, and motor vehicle accident. The therapist noted possible 'irrational beliefs' to be explored during the cognitive restructuring component.

In the first session, psychoeducation on the common responses to trauma and the ABC model were discussed. Client's commitment to participate in TF-REBT was obtained by validating client's negative emotions and highlighting the potential for symptom relief. In the next few sessions, psychoeducation and breathing retraining were the main goals of therapy. These included information on the theories of PTSD and the process of habituation. Breathing retraining was introduced to assist with anxiety symptoms. The rationale for conducting TF-REBT, including exposure therapy, was discussed alongside its format and client's involvement.

In subsequent sessions, the main focus was exposure therapy and cognitive restructuring. A hierarchy of symptom severity was created. Jenny participated in vivo exposure outside of the session, in which she thought about events surrounding her mother's car accident, while monitoring her levels of SUDS. The first exposure was conducted on the event associated with moderate anxiety. In session, she participated in imaginal exposure, during which she recounted an event associated with moderate anxiety (i.e., attending her mother's funeral). After the imaginal exposure, debriefing was used to discuss her experience during the exposure.

Cognitive restructuring was conducted using the ABC model. As anger is an identified barrier to habituation, the associated thoughts were examined first. Jenny recounted feeling angry at her mother's friends for "being rude" and for arriving early to the funeral. Socratic questioning led to the thought, "They should know how to behave at a funeral." Thus, 'inference chaining' was used to elicit client's

beliefs. Accordingly, Jenny stated that "they should know that I needed more time to prepare," and subsequently, the 'demand': "I absolutely should have had more time to prepare for my mother's death," as well as the evaluative derivatives of 'awfulizing' ("It's awful that I didn't have more time to prepare for her death"), 'low frustration tolerance,' ('I cannot stand not having had more time to prepare for my mother's death"), and global ratings of worth ("I am a bad person for not having spent more time with her before her death"). The validity of the demand was disputed, with Jenny accepting that "[she] strongly wished for more time with [her] mother, but that was not within anyone's control". Logically, she acknowledged that the situation was not ideal but could have been worse if she never developed a good relationship with her mother; empirically, she knew that she survived not having had sufficient time with her mother. Further, she concluded that her worth cannot be measured by one event or several attributes.

As CPT's written account was shown to be particularly helpful for individuals with a tendency to dissociate, this was used to manage Jenny's intense emotions during exposure. She wrote about the most distressing event, while focusing on the five trauma-related schemas: (1) safety, (2) trust, (3) power/control, (4) esteem and (5) intimacy. In relation to "control," she noted a recurring thought associated with anger, "Things will never go right for me." This belief led her to make career and interpersonal decisions that were incongruent with her values, resulting in conflicts at work and uncertainty about her decisions. When discussing this inference, the core belief that perpetuated the anger was elicited, "Things should absolutely go right for me because I have been through so much." Through disputation, Jenny began to realize that neither the world nor others had to treat her differently because she had experienced many traumas. Although it was difficult to acknowledge her limited control over her future, she listed opportunities to maximize the potential for her chosen outcome. This acceptance helped her to feel less angry, and to be able to make decisions that adhered to her own values.

After completion of exposure therapy and cognitive restructuring, she was asked to prepare a new narrative with 'E', the new effective response, which included the new 'rational beliefs' within the trauma narrative. Using the most distressing event, the therapist and client jointly replaced 'irrational beliefs' with the 'Es'. The client then read the new narrative aloud in session. In preparation for termination, psychoeducation on relapse of symptoms, especially during stressful periods or significant anniversaries was provided. Client was given a review on cognitive restructuring as well as the coping skills acquired during therapy.

What We Have Learned about Using REBT with PTSD

Accomodating Individual Differences

Although empirical evidence is needed in this area, client gender does not appear to affect treatment adherence or effectiveness. However, clients' trauma history may lead to preferences in therapist gender. Socio-economic status (SES) also does not directly determine treatment effectiveness; yet, clients from lower SES may find it more difficult to commit to weekly 90 min sessions due to possible work or family demands. Accommodations for frequency and duration of treatment could be made under these circumstances. With regards to intelligence, the exposure component should be equally effective for individuals from a range of measured intelligence. For clients who have difficulty understanding the cognitive restructuring component, therapists can attempt to offer more guidance in the disputation and in formulating the new effective response. In terms of ethnicity, there may be culturally-specific themes to clients' core beliefs. For example, many cultures place values on caring for older generations, which may impact traumatic bereavement. Rape victims may be affected by certain cultural norms relating to modesty, or "purity." However, these beliefs should be examined in relation to the 'imperative demands,' and their derivatives.

The Dos and Don'ts

Do's

When conducting TF-REBT, one is encouraged to openly express empathy for clients while remaining disciplined in disputing irrational beliefs. Clients who have experienced trauma, especially chronic interpersonal trauma, often think that "nobody can be trusted." In turn, they behave consistently with these thoughts (e.g., withdrawal from social networks). Although these are unhealthy cognitions, it is important to target disputing schematic demands and their derivatives when conducting disputations. Empathisizing with the client's emotions, and expressing an understanding for their difficulties, while illustrating that their beliefs vastly contribute to the symptoms for which they sought therapy. When conducting exposure therapy, it is important to specify the anchors for the beginning and end of therapy. Specifically, the treatment course should be described to include an examination of the trauma-related beliefs and processing their experience of trauma, preparing the client for increased negative emotions.

Dont's

Clients who seek therapy for PTSD have usually spent considerable effort to avoid trauma cues or feelings associated with the trauma. Hence, avoidance is common, even when commitment to therapy is expressed. Clients may choose to focus on current difficulties, such as interpersonal conflict, etc. while avoiding thinking and discussing the trauma. This may be due to avoidance, or a general perception that those "As" are most pressing. The therapist's role is to illustrate how current difficulties may be related to the client's 'core irrational beliefs.' thereby contributing to current behavioral and emotional difficulties. This requires the therapist to balance validating the client's perspective and goals, highlighting how trauma-focused therapy would be most efficient and effective in meeting those goals, and redirecting to the main task of eliciting and challenging the most pertinent core beliefs. By not targeting trauma-related symptoms, progress may be slow, thereby challenging client's commitment to therapy. Further, therapist's "avoidance" may reinforce client's belief that trauma triggers are to be avoided.

Aspects of REBT that Deliver the Most Benefits for Change and Aspects that Don't

REBT's theory of 'acceptance' is particularly helpful in assisting client's in giving up their demands for "the world must absolutely be fair." Trauma victims are exposed to situations that are often shocking, inhumane, or unfathomable, and inherently are "unfair." Yet, it is only the victim him/herself, who is capable of changing the unhealthy emotions by recognizing the role of his/her thinking in the current predicament. Therefore, embracing acceptance as an overall philosophy, that is also modeled by the therapist, is most beneficial in working with individuals with PTSD. On the other hand, REBT's emphasis on change (cognitive, behavioral, emotional) can be motivating to clients, but also daunting because they have worked hard at avoiding negative emotions or trauma cues. Clients may be more amenable when the benefits of treatmet are clearly stated. Addressing client ambivalence is important for treatment adherence.

References

Beck, A. T., Steer, R. A., & Brown, G. K. (1996). *Beck depression inventory-II*. San Antonio, TX: Psychological Corporation.

Clark, D. M. (1986). A cognitive approach to panic. *Behaviour Research and Therapy, 24,* 461–470.

Committee on Treatment of Posttraumatic Stress Disorder, & Institute of Medicine (2008). Treatment of posttraumatic stress disorder: An assessment of the evidence. Washington, DC: National Academies Press.

DiGiuseppe., R.A., Doyle, K.A., Dryden, W., & Backx, W. (2014). A practitioner's guide to rational emotive behavior therapy—Third edition. New York: Oxford University Press.

Ehring, T., & Quack, T. (2010). Emotion regulation difficulties in trauma survivors: the role of trauma type and PTSD symptom severity. *Behavior Therapy, 41,* 587–598.

Ellis, A. (1962). *Reason and emotion in psychotherapy*. Seacaucus, NJ: Lyle Stuart.

Ellis, A. (1992). Post-traumatic stress disorder (PTSD): A rational emotive behavioral theory. *Journal of Rational-Emotive & Cognitive-Behavior Therapy, 12*(1), 3–25.

Ellis, A. (1994). Reason and emotion in psychotherapy: A comprehensive method to treating human disturbance. Revised and updated. New York: Birch Lane Press.

Foa, E. B., Hembree, E. A., & Rothbaum, B. O. (2007). *Prolonged exposure therapy for PTSD*. New York: Oxford University Press.

Foa, E. B., & Kozak, M. J. (1986). Emotional processing of fear: Exposure to corrective information. *Psycholgical Bulletin, 99,* 2–35.

Foa, E. B., McLean, C. P., Zang, Y., Zheng, J., Rauch, S., Porter, K., et al. (2016). Psychometric properties of the posttraumatic stress disorder symptom scale interview for DSM-5 (PSSI-5). *Psychological Assessment, 28*(10), 1159–1165.

Foa, E. B., Riggs, D. S., Dancu, C. V., & Rothbaum, B. O. (1993). Reliability and validity of a brief instrument for assessing post-traumatic stress disorder. *Journal of Traumatic Stress, 6,* 459–473.

Gallagher, M., & Resick, P. A. (2012). Mechanisms of change in cognitive processing therapy and prolonged exposure therapy for posttraumtic stress disorder: Preliminary evidence for the differential effects of hopelessness and habituation. *Cogntiive Therapy and Research, 36*(6), 750–755.

Hollon, S. D., & Garber, J. (1988). Cognitive therapy. In L. Y. Abramson (Ed.), *Social cognition and clinical psychology: A synthesis* (pp. 204–253). New York: Guildford Press.

Hyland, P., Shevlin, M., Adamson, G., & Boduszek, D. (2014). The organization of irrational beliefs in posttraumatic stress symptomatology: testing the predictions of REBT theory using structural equation modelling. *Journal of Clinical Psychology, 70*(1), 48–59.

Janoff-Bulman, R. (1992). *Shattered Assumptions: Towards a New Psychology of Trauma*. New York, NY: The Free Press.

Jaycox, L. H., Perry, K., Freshman, M., Stafford, J., Foa, E. B. (1995). Factors related to improvement in assault victims treated for PTSD. Paper presented at the annual meeting of the International Society of Traumatic Stress Studies, Boston, M.A.

Lee, D. A., Scragg, P., & Turner, S. (2001). The role of shame and guilt in traumatic events: A clinical model of shame-based and guilt-based PTSD. *Psychology and Psychotherapy, 74*(4), 451–466.

Neimeyer, R. A. (1998). *Lessons of loss: A guide to coping*. Boston: McGraw-Hill.

Norris, F., & Sloane, L. B. (2007). The epidemiology of trauma and PTSD. In M. J. Friedman, T. M. Keane, & P. A. Resick (Eds.), *Handbook of PTSD: Science and practice* (pp. 78–98). New York, NY: Guildford Press.

Resick, P. A., Monson, C. M., & Chard, K. M. (2017). *Cognitive processing therapy for PTSD—A comprehensive manual*. New York: The Guilford Press.

Resick, P. A., Nishith, P., Weaver, T. L., Astin, M. C., & Feuer, C. A. (2002). A comparison of cognitive processing therapy, prolonged exposure and a waiting list condition for the treatment of posttraumatic stress disorder in female rape victims. *Journal of Consulting and Clinical Psychology, 70*(4), 867–879.

Resick, P. A., & Schnicke, M. K. (1992). Cognitive processing therapy for sexual assault victims. *Journal of Consulting and Clinical Psychology, 60,* 748–756.

Sareen, J. (2014). Posttraumatic stress disorder in adults: Impact, comorbidity, risk factors and treatment. *Canadian Journal of Psychiatry, 59*(9), 460–467.

Weathers, F.W., Kean, T. M., & Foa, E. B. (2009). Assessment and diagnosis of adults. In E. B. Foa, T. M. Keane, M. J. Friedman & PJ. A. Cohen (Eds.), *Effective treatments for PTSD: practical guidelines from the international socieity for traumatic stress* (pp. 23–61). New York, NY: Guildford Press.

Weathers, F. W., Blake, D. D., Schnurr, P. P., Kaloupek, D. G., Marx, B. P., & Keane, T. M. (2013). The Clinician-Administered PTSD Scale for DSM-5 (CAPS-5). Interview available from the National Center for PTSD at www.ptsd.va.gov.

Whiting, D., & Bryant, R. A. (2007). Role of appraisals in expressed anger after trauma. *Clinical Psychologist, 11*(1), 33–36.

REBT and Complicated Grief

Ruth Malkinson

Introduction: From Decathexis to Continuing Bonds with the Deceased

In our lifetime we may experience the loss through death of a significant other, with grief being a normal and universal human reaction to the loss.

How do we adapt to the loss? What is an adaptive response? When is grief considered complicated? When is it appropriate to intervene?

The answers to some of these questions have undergone remarkable changes in the last few decades, and one such change has taken place in the field of grief and bereavement in our understandings of grief process, its aims and outcomes (Malkinson, 2007, 2017; Rubin, Malkinson, & Witztum, 2012). A major shift has been that from Freud's (1917/1956) conceptualization of grief as a normal process leading to breaking the bond with the deceased (i.e., *decathexis*), to viewing bereavement as a process of reorganizing of one's life and world view without the deceased, where bonds will remain intact and unbroken. Klass, Silverman, and Nickman (1996) proposed the term "continuing bonds" which has since been accepted and is widely used. Similarly, new models of grief have been proposed, and notably the Two Track Model of Bereavement (TTMOB) (Rubin et al., 2012), and the Dual Process of Mourning (DPM) (Stroebe & Schut, 1999). Both emphasize the complexity and the multidimensional nature of the grief process as well as its being a life-long developmental process.

The Two-Track Model of Bereavement developed by Rubin et al. (2012) views response to loss with two lenses, as its name suggests—continuing with life and con-

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Table 1 What affects the grief process and outcomes: circumstantial and personal variables

Mode of death: expected/sudden, traumatic (suicide, homicide, terror, war, natural disasters)
Who died? (parent, child, sibling, partner, close family member, close friend)
Age and gender of the bereaved
Personality variables (spiritual and religion) and attachment style (secure/insecure) resilience and view of self
Perceived relationship to the deceased
Previous experiences with loss
Availability of support system
Socio-cultural context within which grief is experienced

tinuing bonds with the person who died. The model examines both biopsychosocial functioning and the nature of the ongoing relationship with the deceased and the death story in working with the bereaved. It is particularly suited to identify adaptive and maladaptive responses to loss and to optimally focus on interventions where needed. Track I of the model addresses the biopsychosocial functioning; how do the bereaved find a way to continue with life, while Track II addresses the way the bereaved construct an ongoing, inner relationship with the deceased. An adaptive grief response is the balance between attending to life challenges with a flexible connection to the deceased, and when difficulties in this response, they typically reflect some interdependence of the two tracks.

More recently, studies have focused on the long-term outcome of the grief process, suggesting that throughout the years the process becomes less intense but never really ends. The implications of these conceptual changes on defining adaptive and maladaptive[1] course and outcomes of grief and on therapeutic intervention will be examined.

Different forms and circumstances surrounding the death event apparently affect the process, its duration, intensity and outcome as shown in Table 1.

Factors identified as affecting the normative course include the circumstances of the death, sudden and unexpected death events such as suicide, homicide, and terror attacks, man-made or natural disasters—also termed "violent death" (Malkinson, Rubin, & Witztum, 2000), or "powerful situations" (Janoff-Bulman, 1992), that are outside the range of usual human experience and hence more likely to have a markedly distressing, traumatic, or overwhelming effect (American Psychiatric Association, 1994); types of lost relationships, e.g., loss of a child, that are known to impose additional stress on survivors and are associated with higher risks, social-cultural context within which grief is experienced (Witztum, Malkinson, & Rubin, 2001); gender, age at time of the loss, previous experiences with loss, and personality variables such as spiritual and religious world view, past experiences with adverse events, resilience and availability of adequate support networks (Bonanno & Kaltman, 2001).

[1]Maladaptive and complicated grief signifies when grief goes awry; prolonged grief is a term suggested for diagnostic purposes.

How is normative (adaptive) grief defined? What constitutes normal grief varies greatly from culture to culture. Different cultures have different views and customs on the mourning process that follow a death event, but all view it as one necessitating some kind of adjustment which takes place over time. In many cases the society or culture provides a set of mourning guidelines specifying what is expected of the bereaved and the community (Malkinson, 2007).

In line with Rubin's (Rubin et al., 2012) Two Track Model of Bereavement (TTMoB) bereavement is a response to a stressful event (Track I), and reorganizing the now inner relationship with the deceased (Track II). Klass et al. (1996) coined the term "Continuing Bond" stressing negotiation and renegotiation of the meaning of the loss over time. While death is permanent and unchanging, the process of bereavement does change, affecting the mourner differently at different times over the rest of his or her life.

Adaptive or uncomplicated grief reactions, as it is referred to, are those that, though painful, move the survivor towards an acceptance of the loss and the ability to carry on with his or her life and investing in new relationships and maintaining a sense of self-efficacy. Uncomplicated grief is characterized by feeling very saddened by the death of an intimate, but nevertheless, the ability to feel that life still holds meaning and the potential for fulfillment exists. In uncomplicated grief one's ability to trust others, maintain one's positive attitudes alien to those with complicated grief.

An important aspect of uncomplicated grief is the will to reinvest in an interpersonal relationship and activities, and willingness to explore new relationships and roles despite the pain of the loss, a component missing from complicated forms of grief.

In contrast, in complicated grief bereaved persons view their lives as having stopped, with no future. They don't believe that life holds anything worth investing in. Prigerson and colleagues (1995) conceptualized complicated grief distinct from normal, uncomplicated one. In complicated grief bereaved persons feel acute separation distress and traumatic distress—a sense of emptiness that do not decrease over time (Shear, & Frank, 2017).

Most bereaved individuals find ways to continue life without the deceased, but for others, bereavement increases the risk of developing complications (Table 2).

Concurrently, the bereavement process is viewed as a process which includes coping with the distress evoked by the death event on the one hand, and ongoing relationships with the deceased on the other (Rubin et al., 2012; Stroebe & Schut, 1999). Traumatic bereavement is yet another concept that has been discussed in the literature to convey the linkage between trauma and bereavement as components each requiring an assessment prior to planning intervention (Rubin et al., 2017). With the publication of the 5th edition of the DSM, a debate aroused as to whether complications in the process and outcome of grief justify diagnostic criteria in the Diagnostic Criteria Manual (DSM) (American Psychiatric Association, 2013). Those opposing it expressed a concern of pathologizing a normal and human response to loss, whereas those supporting the inclusion emphasized the need to diagnose and treat the bereaved when their process goes awry. They stressed the unique symptomatology of complicated or prolonged grief rather than giving it a diagnosis of depression or

Table 2 Assessing grief

Uncomplicated grief	Complicated grief
Acceptance of the loss and an ability to carry on with life	A sense that life stopped and lost its meaning—inability to carry on with life
Maintaining a sense of self-efficacy	The sense of self-efficacy is lost while a sense of guilt is maintained
Re-investing in life tasks and new relationships	Difficulties in re-investing in life tasks and new relationships
Pain and yearning are assimilated with ongoing life	Difficulties in assimilating pain and yearning with ongoing life
Positive attitude to life	Negative attitude to life

PTSD (Shear, 2017). Research studies indicated that grief complications may affect 7% of the bereaved population thus supporting the inclusion of criteria that will allow a diagnosis and specific psychotherapeutic interventions (Shear, 2017). The form of prolonged grief or persistent complex bereavement disorder, as it is also referred to appears in DSM-V, (2013) as a set of symptoms identified which impose difficulties in assimilating the reality of the loss in the bereaved person's life (Rubin et al., 2012). This requires a thorough assessment to be followed by specifically tailored interventions (Malkinson, 2012; Shear & Frank, 2017).

Key REBT Theoretical Concepts in Working with Grief

The ABC model of REBT, wherein a distinction is made between healthy and unhealthy, functional and dysfunctional consequences fits perfectly with distinction between "normal" healthy, adaptive grief and maladaptive, complicated grief. Furthermore, the distinction in this model between healthy negative emotions such as sadness and unhealthy negative emotions (depressive response) supports the notion that grief involves negative but healthy emotions. These negative, unhealthy emotions impede the adaptive course and thus make ABC-based assessment and interventions towards a natural grief process, relevant and applicable (Malkinson, 2007, 2017).

Theory of Change: From Irrational to Rational Beliefs

REBT as "…a theory of personality and personality change accepts the importance of emotions and behaviors and particularly emphasizes the role of cognitions in human problems." (Ellis & Bernard, 1986, p. 11).

According to Ellis's ABC formulation, almost always when C consist of emotional disturbance it is the Belief that creates it. However, emotional disturbance

may at time stem from powerful A's. In other words, the powerfulness of the event may affect our tendency to think irrationally. Loss through death is an example of an A that has the potential to increase irrational thinking and consequently lead to emotional disturbance. In Reason and emotion (Ellis, 1994). Ellis's notion about human inborn tendency to think irrationally, along with his emphasis about the ability and motivation to change beliefs into rational ones, is fundamental in applying Rational Emotive Behaviour Grief Therapy.

While death is final and irreversible (A) the cognitive evaluation (B) of the loss is changeable from irrational to rational and thus the emotional consequences (C) as a result. Bereaved individuals are often sceptic of their ability to change their belief system with regard to the loss event and to the deceased for various reasons, some are related to the circumstances of the loss while others are related to the relationship with the deceased. The irrational beliefs that "I must not forget my loved one", or "It's too painful to think that my loved is dead", are beliefs that create fear of either forgetting the deceased or avoidance of being overwhelmed by memories of him or her. Thus, basic understanding of grief process and its outcomes integrated with REBT framework is necessary when working with bereaved clients.

Negative Healthy Emotions and Negative Unhealthy Emotions

A major element in REBT refers to the distinction between healthy (adaptive) and unhealthy (maladaptive) negative emotions and their relatedness to rational and irrational thinking. The difference between disturbed emotions and non-disturbed emotions is the quality, the intensity and frequency of unhealthy negative emotions (DiGiuseppe, Doyle, Dryden, & Backx, 2014). This distinction between Negative Healthy Emotions (NHE), and Negative Unhealthy Emotions (NUE) (Ellis & Dryden, 1997) is particularly relevant to grief. Grieving (healthy negative emotions) as distinct from depressive response is the "heart" of the process. Therapeutic interventions REBT-based include psychoeducation towards normalizing, legitimizing and providing thinking alternatives to facilitate an adaptive process.

Secondary Symptoms—Avoidance or Sustaining the Pain in Grief

Pain in grief is unavoidable. The thought of experiencing pain is often too stressful, and frequently bereaved persons will tend to find ways to avoid or bypass it only to realize that this is almost impossible ("It's too painful"). At other times bereaved will sustain the pain for fear of forgetting the deceased or as a way to punish themselves for not saving him or her ("I deserve the pain"). In REBT terms the loss (A) is followed by an emotional consequence of pain (C) related to the belief (B) that "I will

never see her again, and my life is not worth any longer". According to Ellis (1976, 1994) humans have a pronounced biosocial tendency, particularly following adverse events like death, to evaluate emotions in a dysfunctional way which often creates a disturbance about disturbance. In the case of pain following a loss through death, the appraisals of the primary emotion i.e., pain, as too painful or that "I must keep the pain" are dysfunctional because they create a secondary symptom of pain or anxiety about pain. Meta-cognition or cognitive attentional syndrome (CAS) are terms used to describe dysfunctional evaluation related to human nature of thinking about thinking (Kassinove & Taftre, 2002; Wells, 2005). It is a cyclical dysfunctional evaluation about the harmful consequences (cognitive, emotional, physical or behavioral) that frequently result in efforts to avoid the undesired or feared consequences. Therapeutic help of bereaved clients not to evaluate pain as dreadful but to accept it as a normal part of grieving, and to teach them functional ways to manage the pain in a balanced way in order to facilitate a more adaptive process.

Key Best-Practice REBT-Based Assessment and Treatment Strategies and Techniques in Working with Grief

REBT Studies Showing Positive Effects on Problem/Population

There is no REBT reported research targeted at working with bereaved population or detailing positive effects specifically tailored to working with bereaved. There are however, studies on the efficacy of REBT for various population and problems. When applying a psychoeducational program in a graduate-level practicum on stress management, the ABC model of REBT was used. The aim was to reduce irrational/dysfunctional thinking patterns. The practicum included introducing the ABC model of REBT, identifying rational and irrational beliefs and their emotional consequences, disputing irrational beliefs and changing them into rational ones, and homework assignments (reading, written and experiential exercises). Results indicated reduction in irrational beliefs in the treatment group, and a significant reduction in LFT scores (Kushnir, Malkinson & Ribak, 1998). Similarly, in a training workshop for blue-collar female workers, the Rational Emotive Behavior training was applied including psychoeducation and homework strategies focusing on health promotion and stress-reduction related to work-home conflict experienced by female workers. Results showed reduction on all measures, indicating that use of REBT principles is an effective model for blue-collar females (Malkinson et al., 1996). In a study by Daniel, Szentagoi and colleagues (2008) a comparison between REBT, CT and medication in Major Depressive Disorder was carried. Demandingness and self-downing and the relationship between dysfunctional negative emotions and irrational beliefs were hypothesized as mediators in depression, and strategies applied aimed at reducing secondary symptoms and increasing unconditional self-acceptance, the two central strategies in REBT (Daniel et al., 2008). Secondary symptoms, demand-

ingness and self-downing are frequently assessed among bereaved individuals and the application of these strategies in grief therapy is effective (Malkinson, 2007).

REBT Special Practices with Grief

Psychoeducation: The ABC of Rational Emotive Grief Therapy

The ABCDE framework applied to working with the bereaved offers a humanistic approach to facilitate the natural healing process of grief following loss. The ABC model of Grief: Adverse event (A) of death over which I had no control, and what do I tell myself (Belief)? What are the emotional behavioural and somatic Consequences?

In working with bereaved clients, the component of psychoeducation is very powerful as it provides information and emphasizes the relationship between adversity event of loss through death, beliefs and emotional consequences (Table 3). It details the ABC of grief-related rational and irrational evaluations and their functional and dysfunctional emotional consequences.

Psychoeducation about grief process and the ABC of REBT also includes normalizing grief process through stressing and teaching the difference between healthy and unhealthy belief-consequence connection. Provision of information about grief process, its components, intensity and duration are an important element of the psychoeducation.

Homework Assignments: Practicing Between Sessions to Facilitate Adaptive Grief

In a workshop in Israel in 1989, Ellis introduced the ABC model of REBT, and presented three related insights: (1) People have a choice whether to become disturbed. They become disturbed when they make their preference into a demand. (2) Emotional disturbance is not necessarily related to people's past but to their demandingness about themselves, others and the universe. (3) And the third and most important insight is: Practice, practice, practice… In other words, in order for clients to achieve cognitive, emotional and behavioural adjustment clients need to actively practice rational thinking (and emotional, behavioural and physical as well). Between-sessions practice is therefore a "must" in order to gain the desired change. DiGiuseppe and colleagues (2014) explain the rational for homework as an integral part of therapy detailing a variety of cognitive, emotional and behavioural homework assignments to assist clients learn and maintain cognitive changes. The relevancy of between-sessions practice in grief therapy is two-fold: Practicing the ABC of the model, and normalizing negative healthy emotions as part of natural grieving process.

Table 3 The ABC of grief: rational and irrational evaluations and healthy functional negative and unhealthy dysfunctional negative emotional consequences

A	Rational evaluation: flexible, non-rigid		Irrational evaluation: rigid, extreme	
Adverse event Loss through death	B	C Functional emotional	B	C Dysfunctional emotional
	Rational belief	Consequence	Irrational belief	Consequence
	I remember her everyday but life goes on	Yearning	Life without her is killing me, I will never get over the loss	Depressive response
	My life without her has changed forever	Sadness	Since the death my life is worthless	Depressive response
	I realize that since her death pain is part of my life	Frustration and experiencing pain	When I think about his death I can't stand the pain	Discomfort anxiety and avoidance
	I asked him to stay at home but he refused and got killed in a road accident. There was nothing else I could have done	Moderated anger	I should have insisted on him staying at home. I will never forgive myself. It's my fault	Intensified anger and guilt

D: Disputation in Grief Therapy

Within the REBT framework the D—disputation is the core of therapy towards the change of dysfunctional cognitions and related emotional consequences: B-C connection, using cognitive emotional and behavioural strategies some of which are most pertinent to be applied in grief therapy with a focus to facilitate a healthy grief process. In grief therapy, cognitive restructuring, emotional and behavioural strategies are more suitable types of disputations to be applied in working with the bereaved especially during the acute phase. An expanded version of Rational Emotive Imagery, letter-writing "as if" to the deceased, visiting the grave will be elaborated as examples of strategies adopted to grief therapy (Malkinson, 1996, 2007).

Rational Emotive Body Imagery (REBI)

Rational Emotive Body Imagery is an expanded version of the REI first developed by Maultsby (1971) as a technique to assist clients feel less disturbed by imagining the stressful event (A) and the emotional consequence (C). Ellis (1993) modified the REI to be applied "in a more emotive-evocative and less dysfunctional way" instructing the client to imagine the worst that can happen (A), and feel the inappropriate emotional consequence as vividly as possible, and "then work on your dysfunctional feeling until you truly change it to appropriate or self-helping negative feeling" (pp. II.8–II.9). Ellis postulated that the change in intensity of emotions enables a self-prescribing of a rational belief or a coping statement emphasizing nonjudgmental self-acceptance (Ellis, 2006). In other words, concentrating on the dysfunctional emotion and changing it to a functional one evidently signifies a change into a rational belief. It is a self-change strategy carried by the client through imagery.

The emotional consequences in grief such as pain, anger shame and depressive response, are frequently very intense and overwhelming. The flooding effect of emotions and body sensation can lead to an evaluation (a secondary symptom) by the bereaved person as too painful and therefore be avoided. A more adaptive way however, would include awareness and acknowledgment of the emotions and body sensation and accepting them in a non-judgmental way as part of healthy grief can help in experiencing an adaptive process.

Characteristic to grief is rumination over the loss event with "why" questions repeatedly being asked thus maintaining unhealthy negative emotions of anger, guilt and shame—a loop that blocks the natural healthy process. Imagery is an effective strategy to assist the bereaved change the intensity of emotions, a central element in an adaptive grief. Indeed, it marks the difference between a healthy functional feeling and unhealthy dysfunctional one, enabling the bereaved to cognitively increase self-control over what seems to be overwhelming emotionally and physically, it feels uncontrollable. In line with the third wave CBT, mindfulness-based cognitive therapy in particular (Segal, Williams, & Teasdale, 2002) the body component is incorporated in the imagery: Rational Emotive Body Imagery (REBI) (Malkinson, 2012).

A basic assumption underlying Rational Emotive Body Imagery within the ABC of REBT framework is that the client links his/her emotional distress as well as the accompanying body sensation (Consequence-C) to the loss event (Activating event), and not to his or her appraisal (B) of it. The aim of REBI is through constructing a safe setting for the client, to reduce the emotional distress by introducing the understanding that beliefs about the event act as mediators between the event and the consequences—a Belief-Consequence connection. In other words, the client is helped to understand that despite not having a control over highly negative events, the right to choose one's belief and interpretive framework remains (Malkinson, 2007, 2012).

Three stages to applying the strategy:

The first step is preparation: explaining to the client what rational–emotive-body imagery is and its usefulness in treatment along with an introduction to the SUDS

scale (subjective units of distress scale). The second: The therapist guides the client to re-live the event and directs her efforts to do so especially with regards to non-verbal expressions. The third step is the follow up after completing the imagery exercise and preparing its practicing between sessions.

In cases where verbal communication by client is not present, the therapist may encourage nonverbal communication such as suggesting they nod their head to signal progress.

The REBI intervention
1. Constructing the image (A)
2. Identifying the emotion and/or body sensation (C)
3. Measuring the intensity of the response (SUDS)
4. Reducing the intensity of the response (that the client is experiencing in the moment at his or her own pace)
5. Measuring the change of intensity of the emotion and/or body (physical) response (SUDS)
6. Evaluating the cognitive change (B)
7. Discussing the cognitive change and its new emotional and body consequences
(B-Connection)

Letter Writing, "as if", to the Deceased

The healing potential of writing is well established (Pennebaker, 1997; Rubin et al., 2012). The act of writing puts into words thoughts and feelings about the writer's past present and future life. Because writing involves cognitions and emotions and has psychological as well as physical benefits it is frequently applied in cases of complicated grief in a number of ways. In some cases, it is one-time letter writing; at times it is done over a limited number of consecutive days, while in other cases this technique can be carried out daily as a continuous letter writing for a period of time. Whatever the chosen structure or setting, writing is believed to help he bereaved individual express the often time avoided pain in "private" way with the writer choosing the words the pace, and emotions. Put it differently, it allows the bereaved writer to experiment with alternative reconstructions of the loss narrative in a more organized way. Letter-writing "as if" (Ellis & Dryden, 1997) allows the bereaved "to talk", write; think as if the deceased were present. In line with REBT tenet of normalizing grief responses, the application of "as if" letter writing provides means to legitimately let the bereaved to express otherwise unexpressed "crazy" (irrational) thoughts (Malkinson, 2007). Structured treatment of letter writing is based on the four steps of "leave-taking" rituals of preparation, reorganization, finalization and follow-up.

Treatment Guidelines from the Empirically-Supported Therapy Literature that Inform Best Practice in REBT with Grief

While the debate continues with regard to inclusion of a diagnostic criteria for prolonged grief disease (PGD) in the DSM, empirically-based cognitive grief therapy protocols have been developed to assist bereaved who experience difficulties in reorganizing life following a loss. Reported studies applying CBT in complicated grief and PTSD were found to be efficacious: a comparison between exposure therapy cognitive restructuring support therapy (Boelen et al., 2007), PE (Foa & Rothbaum, 1998), Imagery re-scripting (Holmes, Arntz, & Smucker, 2007) and letter-writing (Pennebaker, 1993) are but some examples. In a meta-analysis of studies for the treatment of Prolonged Grief Disorder, cognitive grief therapy, specifically exposure therapy (ET) and cognitive restructuring (CR) were found to be more effective than supportive, nonspecific therapy and waiting list (Boelen, de Keijser, van den Hout, & van den Bout, 2007). In particular, evidenced-based studies indicated CBT as an effective treatment for complicated grief (Malkinson, 1996; Shear, Frank, & Hauck Reynolds, 2005; Boelen et al., 2007). In their study Shear and associates (2005) have modified the standard IPT (Interpersonal Psychotherapy) for complicated grief and included elements of cognitive behavior (Shear et al., 2005) which later was developed as complicated grief therapy (CGT) addressing both separate anxiety and traumatic anxiety elements (Shear & Gribbin, 2017).

Shear and associate's is a 16-sessions evidence-based protocol based on CBT and strategies and procedures from other evidenced-base psychotherapies (Shear & Gribbin, 2017). Sessions are structured and combine cognitive behavioral and imaginal strategies to facilitate the natural course of grief. The sessions are organized in four phases: Getting started, core revisiting sequence, midcourse review and closing sequence. Therapy is designed based on the Dual Process Model (Stroebe & Schut, 1999) viewing grief process as oscillation between loss orientation and restoration orientation. Strategies include among others grief monitoring dairy, imaginal and situational revisiting exercises (Shear & Gribbin, 2017).

Imaginary exposure and imagery re-scripting are forceful strategies used in the service of recollection of painful memories or processing of feared emotional outcomes and introducing a new meaning to them. These procedures are reported as effective in reducing distress following trauma and loss (Holmes et al., 2007; Shear & Gribbin, 2017). From REBT perspective, each of these strategies can be modified to include the central elements of rational and irrational beliefs and the distinction between NUE and NHE. For example, focusing on irrational beliefs preventing the bereaved to approach reminders of the deceased because of the pain it entails ("its' too painful") strategies such as letter-writing, visiting the grave, imagery exposure can be easily incorporated to assist the bereaved overcoming avoidance.

Brief Case Example

The framework of treatment utilized in the case example with Nora included establishing a therapeutic alliance; joint evaluation of the problem, provision of social support, cognitive assessment of the B-C belief-emotional framework, and assessment of the potential for change and potential obstacles to change.

Nora married in her late 30s requested therapy following still birth she experienced 12 months earlier and was 12 weeks pregnant. Therapy was once a week and continued throughout her pregnancy.

She was suffering from anxiety symptoms (heart palpitation, sleep difficulties, loss of appetite) as pregnancy was progressing she was agitated and restful of the upcoming delivery (fearing she will have to experience once more the nightmare she went through in the first delivery), and depressive response with images of the unborn baby, symptoms of traumatic grief. The ABC of Rational Emotive Behavior Grief Therapy was applied to help Nora experience an adaptive healing process but firstly attending to the traumatic circumstances of the loss that hindered the natural course of grief (Track I of the TTMoB). Subsequently, focusing on grief elements of remembering the unborn baby and the pain and yearning these involve (Track II of the TTMoB). The first few sessions included providing Nora with information about grief over the loss of the baby and its traumatic circumstances, normalizing and legitimizing the flooding effect of her experience. The ABC of adaptive grief was explained, teaching Nora the Beliefs-Consequences connection and the distinction between HNE and UNE. Between session assignments included reading material about REBT and grief, breathing exercises and to record in writing her irrational thoughts when she felt distressed. When Nora reported a relief in the symptoms (slept better, regained her appetite), therapy focused on the relationship with the unborn baby (Track II in the TTMoB).

Can I Tolerate and Control My Pain?

Nora's description of the recurrent and persistent image of the time of delivery when there was no pulse on the monitor followed by a still delivery and the intolerable pain that accompanied the recollection led to apply REBI strategy and one-time letter writing to facilitate a healthy grief process. I described REBI to Nora and explained its usefulness in her treatment along with introducing the Subjective Units of Distress (SUDS) scale and how to apply it during the REBI. Nora was prepared to reconstruct the image and apply SUDS. When feeling distress at any stage, she was to signal the therapist and would be assisted. Nora was instructed to recreate the image or a picture of the event of the delivery and was given a choice to keep her eyes open or shut. With her eyes closed she was asked to recall as closely as possible the feeling she experienced when it happened and signal when she had done so (*Constructing the Imagery*). Tension in her body and tears were the consequences of the reliving

the experience. She was guided to attend to the emotion and the body sensation and be aware of them (*Identifying the emotion and the body sensation*) and measure its intensity on the SUDS scale. With her hand on her chest, and concentrating, Nora answered 10 (*Measuring the intensity of the response*). Having measured the degree of the emotion, she was asked to concentrate on the intensity of the response and try to do something in any way she thought would help her reduce its intensity, taking her time to do so. With her eyes closed she was asked to make a sign when she accomplished this. As Nora continued to hold her hand on her chest, I encouraged her "to listen" to her body while doing something to reduce the intensity of her distress as a way to empower her and giving her a degree of control over her distress. Nora concentrated and at a certain moment there was a look of relief in her face and her body seemed relaxed somewhat (*Reducing the intensity of the response*). Nora was told she could open her eyes and was asked whether there was a change in the intensity of her pain and to report on its level. Nora answered 9 and opened her eyes (*Measuring the change of intensity and/or physical response*). Nora was praised for her efforts to do the imagery and change the intensity and was asked what she did and what she said to herself to lower the intensity from 10 to 9, and also assess the difference (*Evaluating the cognitive change*). Nora answered that she said to herself: "I can stand the pain, I have the strength to tolerate the pain and remember my angel, and then I felt a relief". To the question what was the difference between 10 and 9 she said: "I could breathe". The change of cognitive evaluation in her statement and the emotional and physical consequences were noticeable. Nora was supported and encouraged to re-experience the difference in the change of the emotional and body sensation, to give it validity in a way of practicing between sessions. Being aware and mindful of her emotions and body sensation and changing her belief and telling herself, "I can stand the pain, I have the strength to tolerate the pain and remember my angel" decreased the tension. Being aware of the tension and "listening to it" made Nora feel she has more control over her body and while focusing in a mindful way she was able to accept the pain of grief.

Between session homework and practicing REBI was given to strengthen Nora's belief in her ability to regulate and control the level of her distress. Nora reported practicing the imagery which she said helped her to identify her irrational thoughts and change them into more rational ones and exercise mindful breathing as a way of regulating the pain. As pregnancy was progressing Nora became very anxious saying she feels disconnected to the fetus: "I keep on thinking about my baby that I lost and I am afraid to think about the one I am carrying." A one-time letter writing to the lost baby was the chosen strategy suggested to Nora to help her express in writing her thoughts and emotions regarding the loss, as she chooses the words, construct the narrative, the pace of writing the emotional tone. Letter writing to the deceased is a technique with a proven therapeutic potential (Pennebaker, 1997; Rubin et al., 2012) that from a REBT perspective enables the bereaved to release "locked in thoughts", many of them are irrational accompanied with distressing emotions. Also, writing a letter "as if" to the deceased provides an opportunity to identify and express these irrational beliefs and change them into more rational ones and explore ways of forgiving oneself, others or the world.

Nora accepted the suggestion and wrote a letter which she brought and read at the following session.

This is an extract from her letter:

"My sweet girl, we were together 9 months, I always talked to you and each time I ate something sweet you were "running wild" and I loved this sensation… even during the most difficult days I knew you were there and everything became dwarfed because I had you…. When they didn't find your pulse in the monitor I felt that blood was coming out of my body…I miss you so much and sometimes I think that perhaps you tried to warn me and I wasn't attentive… I promise you that I did everything I could, and what can I say, not always we manage to be saviors…not everything is in our hands. I know you are in a good place because you are my little angel and always will be".

Nora was crying as she read the letter and added that though it was very difficult to write it she felt relieved upon completing it and felt that she could concentrate on the present pregnancy. Therapy continued until Nora gave birth to a little baby girl. Nora called to update me, said that it wasn't easy but the baby is beautiful and she "told" her about "the angel".

Rational Emotive Imagery with added elements of awareness to physical sensation provides a mind-body experience in which the client is guided in a safe setting to choose a way to reduce the distress associated with the traumatic loss.

Choosing the event experiencing mindfully emotions and body sensation to reduce the intensity and changing cognitions is a way to empower the client to be more self-accepting, and thus increase inner control, and enabling a healthy grief.

What I Have Learned About Using REBT with Grief

Accommodating Individual Differences: Client Gender, Ethnicity, Socio-economic Status, Intelligence and Other Factors

Though mourning is human, normal and universal it always occurs within a socio-cultural context that impacts both process and outcomes. The socio-cultural religious and spiritual lenses are critical to the understanding of the individual's grief. Similarly, mourning customs differ from one culture to another and need to be assessed when intervention is planned. Age, gender, relationship to the deceased (child, parent, sibling etc.) as well as assessment of attachment styles and past experiences with losses are important variables to be assessed because they affect grief process and the structure of the therapy (Rubin et al., 2012). Although grief is an idiosyncratic process based on the unique relationship the bereaved had with the deceased, the bereaved person's belief system is always shaped within socio-cultural context. REBT distinguishes between moral, ethical spiritual and religious values, and the tendency to interpret them in irrational absolutistic way which increases emotional

distress and therefore encourages the adoption of rational beliefs as way to cope with adverse events.

The Do's and Don'ts

The Do's

Remind yourself as a therapist that there are many paths to grieve and remain non-judgmental to different ways of experiencing it.

During the acute phase provide information, normalize the process and explore possible cognitive attitudes alternatives that lead to experiencing an adaptive grief process.

Explore the individual style and preferences towards making the change.

As therapy progresses re-evaluate with the clients the goals and accommodate the tasks and the pace accordingly.

The Don'ts

Don't try to lead the bereaved through "the right way" to grieve. There is no right way one way, and there are no stages to grief. Remember that though grief universal it is an idiosyncratic process. There is no one suit that fits all.

Because loss in most cases is unexpected, undesirable and traumatic, and in many ways "illogical" and the grief that follows is a process to reorganize "shattered assumptions". Do not use at this phase rigorous forms of disputation such as logical disputation or empirical disputation (Malkinson, 2007).

Which Aspects of REBT Deliver the Most Benefit for Change and Which Don't

Which Aspects of REBT Deliver the Most Benefit for Change

REBT therapist is active and directive and flexible in forming the therapeutic alliance in accordance with the individual client's style (Dryden, 1991). This is especially relevant in forming therapeutic alliance in REBT with grief that includes the therapist, the client and the deceased. Accurately perceiving the client's cognitive, emotional, behavioral and non-verbal communication is most important to understanding the individual client's grief as well as conveying this understanding. Moreover, REBT's

philosophy of human tendency to think irrationally along with a belief that humans can change their way of thinking and moderate their distress makes REBT most suitable to working with bereaved individuals and families. The therapeutic goal in REBT with grief is to help the bereaved process a painful experience in a healthy adaptive way, using the client's idiosyncratic language and metaphors not only as a way to express empathy but as a way to introduce cognitive emotional behavioral and physical change.

Based on my clinical experience, I view the ABCDE of REBT as a Hungarian Cube; it holds given components that can be arranged and rearranged in so many ways and variations. Both therapist and client have access to the cube and can negotiate changing it. The simplicity of the model (in Hebrew it translates to "EMET"-"truth" which can be questioned upon disputation!) and yet at the same time it allows for many twists and turns accommodating for individual idiosyncratic needs towards a cognitive emotional behavioral and physical change. The ABCDE model consist of a set of principles and at the same time allows flexibility. Therapy with clients who experienced a loss through death is likely to impose strain on therapists as they confront an adverse event that potentially can evoke irrational beliefs. However, the ABCDE of REBT when A is death—an irreversible event—provides an opportunity to apply a model that fits the normal, human and universal phenomena when it goes awry.

Unconditional Acceptance of Self, Others and the Circumstances of the Death Event

Evaluating or rating one's behavior or actions rather than global evaluation of oneself as worthless is in my eyes the "Jewel in the Crown" of REBT. As its psychological and philosophical stance, it emphasizes that it is human to make mistakes, and accepting it involves practicing cognitive, behavioral and emotional flexibility towards acknowledging one's imperfection (DiGuiseppe et al., 2014). Unconditional acceptance of oneself, others and the world (or life) is pertinent to working with bereaved individuals who feel guilty and/or experience unhealthy anger at themselves, the deceased, the world's injustice or God. Changing rigid global rating into unconditional acceptance will help moderate emotional distress and enable an adaptive grief process.

The Belief-Consequence Connection

Cognitions and emotions are central components in general CBT but the emphasis on the connection between the two as a source of distress and the key to reduce it, is characteristic to REBT, and relevant in applying it following loss. The idea rooted in REBT that "it's all in the head" is basically an optimistic one highlighting free-

dom of choice we, as human creatures, have: "All is foreseen but freedom of choice is given". (Ethics of the Fathers, C, 15). Therapy than can be viewed as a psychological and philosophical dialogue between therapist and client about choices and their implementations in distinguishing between healthy functional and unhealthy dysfunctional emotion when death is the adverse activating event. Thus, in working with a bereaved father who feels guilty over not protecting his son who was killed in a road accident, we searched for the belief that increases guilt: "I should have protected him and if I failed, I am a worthless father". Introducing the distinction (D) in the Bible between thinking and acting willfully or unintentionally, enables exploring emotional consequences, and offer a healthy negative emotion such as remorse which is a normal response in grief (B-C connection).

Which Aspects of REBT Do Not Deliver the Most Benefit for Change

As elaborated throughout the chapter the aim of grief therapy is to facilitate an adaptive grief process following an adverse event of a loss through death. In most cases, logical and empirical disputation strategies are unsuitable and ineffective in particular during the acute phase, during which time assumption about the self, others and the world have been shattered. Bereaved, during the acute phase are sensitive to questioning or debating the catastrophe that befell on them, and express resistance which may also affect the therapeutic relationship. Arguing about the "truth" of the evaluation is perceived as insensitivity on behalf of the therapist. Rather, teaching the ABC of adaptive grief, emphasizing negative healthy emotions to normalize grief process towards accepting life without the deceased. D for dialogue is preferable.

Refrain from insisting on the terminology of "should" and "musts" during the acute grief.

Concluding Remarks

Grief is a cognitive, behavioral, emotional and somatic process of accepting the changes enforced on one's life caused by death. Rational Emotive Behavior Therapy with its distinction between NHE (a core element in grief), and UNE (that block the natural course and increased emotional distress) is a most appropriate framework for working with bereaved in assisting them to adaptively experience grief.

References

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: American Psychiatric Association Press.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: American Psychiatric Association Press.

Boelen, P. A., de Keijser, J., van den Hout, M. A., & van den Bout, J. (2007). Treatment of complicated grief: A comparison between cognitive-behavioral therapy and supportive counseling. *Journal of Consulting and Clinical Psychology, 75*(2), 277–284. https://doi.org/10.1037/0022-006x.75.2.277.

Bonanno, G. A., & Kaltman, S. (2001). The varieties of grief experience. *Clinical Psychology Review, 20,* 1–30.

Daniel, D., Szentagotai-Tatar, A., Viorel, L., & Cozman, D. (2008). Rational emotive behavior therapy, cognitive therapy and medication: A randomized clinical trial, posttreatment outcomes and six-months follow-up. *Journal of Clinical Psychology, 64*(6), 728–746.

DiGuiseppe, R. A., Doyle, K. A., Dryden, W., & Backx, W. (2014). *A practitioner's guide to rational emotive behavior therapy* (3rd ed.). Oxford: Oxfrod University Press.

Dryden, W. (1991). *Reason and therapeutic change*. London: Whurr Publishers Ltd.

Ellis, A. (1976). The biological basis of human irrationality. *Journal of Individual Psychology, 32,* 145–168.

Ellis, A. (1993). *Rational -emotive imagery: RET version*. In M. E. Bernard, & J. L. Wolfe (Eds.). The RET resource book for practitioners (pp.II.8-II/10). New York: Institute for rational Emotive Therapy.

Ellis, A. (1994). *Reason and emotion in psychotherapy. A comprehensive method to treating human disturbance (revised and updated*). New York: A Birch Lane Press Book.

Ellis, A. (2006). Rational emotive behavior therapy and the mindfulness based stress reduction training of Kabat-Zinn. *Journal of Rational Emotive Therapy & Cognitive-Behavior Therapy, 24*(1), 63–78.

Ellis, A., & Bernard, M. (1986). *What is rational emotive therapy (RET)*? In A. Ellis & W. Dryden (1997). *The practice of rational emotive behavior therapy*. New York: Springer Publishing Company.

Ellis, A. & Dryden, W. (1997). The practice of rational emotive behavior therapy. New York: Springer.

Ellis, A., & Grieger, R. (Eds.). (1986). *RET: A handbook of rational emotive therapy*. New York: Springer Publishing Company (pp. 3–31).

Ethics of the Fathers (Chapter 3, 15) (in Hebrew).

Foa, E. B. & Rothbaum, B.O. (1998). *Treating the trauma of rape: Cognitive -behavioral therpay for PTSD*. New York: Guilford Press.

Freud, S. (1957). *Mourning and melancholia*. In J. Starchey (Ed. & Tran.), *Standard edition of the complete psychological works of Sigmund Freud* (Vol. 14, pp. 237–258). London: Hogarth (Original work published in 1917).

Holmes, E. A., Arntz, A., & Smhucker, M. R. (2007). Imagery re-scripting in CBT: Images, treatment, techniques and outcomes. *Journal of Behavior Therapy and Experimental Psychiatry, 38,* 297–305.

Janoff-Bulman, R. (1992). *Shattered assumptions: Towards a new psychology of trauma*. New York: Free Press.

Kassinov, H., & Taftre, C. (2002). *Anger management: The complete treatment book for practitioners*. Ayascadero, CA: Impact Publishers Inc.

Klass, D., Silverman, P. R., & Nickman, S. L. (Eds.). (1996). *Continuing bonds: New understanding of grief*. Washington, DC: Taylor and Francis.

Kushnir, T., Malkinson, R., & Ribak, J. (1998). Rational thinking and stress management in health workers: A psycho-educational program. *International Journal for Stress Management, 5*(3), 169–178.

Malkinson, R. (1996). Cognitive behavioral grief therapy. *Journal of Rational-Emotive & Cognitive-Behavior Therapy, 14*(3), 155–171.
Malkinson, R. (2007). *Cognitive grief therapy: Constructing a rational meaning to life following loss*. New York: W.W. Norton.
Malkinson, R. (2012). The ABC of rational response to loss. In R. A. Niemeyer (Ed.), *Technique's of grief therapy: Creative principles for counseling the bereaved* (pp. 129–132). New York: Routledge.
Malkinson, R. (2017). Introduction to the special issue on grief. *Journal of Rational Emotive & Cognitive Behavior Therapy, 35*(1), 1–5.
Malkinson, R., Kushnir, T., & Weisberg, E. (1997). Stress management and burnout prevention with blue collar female workers. *International Journal of Stress Management, 4*(3), 183–195.
Malkinson, R., Rubin, S. S., & Witztum, E. (Eds.). (2000). *Traumatic and non-traumatic loss and bereavement: Clinical theory and practice*. Madison, CT: Psychosocial Press.
Maultsby, M. J., Jr. (1971). Rational emotive imagery. *Rational Living, 6*(1), 24–27.
Pennebaker, J. W. (1993). Putting stress into words. *Behavior Research and Therapy, 131*, 539–548.
Pennebaker, J. W. (1997). Writing about emotional experiences as a therapeutic process. *American Psychological Society, 8,* 162–166.
Prigerson, H. G., Frank, E., Kasl, S. V., Reynolds, C. F., III, Anderson, B., Zunebko, G. S., et al. (1995). Complicated grief and bereavement—Related depression as distinct disorder: Preliminary empirical validation in elderly bereaved spouses. *American Journal of Psychiatry, 152,* 22–30.
Rubin, S. S., Malkinson, R., & Witztum, E. (2012). *Working with the bereaved: Multiple lenses on loss and mourning*. New York: Routledge.
Rubin, S. S., Malkinson, R., & Wiztum, E. (2017). Bereavement and traumatic bereavement: Working with the two track model of bereavement. *Journal of Rational Emotive & Cognitive Behavior Therapy, 35*(1), 78–87.
Segal, Z. V., Williams, J. M. G., & Teasdale, J. D. (2002). *Mindfulness-based cognitive therapy for depression: A new approach to preventing relapse*. New York: Guilford Press.
Shear, K. A., & Gribbin, C. (2017). Complicated grief treatment: An evidenced-based approach to grief therapy. *Journal of Rational Emotive & Cognitive Behavior Therapy, 35*(1), 6–25.
Shear, M. K., Frank, E., Houck, P. R., & Reynolds, C. F., 3rd' (2005). Treatment of complicated grief: Randomized control trial. *JAMA 293*(21), 2601–2608. https://doi.org/10.1001/jama.293.21.2601.
Stroebe, M. S., & Schut, H. (1999). The dual process model of coping with bereavement. Rationale and description. *Death Studies, 23*(3), 197–224.
Wells, A. (2005). Detached mindfulness in cognitive therapy: A metacognitive analysis and ten techniques. *Journal of Rational Emotive & Cognitive Behavior Therapy, 23*(4), 337–355.
Witztum, E., Malkinson, R. & Rubin, S. (2001). Death bereavement and traumatic loss in Israel: A historical and cultural perspective. *Israeli Journal of Psychiatry, 38*(3/4), 157–170.

REBT and Personality Disorders

Raymond DiGiuseppe and Ennio Ammendola

Key REBT Theoretical Concepts in Working with Personality Disorders—Which Aspects of REBT Theory We Particularly Rely on for Conceptualization and Why

The present Diagnostic and Statistical Manual Fifth edition (DSM-5; American Psychiatric Association, 2013) defines personality disorders (PD) as "enduring pattern of inner experience and behavior that deviates from the expectation of the individual's culture." PD disturbance is consistent across time and the symptoms occur across many domains of life. DSM-5 includes 10 distinct PDs. The present DSM-5 PDs include Paranoid, Schizoid, Schizotypal, Antisocial, Borderline, Histrionic, Narcissistic, Avoidant, Dependent, and Obsessive-Compulsive. Several other PDs are frequently mentioned that do not yet appear in DSM such as negativistic or passive aggressive, depressive, self-defeating, and sadistic. A high degree of comorbidity usually occurs among personality disorders. This has led to some controversy in the field about the validity of the PD diagnoses. Some theorists proposed that PD disorders be replaced with a system of describing all patients on the dominant model of normal personality functioning—the Big Five model (Widiger & Sweatt, 2009). This model includes the traits of Neuroticism, Extroversion, Openness to Experience, Agreeableness, and Conscientiousness. This proposal recognizes that personality traits exist along a continuum and that PDs reflect extreme traits of normal personality functioning.

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Paranoid, Schizoid, Antisocial, Histrionic, Narcissistic, Avoidant, Dependent, and Obsessive-Compulsive PDs represent extreme examples of normal personality traits. However, Borderline and Schizotypal PDs do not represent variations of normal personality function, but a form of psychopathology. This chapter discusses some principles for treating PDs, a category of disorders, within an REBT framework.

REBT Theories of Personality Disturbance

Ellis's (1999, 2002) hypothesized that personality disturbance like all emotional disturbances includes cognitive, emotive, and behavioral symptoms, and this is particularly true of individuals with a PD, especially those with borderline personality behaviors (BPD). Ellis (1999, 2002) noted that patients with BPD had a tendency to catastrophize about their negative event, have rigid modes of thinking, acting, and their emotions. They experience severe self-downing, purposelessness, cognitive impairments in recalling and recognition, and are deficient in semantic encoding. He also hypothesized that BPD patients usually have secondary irrational demands about their disorder such as, "I must do better than I am actually doing!"; "Other people absolutely must not treat me unfairly for my handicaps!" and "The conditions under which I live must not be so handicapping!"

Ellis (1994, 1999) hypothesized that most patients with PDs have a biological predisposition for rigidity and poor emotional regulation and a tendency to think, feel, and behave abnormally. These problems are exacerbated by a negative life circumstance, which results in their encountering more negative activating events that they create for themselves because of their biological predispositions.

Ellis (1994, 1999) also described several variables that are responsible for the resistance to change displayed by PD patients. These include (1) strong biological tendency for thinking, feeling, and behaving rigidly, (2) a long history of disturbed emotions that results in over learning and rehearsal of disturbance, (3) poor social relationships, (4) an innate and acquired tendency to take the easy way out and avoid facing their problems, (5) self-condemnation of themselves for their symptoms, and (6) strong feelings of shame from beliefs of worthlessness and hopelessness. The first four of these represent primary symptoms of PD while items 5 and 6 recognize the contribution of secondary disturbance.

Personality Theories and Personality Disorders

If PDs represent an extreme form of personality traits, how can personality theories help us to conceptualize these disorders? Personality theories usually include two types of constructs (Maddi, 1996). The "core" aspects of a theory include its basic assumptions concerning human nature. The "peripheral" aspects describe the individual differences along dimension, traits, and behaviors. Ellis developed an REBT

personality theory that he formalized before his death (Ellis, Abrams, & Abrams, 2009). The REBT theory focuses mostly on core aspects of personality concerning human nature. It includes little concerning peripheral aspects or individual differences in personality traits. It says little about which irrational beliefs (IBs) relate to which dysfunctional emotions, behaviors, or personality traits. If PDs represent an extreme variation of personality traits, REBT needs to rely on other theories to describe the peripheral aspects of personality.

REBT's focus on the core aspects of personality stands in sharp contrast to other CBT approaches to PDs. Both Beck, Davis, and Freeman (2015) and Schema Focus (Bernstein & Clercx, 2018) have elaborate models of the peripheral aspects of personality. They identify specific schemata associated with each PD. Considerable overlap exists between Beck's, Young's, and Millon's description of the peripheral aspect of PD and their schemata content. Millon's (2011) model represents the foundation for these peripheral personality theories. They all provide clear concise descriptions of personality that can provide hypotheses for exploring the content of the schemata associated with different PDs.

Such schemata include beliefs about the self, others, and the world. The schema involves beliefs concerning the traits and skills that make up the self (e.g., I am ineffectual). The schemata include information that can include distortions or inaccuracies concerning the self, others, or the world. The schemata also include aspects that represent the imperative or evaluative beliefs that are typically associated with IBs in REBT and comprise ideas of demands, awfulizing, frustration intolerance, and global evaluations of the self or others (e.g., I should be more effective and I am worthless if I am not). Thus, the schemata can involve factual errors about the self, others, or the world, imperative statements, and evaluative errors about these perceptions. Therapy can focus on challenging the factual distortion of the schemata, the imperative or evaluative aspects of them, or all three.

For example, a patient with Obsessive Compulsive Personality Disorder (OCPD) might have the belief that other people are incompetent, irresponsible, or indulgent. In addition to these factual aspects of others, OCPD patients might demand that the people in their life "SHOULD NOT BE" incompetent, irresponsible, or indulgent; and if they are they are condemnable. The schemata proposed by Beck et al. (2015), Millon (2011), and Young provide examples of the content of the schemata for each PD; they might involve themes of incompetency, abandonment by others, avoiding control by others, being weak, desiring attention, being strong, or being special. They often tell us something about the type of IBs that occur in the PD. Some IBs in PD patients involve condemnation of the self, condemnation of others, failure to accept the self, others, or the world as it is, and frustration intolerance.

Once one understands the content of patients' schemata, it is important to make the distinction between the inelegant and elegant solutions in REBT. To help therapists make this distinction we identify three aspects of schemata (1) factual information, (2) imperative aspects of schemata, and (3) evaluative aspects of schemata. Because the nature of PD pathology is so pervasive across time and situations, it is easier for these patients to want to seek practical solutions to emotional problems. Applying the elegant solution appears to be more important than for non-PD patients.

Two core aspects of REBT's theory of human nature are most influential in understanding the nature of IBs in patients with PDs. These include Ellis' notion of discomfort anxiety and frustration tolerance. Given the pervasiveness of these patients' problems they are likely to encounter activating events in many areas of life that trigger their emotional disturbance. They will deal with more events and will face more discomfort than most other patients will. Getting them to accept the negative disturbance and deal with the frustration they face is a major focus in REBT sessions.

Key Best-Practice REBT-Based Assessment and Treatment Strategies and Techniques in Working with Personality Disorders

PD patients do not come to therapy to change their personality. They come to eliminate their intrapersonal suffering; and they want to leave therapy when this is accomplished. This situation presents two problems. The first is the issue of Assessment, which we will discuss below. The second is the therapeutic alliance. As the therapist, you might want to help these patients work on reducing their PD symptoms. This requires some negotiating on the goals of therapy as you change from working on their immediate emotional disturbance to helping them to understand and work on their longer-term problems. We will discuss this below.

Assessment

We believe that therapists' case conceptualizations of PD patients benefit immensely from the results of personality tests. At the Albert Ellis Institute (AEI), we administer the MCMI-IV (Millon, Grossman, & Millon, 2015) to all new patients. We have found it helpful in diagnosing PDs and useful in understanding the peripheral aspect of their personalities. Millon's (2011) model provides interpretive data on the patients' personality style, expressive behaviors, interpersonal behaviors, cognitive style, and defensive or compensatory behaviors. This information helps therapists develop hypotheses and case conceptualizations concerning the patients' major schema, the content of their IBs, and their emotional themes. Therapists can use other PD tests and structured, semi-structured, or informal interviews to assess the presence of PDs and the schemata.

After the assessment we explain the results to the patients. We want PD patients to understand that they have extreme traits that limit the range of behaviors they perform, and they frequently become upset in situations that require behaviors inconsistent with their personality style. For example, patients with dependent PD will act independently less often and are likely to become upset in situations when they cannot

rely on others. Patients with avoidant PD are likely to avoid social contacts, and experience anxiety when they are required to be in social situations.

Administering an IB scale is also helpful. At the AEI we administer one to all new patients (DiGiuseppe, Leaf, Gorman, & Robin, 2018). Most IBs measures have subscales that assess the four IB cognitive process—demandingness, self or the downing, frustration intolerance and awfulizing. However, the content about the IBs focus differ and focus on areas such as approval, achievement or comfort. Thus, patients with dependent, histrionic, and avoidant PD would endorse IBs about approval as social approval is part of the schematic themes for all these PDs. In the companion volume to this book, David et al. (in press) identified more than 50 IB scales. None of these sales has been developed to identify the IBs associated with the schematic themes associated with the various PDs. However, most of the scales focus on the IBs associated with a specific clinical problem, such as academic performance, gambling, and medical illness, or specific populations such as parents, women, teachers, or nurses. The items in such tests differ mostly by the themes or content and usually include the four cognitive processes mentioned above.

We recommend some form of weekly monitoring of patients' progress, and at the AEI we use the Outcome Questionnaire (OQ: Lambert, 2007). These weekly assessments help therapists evaluate the degree of change, identify when the patients backslide, and by observing the items the patients endorse highly, the therapist can understand the symptoms that have not changed and require attention. These measures will also help us navigate the different stages of treatment with PD patients that we shall discuss below.

Treatment Strategies and Techniques

We distinguish between three critical phases of treatment of PDs in REBT. The first phase focuses on the therapists, the second on the ABC and the ability to make patients aware of their negative interpretations, and the third phase focuses on the prevention of daily relapses.

Phase One of Treatment—Overcoming Countertransference

Clinicians usually hold pessimistic expectations when they encounter patients with PDs. Therapists often assume that PD patients will be difficult, obstinate, uncooperative, and intransigent. The patients' problem fosters dread in the therapist. Because we expect patients with PDs to be difficult, we can absolve ourselves from responsibility for any poor outcomes of therapy. The first problem we face in treating PD patients is our own emotional reaction to them. Psychodynamic therapy uses the term "countertransference" to describe therapists' emotional reactions to patients. Although REBT and CBT focus less on this concept in models of treatment, Ellis (2002) identified countertransference as an important factor in the treatment of PD

patients. We need to first work on our discomfort anxiety at having difficult patients, our sadness, fear and bruised egos from expectations of failure, and our anger at them for making us work harder. One of us (RD) recalls Ellis revealing his attitude toward treating PD patients in supervision. "I think about myself differently when working with patients with personality disorders. I need to accept that I will have to work harder and be on my toes, and that I can stand the hard work. I need to take care of my nutty thinking first, because they (the patients) have enough for both of us."

Even if therapists work hard at taming their own emotional upset about treating PD patients, having a negative expectation for therapy outcome with PDs can limit our effectiveness. Therefore, it is important to review whether the treatment outcome for PD patients is so bleak. Although literature review on PD is beyond the scope of this chapter, research suggests that optimism is justified. Several authors (Beck et al., 2015; Budge, 2015) concluded that the outcome studies aimed to reduce PD symptomology are positive. Also, other studies have shown that PD symptoms change over long periods (Lenzenweger, Johnson, & Willett, 2004). Many therapists believe that PD patients require substantially more sessions than patients without PDs will. At least for REBT, studies by Feldman (2009) and Matweychuk (1990) disconfirmed this. PD patients had as many sessions of REBT as patients without PD. Work with these patients as if you can help them.

Phase Two—Working on ABC of the Presenting Problems

A central REBT strategy in treating PDs is using the ABC model. REBT holds that patients can think rationally and irrationally (Dryden, 2005, 2009), but in working with patients with PDs, most of the attention is identifying the IBs that contribute to patients' psychological disturbance. The therapist's primary goal is to facilitate patients' awareness of one or more of the four main IBs and then to facilitate their awareness of rational alternatives for each of them. The role of the therapist is to identify the patient's core schema, analyze problematic activating events that identify that schema and arouse disturbed emotions, and challenge the IBs to replace the disturbed emotions with negative adaptive emotions.

Several differences have emerged in treating PD patients between REBT and other forms of CBT. First is the timing of targeting the schematic or core beliefs. Remember that most forms of CBT advocate that therapists identify and challenge patients' negative distorted automatic thoughts for at least the first 8–10 sessions of therapy. Based on the content of the thoughts revealed in this process, therapists formulate a hypothesis concerning what the patients' core schematic beliefs might be. After this is presented to the patient and he or she accepts the hypotheses, therapists target the schema for change. In REBT, therapists do not challenge the distorted thoughts and instead use strategies like inference chaining to identify the beliefs that are at the basis or core of the cognitive distortion. For this reason, we hypothesize that REBT strategies make it easier and quicker to identify the PD patient's schema.

Thus, in REBT the therapist identifies the schema and targets them for change much earlier in therapy than other forms of CBT.

The second major difference focuses on which aspects of the schema are targeted for change. This can be a difficult concept for therapists to recognize. We propose that schemata are composed of at least three elements. The first involves organizational or factual components of perceived reality. Schemata are cognitive maps or models of the world. They represent the patients' beliefs about the way the self, others, and the world are. By the factual aspect of schemata, we mean the models the person/patient uses to construct, predict, and forecast reality. In CBT, this aspect of PD patients' schemata is considered exaggerated and inaccurate. However, they are viewed and experienced by the patients as realistic and factual, even though therapists might eventually attempt to prove them wrong.

The second element of a schema we call the imperative component, and it represents how the person believes the self, others, or the world should be. Some people clearly recognize that there is reality they want which does not reflect truth. Others, and REBT would posit PD patients among them, fail to discriminate between what they desire and what is. They distort their schema of the world to reflect what they want.

The third characteristic of a schema is evaluative. Because schema include not only information about what the person expects reality to be, but also whether that perception is good or bad. The evaluative component would be represented by negative evaluations such as an event is awful or catastrophic, the self or other is worthless or condemnable and the situation can be intolerable or unbearable.

Most writings, but not all, on PD schemata present the first component of the schemata. Beck (2015) presents all three components for many of the schemata. Because schemata are tacit, deep, and non-conscious cognitions, the therapist can identify them and think they are targeting the irrational nature of the schema when they are actually focusing on only the factual inaccuracies of the schema. Thus, REBT differs from other forms of CBT in focusing the intervention on the second and third aspect of the schemata and spending much less time targeting the first aspect of the schemata. To make this clear, we will review the schemata associated with all the DSM PDs and highlight the three aspects of each schema and how REBT would propose treating the problem. These examples of PD schemata are taken from Beck et al., (2015).

Antisocial Personality Disorder. These individuals see themselves as alone in a fight for survival. They are unlikely to feel that they are a member of a team or in collaborative relationships. The factual element of their schema is that they live in a hostile world. Other people are seen as potential abusers who might exploit them, or as weak people who can be exploited. The imperative elements of their schemata are that they must win, gain all resources, and have what they want. Also, they think that others should be submissive and obedient. The evaluative aspects of their schema is that it is awful not have to what one wants, or to lose. They see others as devalued and themselves as superior.

Avoidant PD. For these patients, their schema revolves around the idea that they are inferior, unlovable, and unlikeable. The factual aspect of this schema is the idea that,

they are unlikeable. The imperative aspect of the schema is the idea that, "I should be more likeable, socially skilled and able to connect with people" and, "They should like me." The idea that one is unlikeable is clearly an exaggerated false claim, and it is easy to see why a therapist would want to target this thought first. For most avoidant PD patients, the factual aspects of their schemata are incorrect and would result in pessimism towards engaging in any new social actions. However, for many of such patients their social skills and social history are such that some people might dislike them. For others it is truly a hyperbole. REBT would acknowledge that the factual aspects of these patients' schema represent a self-fulfilling prophecy. REBT would recommend that therapy target the imperative and evaluative aspect of the schema first. The imperative targeted intervention would teach the patient that some other people might not like them, that they are who they are, and they can accept themselves. Targeting the evaluative aspect of the schema would teach them that they are not worthless because of their social situation and they could stand the discomfort of working to make friend.

Borderline Personality Disorder. This disorder differs from other PDs in that it does not represent an extreme version of a normal personality trait. They lack a sense of self-identity and they have poor emotional regulation skills. Their schema might identify theirself as inadequate, vulnerable, and weak. They see other people as untrustworthy. The factual nature of their schema is their view of the, self as weak and others as untrustworthy. These aspects of the schema might turn out to be true because the patients' extreme emotional dysregulation might result in their failure at many tasks and roles, and other people's loss of affection and tolerance for them. The imperative aspect of their schema would be, "I should be more effective and less disturbed than I am," and "Other people should be more reliable than they are." The evaluative component of their schema would focus on their discomfort and frustration intolerance.

Dependent Personality Disorder. These patients' problematic factual aspects of the schema revolve around the idea that they are needy, weak, fragile, helpless, and unable to care for themselves. Others in their life are seen as powerful and capable. Once again, the exaggeration of the factual content of this schema is so extreme that it cries out to be challenged, and a cursory examination of facts indicates that even the most dependent patients can do something for themselves. REBT would recommend first targeting the imperative and evaluative aspects of the schema. The imperative aspect of the dependent PD schema would be "I must be taken care of" or "Other must take care of me." The evaluative aspect would be "I am worthless for being so dependent," and "It is too hard to do things on my own." Working with these irrational beliefs could result in the patient being able to act more independently and then change the factual aspect of their schema.

Histrionic Personality Disorder. This group is likely to believe that they are inadequate and unworthy and need the approval of others to prove their worth. They also believe that they can actively gain attention and thereby have validation and worth. The factual element of their schema is that they are inadequate, unskilled, or have no desired traits. These ideas can be empirically challenged. The imperative aspect of

their schema is that they must have the constant approval of others. The evaluative facet of their schema is that they lack worth and need others to validate them.

Narcissistic Personality Disorder. These patients see themselves as special, superior, and exceptional. Others are seen as inferior and exist to ratify the patients' prestige. The factual element of the schema is the patient's specialness and other people's inferiority. Of course, the truth of these ideas is often challenged by any failure by the patient or success by another. Convincing this group that they are not special is difficult. The imperative element of their schemata is that they are entitled, and that others and the world must give them what they want. The evaluative aspects of their schemata are that they have more worth than others do. It is awful to be on the same level as others and it is awful not to get one's way.

Obsessive-Compulsive Personality Disorder. The factual aspect of these patients' schema includes thoughts about order and perfectionism. They see themselves as accountable and an example to others in how to behave. They see others as incompetent, bungling and not serious enough to do things correctly. The imperative aspect of their schema is that they must behave correctly, that others must recognize the standards that they set and must live up to these standards. The evaluative aspects of their schema focus on condemnation of themselves or others who do not live up to their standards and they think that it is quite catastrophic if they or others do behave correctly.

Paranoid Personality Disorder. Patients with this disorder have the thought that the world is a dangerous place and that most people are dishonest and hostile with designs to take resources from or hurt the patient. They tend to see themselves as loners who are righteous and noble but under siege. They see any conflict or accident occurring between themselves and others as involving purposeful intentions to harm them. The imperative component of their schema reflects a demand that the world be fair and that others do not compete with them or pose any threat to their resources. The evaluative aspects of their schema involve thoughts that it is awful to live under such threat and that it is more desirable to avoid interactions with others. They are also condemning of others whom they see as threatening. Personally, we have found it unsuccessful to challenge paranoid patients' thoughts that others are a threat and purposefully want to harm the patients. Such interventions are sometimes met with accusations that we do not understand the patient, are naive to the evils in the world and people's hostile mactivating event about which they have irrationalotives, or that we are siding with their nemesis. REBT would focus interventions on accepting that some people are hostile and still try and get the most joy from life. It might be helpful to challenge the factual parts of these schema because thinking the world is so filled with danger will result in isolation from others. We have found it easier to help these patients see the world as less hostile after they learn to accept that there is a degree of threat and that the threat is not catastrophic, and they are strong enough to tolerate and cope with it.

Schizoid Personality Disorder. Patients with this PD see themselves as strange and eccentric. They think that they are different from most other people and as a result will not fit in. They also see others as demanding and intrusive. The factual aspects of their schemata might be partly true. Those with schizoid PD might be less

sociable and have less common interests than most people. The imperative elements of their schema would involve the demand that they should be like other people and that others should leave them alone and not be so difficult to live alongside. The evaluative components of the schema would focus on their self-downing for being atypical and other condemnation for interfering in their lives. They would also think that social encounters are too difficult and they are too weak to tolerate social contact. Many scholars see schizoid and schizotypal personality disorder as very similar. They share the same basic schema and are loners. The major difference is that patients with schizotypal PD display odd beliefs and behaviors, they present with an unusual appearance or dress considering the norms of their cultural, and they display magical, non-logical thinking. This group can see their bizarre presentation as a strength that will make them special.

The CBT clinical literature on PDs discuss patients as having self-schema that include the patient's inadequacy or undesirable characteristics, or the patients' specialness and entitlement and the responsivity of others for failing to acquiesce to the patients' desires for patients-? However, these theories do not explicitly state that the patient might globally devalue themselves or others for the display of these weaknesses or undesirable traits. Nor do they explicitly identify demandingness that the patient must have desired traits or that others must acquiesce to one's desires. For example, patients with avoidant personality disorder are described as having the thoughts that they are globally socially inadequate and incompetent. Such a conceptualization that one is globally socially inadequate and incompetent remains, in REBT terms, an inference. Although it is rare that a patient could be totally socially inadequate or incompetent, it could be true. The therapist might have the urge to first convince the patient that s/he is not so unskilled or to teach social skills. But the REBT elegant solution would be to hypothesize that the client is correct and help him/her accept themselves even if they are so unskilled.

REBT uses a transdiagnostic approach to treat PDs. It recommends that therapists look for the common IBs associated across each patient's presenting activating events of disturbed emotional experience. The REBT constructs of demandingness, global evaluation of human worth, and frustration intolerance are implicitly embedded if not stated in these other theories. In REBT terms, the schema about the self, others, and the world involve a rigid, irrational, demanding nature. Rigidity, and therefore demandingness, is the hallmark of patients with PDs, and challenging these beliefs and working on increasing acceptance of reality and behaving more flexibly is the most important aspect of REBT with PD patients. Because patients with PDs are rigid, they find change difficult. The IB that comes up the most frequently in PD patients is frustration intolerance (Ellis, 2002). Also, central to treating PD patients is Ellis' (2002) distinction between ego anxiety and discomfort anxiety. PD patients experience change that is slow and difficult. Change is uncomfortable. Challenging the IBs associated with this discomfort anxiety will be crucial to success in this population.

Working on Secondary Disturbance: Another central REBT construct in the second phase of treatment of PDs is secondary disturbance. Here the patients' "C" in the A-B-C becomes a new activating event about which they have irrational beliefs

that cause a new and escalation of more negative emotions about the negative emotion in the first A-B-C (DiGiuseppe, Doyle, Dryden, & Backx, 2014). Many PD patients have difficulty with emotional regulation. They become emotionally upset easily; they stay upset longer and experience more extreme elevations in emotional arousal. That is, such patients are intolerant of their emotional experiences. Therapists can work on helping patients tolerate the more frequent more disturbed and more intense emotions that they might be predisposed to experience. In addition to targeting this secondary upset, patients could develop acceptance of the idea that they do experience more frequent and intense emotions and that they can live with these experiences.

Homework Review. Finally, the third central REBT construct in the second phase of treatment of PDs is the review of homework. This includes analyzing problems that impeded the completion of homework and assigning additional homework that will be next on the gradual hierarchy of assignments. Assigning homework regularly is important. It might be required to teach them the corresponding RBs that support their homework completion. PD patients have a long history of rehearsing their IBs and dysfunctional behavior. Behaving against one's IBs is the best assignment.

Phase Three of Treatment—Working on Longer-Term Problems

The Chronic Disorder Model. Medicine makes the distinction between acute and chronic disorders and subsequently acute versus chronic care. Acute disorders, such as infections, lacerations, and fractures and the flair up of symptoms requires immediate interventions. Chronic diseases such as diabetes, coronary artery disease, or chronic obstructive pulmonary disease require different interventions. The DSM definition of PD clearly views them as chronic disorders and symptoms are likely to reappear. As a consequence, when PD patients have made substantial improvement in their emotional disturbance, we ask them to consider a change in the goals of therapy. We propose exploring how they could maintain their therapeutic gains. We want to teach PD patients to accept that they have a chronic condition and symptoms might return.

Achieving Goodness of Fit. We teach patients the concept of Goodness of Fit (Hipson & Seguin, 2017). This theory acknowledges that every personality trait is functional in some environments, yet dysfunctional in others. Every personality trait has an environmental range that is congenial to the trait, called the goodness of fit. Correspondingly, each trait can provide an activating event when it is non-adaptive in other environments. Consider a person with strong histrionic traits; such patients will be symptom free when they are in an environment where they can pursue social approval, such as a theatre company. However, they are likely to feel distress in a serious, sober workplace where attention seeking is sanctioned, such as the military. A dependent personality will have high goodness of fit in an environment where loving people are helpful and supportive and distressed when they are alone or in an

environment where people are distant or competitive. We want patients to understand and accept this relationship and develop the knowledge of the range of environments that are conducive to their personality and to recognize when they will enter an environment outside their goodness of fit.

Relapse Prevention. Even though PD patients make progress in REBT and do not stay in therapy any longer than other patients do, we noticed that they relapse and return to therapy more often than non-PD patients do. We explore steps to help them become their own therapists and prevent or delay relapse. We recommend teaching patients relapse prevention (RP) (Marlott & Gordon, 1985). RP strategies have a long history in addictions treatment. Those with addictive disorders usually learn to predict with whom, where, and what activities will trigger their desire to use substances.

Using RP, we teach patients to become aware of events that could trigger their IBs and disturbed emotions. Can they predict which IBs they are likely to experience in these activating events? Can they prepare challenges to these IBs ahead of time? Can they construct and rehearse rational coping beliefs before they enter the A? The relapse prevention skills build on the awareness and goodness of fit model and prepare PD patients to better avoid a full relapse into the acute stage of their disturbance.

Research on REBT with Personality Disorder Patients. A search of PsycINFO in January 2018 using the key words of "REBT" and "Personality Disorders" yielded a small number of articles, chapters, and dissertations. These included four cases studies on REBT with PD patients, some book chapters and articles describing the applications of REBT to PDs, some research articles on the nature of the As, Bs and Cs associated with PD patients, one study predicting treatment length of patients with and without PDs, and one study comparing the outcomes of patients with and without PDs. No randomized clinical trials appeared that examined REBT to treat PDs. What does the existing research tell us about REBT and PDs? We will summarize this research based on a review by DiGiuseppe, Ammendola, and Fisher (2019).

Most PD patients who seek treatment at the AEI have high comorbidity of PDs. Patients rarely met the criteria for one PD without meeting another or being within a few points of the cut-off score for another PD. As we like to say, "Personality disorders are like potato chips, you cannot have just one." This high co-morbidity of PD diagnoses is a common finding (Budge, 2015), and has clinical implications. If each PD is associated with a specific schema that captures the beliefs of such patients, patients will not have a single core schema driving their psychopathology. If patients meet criteria for more than one PD, they will likely endorse more than one dysfunctional schema.

The AEI research group divided their patients into three groups: (1) patients with an internalizing PD (which included Avoidant, Borderline, Dependent, Negativistic, Schizoid, and Schizotypal), (2) patients with no PD, and (3) patients with an externalizing PD (which included Histrionic, Antisocial, Narcissistic, and Obsessive Compulsive). Over the course of several years, they administered the MCMI and compared patients in these groups on measures of emotional distress, psychological well-being, IBs, the occurrence of negative activating events, social support, and

assessed some patients' improvement on measures of emotional distress. They found a consistent pattern of results across all these variables for the three groups.

Compared to those patients with no personality disorders and those with externalizing PDs, patients in the Internalized PD group scored in the following manner. (1) They had the highest endorsement of emotional disturbance such as depression, anxiety, and social withdrawal. (2) They had the lowest endorsement on measures of life satisfaction, vitality, and psychological well-being. (3) They had the highest endorsement on measures of irrational beliefs. (4) They reported the lowest endorsement of negative life events in the past six months. (5) They reported having the least social supports and, (6) they showed the least improvement on the measures of emotional distress when they left therapy.

Compared to those patients with no personality disorders and those patients with internalizing PD, patients in the Externalized PD group scored in the following manner: (1) they had the lowest endorsement of emotional disturbance such as depression, anxiety, and social withdrawal, but still scored within the clinical range. (2) They had the highest endorsement on measures of life satisfaction, vitality, and well-being. (3) They had the lowest endorsement on measures of irrational beliefs. (4) They had the highest endorsement of negative life events in the last six months. (5) They reported the most social supports and, (6) they changed the most on measures of depression, anxiety, and social withdrawal when they left therapy. No measure of externalizing disturbance was given and thus we do not know if externalizing symptoms changed.

These results indicate that these two groups of PD patients represent differently and they might require a different focus of treatment. The internalizing PD patients represent a challenge to therapists. Their degree of emotional disturbance is high, which suggests that they have difficulty with emotional regulation. They strongly endorsed irrational beliefs as we have traditionally conceptualized and measured them. However, their lower level negative life events surprised us. One could say they have "Bs" and "Cs" looking for "As." More sessions might be needed with this group to challenge their irrational beliefs and build alternative rational beliefs. Their high endorsement of IBs suggested that they require only weak stressors to trigger their beliefs and emotional disturbance. Their low level of satisfaction and well-being was also unusual. Patients in this group are likely to leave therapy with little positive experiences. Perhaps this situation could make it easier for this group to relapse and return to therapy. This low level of well-being and life satisfaction might occur because these patients might not know how to maneuver the world to attain satisfaction or they may have poorer social skills. Therapists might ask these patients to identify the therapeutic goal of increasing life satisfaction and enjoyment by employing behavioral activation, social skills training, or have existential discussions concerning how to increase meaning in their life.

The patients in the externalizing PD group were not criminals, but came from occupations such as law, entertainment, TV and movie production, real estate, and finance. This group did have emotional disturbance scores in the clinical range even though they were significantly lower than that of the no PD and internalizing PD groups. Their most striking feature was their experience of negative life events before seeking therapy. They were likely to be in therapy because of a job loss, an economic

downturn, a serious illness, the death of a family member, or the end of a romantic relationship. Their activating events caused upset despite their relatively lower endorsement of IBs. Given that these patients did experience emotional disturbance but had relatively low scores on IB measures, we need to reconsider whether we have correctly identified and measured the IBs that drives this group's disturbance.

The question remained whether REBT with PD patients is efficacious and effective. A study by Feldman (2009) addressed whether REBT was less or equally effective with patients with PDs than it was with patients without PDs. She used the archival data from the AEI and sorted the patients into the same three groups that Ellis and colleagues used in previous studies. The AEI at this time administered Lambert's (2007) Outcomes Questionnaire to patients across sessions. Using regression statistics, Feldman used PD group status and session number to predict the OQ scores. First, all three groups improved substantially. The internalized PD group had significantly higher OQ scores representing more disturbance at the start of treatment than those in externalized PD and the no PD groups. The internalized PD group also had significantly higher scores at the end of therapy compared to the other two groups indicating they remained more disturbed than the other two groups at termination. However, the results for the slopes of the change in the OQ scores across sessions were the same for all three groups. Thus, all three groups had the same degree of improvement and improved at approximately the same rate on the outcome measure. This non-experimental, effectiveness study indicated that all three groups improved with REBT. The internalizing PD group started therapy with more disturbance and ended therapy with more disturbance. However, they improved to the same degree as the other groups. These results suggest that REBT can be effective with PD patients.

Finally, the research by Ellis and colleagues mentioned above sensitized us to the problem of patients with externalized PDs. Most measures of disturbance used in clinical practice were designed to assess internalized emotional disturbance such as anxiety and depression. Measures of psychopathology, and those used in these studies, included few items concerning anger, hatred, envy, and other emotions experienced by the externalizing PDs. Psychopathology measures have too few items concerning externalizing dysfunctional behaviors. Thus, our finding that those with externalized PD had lower levels of disturbance is likely in error. Externalizing PD patients had lower levels of internalizing disturbance. Externalizing PDs are not likely to think that they are worthless people or that they need other people's approval. The REBT literature has not focused on the IBs of those with externalizing PDs. We need more clinical descriptions of the IBs associated with externalizing PDs and research to develop scales of externalizing IBs.

Treatment Guidelines from the Empirically-Supported (Non-REBT) Therapy Literature that Inform Best Practice in REBT with Personality Disorders

Which Guidelines Do We Particularly Use and Why

In this section we examine some of the treatments from empirically-based therapy and comment on aspects of those therapies that are similar to REBT or could add to the effectiveness of REBT with PD patients. We examined therapies for PD patients based on the criteria of at least one randomized clinical trial. Using these criteria, we uncovered seven different therapies.

Among the evidence-based approaches, Cognitive Therapy for PDs (CBTpd: Beck et al., 2015) shares the most similarities with REBT. CBTpd closely follows the Cognitive Therapy framework. CBTpd recommends several phases of therapy including (1) engagement to develop a careful assessment of the problems from a developmental perspective, (2) development of alternative cognitions and behaviors, and (3) consolidation of gains that involves reviewing the patients' progress with the aim of consolidating and generalizing learning through homework assignments. CBTpd has influenced our thinking about REBT in PD patients. It has developed a clear description of the content of the schemata associated with each PD, as noted above. These schemata include information about (1) how patients view themselves, others, and the world, (2) how the self, others, and the world should be, and (3) standards to evaluate the self, others, and the world. These schemata include the cognitive processes in REBT's IBs. Reading the items of a measure developed by Aaron and Judy Beck (see, Beck et al., 2015) to assess PD schemata revealed that more than half of these items are worded as demands or as global devaluations of the patient's worth, and thus similar in content to the focus of REBT. CBTpd recommends that therapy focus less on challenging patients' negative automatic thoughts and focus more on challenging the tacit underlying schema, which is the stance of REBT. CBTpd recommends that therapists evaluate their goals, move slowly, and include behavioral and emotive interventions to help PD patients control their unhealthy negative emotions, the need to elicit and modify negative thoughts, and the need to change overdeveloped dysfunctional patterns into more functional behavioral strategies.

Dialectical Behavioral Therapy (DBT: Swales & Heard, 2017) integrates aspects of behavioral therapy, Zen meditation, and a dialectical philosophy that guides the treatment. The originality of DBT is in the emphasis on dialectics, which reflects the need for both acceptance and change. DBT was developed for the treatment of BPD, and quickly applied to other disorders with severe emotional dysregulation. Several aspects of DBT are consistent with and are an integral part of REBT treatment of PDs. The first includes the idea of validation. Many PD patients have experienced extreme trauma. They often believe that therapists' attempt to change their beliefs is an invalidation of their experiences. DBT teaches therapists to recognize and validate the negative experiences but to change how patients react to them. This

aspect of validation is the cornerstone of DBT and most helpful with PD patients. We recommend one validate patients' negative experiences as much as possible. DBT recommends skills training sessions that are separate from, and in addition to, the weekly therapy sessions. Skills building sessions teach patients to do relaxation exercises and to identify and challenge their dysfunctional beliefs. We recommend adding skills training to REBT for PD patients. Finally, DBT recognizes that working with Borderline and other PD patients is stressful and takes a toll on therapists. Attending to countertransference issues is a crucial part of DBT and can benefits all of us.

Schema Focused-Therapy (SFT: Bernstein & Clercx, 2018) focuses primarily on modifying early, persistent, self-defeating patterns of thinking and feeling (early maladaptive schemas), maladaptive coping responses, and transient, maladaptive emotional states (schema modes). SFT maintains that patients construe or create maladaptive schemata based on their early life experience. SFT has detailed descriptions of the content of schemata associated with each PD. A perusal of the Schema Questionnaire revealed that these schemata are often worded as IBs. Thus, overlap exists in these cognitive constructs. SFT attempts to challenge these schemata, which are similar to REBT IBs such as self-worth, demandingness, and frustration intolerance. SFT often challenges patients' schemata by asking them to examine the event that triggered the formation of their schemata. Patients do this first from the perspective of the child who they were at the time, and again from the perspective of an adult. This is a most helpful therapeutic strategy on which we shall elaborate below.

Systems Training for emotion predictability and problem-solving (STEPPS: Blum, St. John, Pfohl, & Black, 2017) is a cognitive-behavioral, skills-based group treatment for adult outpatient patients with BPD. The program is meant to be an adjunctive treatment to individual psychotherapy and medication management. STEPPS takes a psychoeducational perspective and teaches patients to become aware of their disorder and reframe it as emotional intensity disorder (EID). It provides a structured group to teach patients emotional and behavioral management. It identifies and challenges core schemata and teaches social skills and problem solving skills. It teaches patients to use distancing and distraction in addition to challenging to change dysfunctional thoughts. Much like DBT, these skills building groups reinforce the skills and concepts needed to improve patient's symptoms.

Those same principles can be quickly adapted by an REBT practitioner with an additional emphasis on other material (self-help books, videos, and self-help forms) that represent learning tools for both the patient and his or her support system. REBT also emphasizes the importance of patients' responsibility to work hard to get better, and like STEPPS, emphasizes patients' responsibility for responding to their world more efficiently and developing more realistic expectations of their support system.

Several empirically supported treatments of PD do not share much with REBT as these models come from a psychodynamic tradition. However, because they have empirical support, the REBT community might learn and adopt something from these models. Transference-Focused Psychotherapy (TFP: Clarkin, Cain, Lenzenweger, & Levy, 2018) is strongly rooted in contemporary attachment theory. The TFP model

acknowledges the necessity of affect arousal in the sessions to provide a safe opportunity to modify extreme cognitions and related affects in the "hot" and immediate experience of others. The TFP model includes a focus on disturbed interpersonal behaviors both in the patient's current life and in relationship to the therapist. TFP believes human behavior can be understood regarding internal conflicts, beliefs, and experiences with early caregivers, some of which are operating outside of our conscious awareness. These unconscious patterns play out in people's lives, as much as they play out in the relationship with the therapist. Analysis of the transference, examining the patients' emotional reactions to the therapist, is not a routine part of REBT; however, it might have some relevance to psychotherapy with PD patients. We have experienced more emotional reactions to us as therapists while treating PD patients than we do from patients without PDs. PD patients might be angry with the therapist, dependent on the therapist, or fearful of the therapist's disapproval. REBT practitioners can help PD patients understand their relationship with the therapist in the present, make these patterns of behavior conscious, discover how these reactions apply to others in the patients' lives, and examine the schemata behind these behaviors and develop more helpful, rational schemata. REBT differs from TFP in that practitioners of this model would provide interpretation of this information concerning the dysfunctional transference but not challenge the IBs behind them.

Mentalization-Based Therapy (MBT: Bateman, Fonagy, & Campbell, 2018) was developed from a psychodynamic attachment theory for the treatment of BPD patients. Mentalization refers to the mind's capacity to make sense or understand social experiences, develop an understanding of what others and the patient are doing and think in the relationship, understand their attachment to these significant persons, and know how to respond to them. Mentalization includes an awareness of mental states in oneself or other people, particularly when it comes to explaining behaviors. Accordingly, one's failure to perceive and accurately comprehend the meaning of other people's actions and intentions will lead to poor impulse control, an insecure self-identity, and result in disturbance in the PD patient's sense of attachment. Mentalization-based therapy (MBT) involves having patients focus on this normal mentalization experiences and learn to think about their experiences and the models of causation they have constructed about the emotions and behaviors of themselves and others. Through a non-judgmental stance the therapist helps the patient explore which of their thoughts and feelings are more functional and learn to trust and analyse their mentalization processes so they can understand social interactions and plan how to respond to them. This therapy seems similar to George Kelly's psychology of personal constructs, which Ellis and Beck both claimed were a foundation for their work. The task of focusing patients to accurately understand the emotions of themselves and others and plan on how to react to them is an important aspect of REBT with PD patients and something we can do more frequently.

Cognitive Analytical Therapy (CAT: Ryle & Kellett, 2018) integrates psychodynamic and cognitive therapy concepts to produce an active, collaborative, time-limited, and relational treatment. CAT focuses on helping patients identify, describe, and reformulate the dysfunctional psychological processes and how these processes help or hinder patients' understanding of the reciprocal role they play in a relation-

ship. CAT focuses on how patients begin dysfunctional relationships, what processes maintain these relationships, and how they can escape from the dysfunctional relationships, and form more adaptive relationships. REBT definitely includes these elements by helping patients identify how they remain in dysfunctional relationships and develop rational beliefs that allow them to form healthier relationships.

Brief Case Example

Charles was a 34-year-old Caucasian man who sought therapy for his social anxiety. He was happily married with two children and appeared to be an excellent father and husband. Charles' anxiety mostly revolved around his work life. He worked in sales, marketing, and patient contact in the family business. He had been lucky enough to be born into this family with a highly successful business that his dad created. His dad, Sam, was not only successful but was a well-liked superstar in the industry. Sam worked constantly and was admired by many. He had great social skills and joyfully interacted with clients and industry leaders. Sam grasped the science and technology of the business, but his strength was his social, outgoing, extraverted personality. Sam had boundless energy and a limitless desire to socialize and meet people. Charles' job involved meeting with clients about their purchases, orders, and use of the company's products. His job involved a lot of client entertainment, and some cold calls to potential new clients. Charles had extreme anxiety when he interacted with patients, especially when he had to sell them something or contact potential new patientsclients. Charles' MCMI-III scores revealed that he scored extremely high on Avoidant and Dependent PD, with a moderate elevation on Schizoid PD.

Assessment. The initial sessions focused on the assessment of the ABC's associated with his anxiety provoking event. The 'As' in the early sessions revolved around experiencing rejection or disapproval from the patientsclients with whom he interacted. He experienced some social anxiety about socializing with friends and neighbors. However, these events did not lead to as much anxiety as the work-related problems. Significant attention was devoted to the assessment of the nature of his anxiety in terms of discomfort anxiety versus ego anxiety; to the assessment of the dysfunctional degree of his anxiety in terms of frequency ("How many times during the day do you feel anxious?"), intensity ("How powerful is your anxiety?") and duration ("How long does your anxiety attack last?"); to the assessment of the presence of a secondary emotion ("How do you feel about your anxiety attacks?"); to the assessment of behavioral consequences ("What do you usually do when you feel anxious?"); to assess under what circumstances his anxiety increases or decreases; and finally, to the assessment of his anxiety provoking irrational thinking patterns ("Are you aware of the presence of any thoughts when you feel anxious?").

Intervention. We spent more than six months working on the IBs concerning Charles' belief that he must have his dad's approval and he was worthless if he did not receive it. Our sessions turned to challenging the idea that Charles might not meet

Sam's expectations and that his dad would be disappointed with him. Sam frequently made critical comments about Charles' failure to be energetic, social, and forceful enough with patientsclients.

Charles learned that he did not need his father's approval, and he was a worthwhile person even if he was a moderately successful salesperson and performed below Sam's expectations. His job did involve much social contact, and he learned that he could stand the negative healthy emotions of apprehension and disappointment about the disapproval from his patientsclients and his father. As Charles reached his resolution, a new IB emerged: "I should be like my father, and I am worthless because I am not the way he was is." This launched a new phase of therapy focused on self-acceptance. Charles was who he was. He had many strengths. He was not as successful in business as his dad, but he was a much more present and better husband and parent that his dad had ever been. His self-worth was not contingent on anyone's approval. It took some time in therapy for Charles to accept that he would never be his father and he was just as worthwhile a person being who he was. His RB was: "I will always accept myself as a fallible human who will make many errors and mistakes. I am not going to universally evaluate myself, and I can still be happy whether or not I perform well or whether or not I am approved by others."

Just as Charles reached his new rational self-acceptance, the therapist asked Charles if they could spend some sessions talking about how he would work to consolidate his gains and cope with the likely persistent fact that his father would be disappointed with him, and that he would remain in a job where he would work hard challenging his IBs about rejection to maintain non-disturbed negative emotions. Charles agreed that this was important to deal with.

First, we reviewed the structure of his personality based on the tests results and what he revealed in the 18 months of therapy. Charles was not nearly as extraverted as his father and never would be despite the fact that he had tried to be so. He was fearful of social rejection, somewhat dependent, and introverted. We discussed what it would mean if he truly accepted himself. Charles volunteered that he would not pick his present job. To flourish in this job a person needed to be more like his father. Charles commented that he was working hard at just remaining emerged in unpleasant activating events, challenging IBs to experience non-disturbed, adaptive, yet negative emotions. We spent some time discussing whether he could stand living with these negative emotions. He reported that he could stand this discomfort, but in one session asked why. He did not need to do it for money; he did it to please his dad. Charles entertained the idea that he could leave the family business and do something else. We spent 3 months talking about this option. Most of the time was spent discussing his father's disapproval if Charles left the company. He realized that he could stand that. We also discussed how he would think, feel, and act in the future when he saw his father. He would anticipate disapproval by his dad but would not condemn himself.

Charles eventually decided that working for his father was not a good fit for him. Charles could stand his dad's disapproval if he left the company and did something that was more to his liking. We spent time discussing these choices and he chose investing. Charles left the family business and started a one-person investment com-

pany. We maintained contact about once every three months for several years. Charles was relieved not to be working for his dad. He kept in contact with this father and weathered well his father's criticism and disappointments. He liked working alone.

Eventually, he was quite successful at trading stocks and he was a much happier person who still was somewhat avoidant but could interact with people when he needed to and stood the discomfort of the non-disturbed emotions when he did so.

What We Learned About Using REBT with Personality Disorders

Accommodating Individual Differences: Patient Gender, Ethnicity, Socio-economic Status, Intelligence and Other Factors

We have found that individual differences across age, gender, and ethnicity have little influence on the process or outcome of REBT treatment of PD patients. Socio-economic status can make a difference. We encounter many cases of PD patients from high SES families where parents provide financial support to the patients, providing monthly stipends that pay for their rent, food, clothing, and recreations. These patients' rigidity and extreme traits usually impair their ability to work, and they engage in little if any social, occupational, educational, or vocational activities. Because of the parental financial support, these patients have little motivation to change and rarely do as long as the family financially supports them. Family sessions that focus on the parents' IBs that they must protect their child from discomfort and result in parental reinforcement of independent behavior can lead to some success. However, because patients are of legal age, they must approve of family sessions and their frustration intolerance often blocks this.

Low level of intelligence is also a hindrance to patients engaging in REBT, which requires thinking about one's thinking. Behavioral family therapy is recommended for these patients.

The Do's and Don'ts of Using REBT with Personality Disorders

The Do's

1. Utilize formal assessment instruments to develop a case conceptualization and to monitor progress. The results of personality tests and IB scales can assist

therapists in identifying patients' PD diagnoses, their personality styles, and their schemata.
2. Clarify the patients' core underlying beliefs. Therapists can make sure the patients' understand the difference between the three elements of their core schema: the factual (what is), the imperative (what should be), and the evaluative (how they evaluate the people events or effort to cope with their As).
3. Help the client accept their personality and understand and predict which activating events will be in their zone of discomfort and when and where they will encounter such troublesome activating events.
4. Teach relapse prevention. Ensure the patient can challenge the IBs in the negative events they predict will happen.

The Don'ts

1. Do not give into your frustration intolerance and pessimism over treating patients with PDs.
2. Do not underestimate the importance of activating events (As): Patients with PDs are more likely to encounter activating events that trigger their emotional disturbance more than patients without PDs.
3. Do not assume that patients with PDs deal with the same discomfort than patients with non-PDs: Given the pervasiveness of these patients' problems, they will face more discomfort and deal with more events than most other patients.
4. Do not assume that you are going to change patients' personality: As the therapist you cannot change your patients' personality, but you can assist them working in reducing their emotional disturbance.
5. Do not set too high expectation for treatment success. Accept that progress can be slow.

Which Aspects of REBT Deliver the Most Benefit for Change and Which Do not?

Which Aspects of REBT Deliver the Most Benefit for Change?

1. Working towards achieving unconditional self-acceptance (USA) and unconditional other acceptance (UOA) Missing in other CBT treatments of PDs is the idea concerning the global evaluations of human worth about one's personality failings or other people's behaviors, and the corresponding strategy of teaching and encouraging USA and UOA. Could the patient accept his or her self even though they have rigid, extreme personality traits? Could they accept other people even if they find their behaviors unpleasant? REBT would agree that it would be best if patients rid themselves of overly negative views of their self, and could

learn to be more flexible, or if the patient could negotiate others to behave differently. REBT recommends teaching USA and UOA before reflecting on the accuracy of the patient's self-schema.

2. Identify Patients' Personality Traits: Knowing the peripheral personality traits from the above theories provides an advantage to therapists. These theories provide information about what the content of patients' style of behaving and thinking and the schemata that are likely to exist with specific personality traits. Knowing patients' traits helps therapists form hypotheses about what events upset patients, what their emotional themes will be, and what their imperative and evaluative IBs could be.
3. Integrate REBT with useful aspects of others therapies: Of all the PDs, Borderline PD appears to be the most difficult to treat and may require special interventions. DBT has been shown to be a successful intervention, especially for reducing suicidal attempts and hospitalization. DBT does include many similarities with REBT, especially working on discomfort anxiety and secondary emotional problems. DBT recommends a higher dose of interventions and the use of some self-soothing techniques to calm patients' emotions. These aspects of DBT can be easily integrated into REBT.
4. Focusing on the patients' "Behavioral Cs" rather than on their "Emotional Cs": Patients with antisocial PD and other externalizing problems rarely can identify emotions that occur with their symptomatic behavior, nor do they seek emotional change. Mitchel, Tafrate, and Freeman (2015) recommend focusing on the patients' 'behavioral Cs' rather than on their 'emotional C.' They note that the negative automatic thoughts experienced by those with externalizing disturbance differ from patients experiencing anxiety and depression. The literature refers to these thoughts as criminogenic thinking. Because such clients have little insight about or desire to change their emotions, using the traditional 'A–B–C' model of assessment stalls when these patients are asked to identify emotions. Tafrate, Mitchel, and Simourd (2018) recommend an alternative "STD" assessment model. First, they ask patients to recall situation "S" when they experiences urges to commit aggressive, antisocial or self-defeating acts. Then they ask the patients for their thoughts "T" in this situation. Next, they ask the patient to identify the decision to act "D". For native non-English speakers, STD represents the acronym for sexually transmitted disease. We have been surprised at how quickly and easily patients report incriminating IBs concerning how entitled, deserving, justified, or superior they are compared to the person they acted against. This innovation has made working with externalizing PD patients much easier.
5. Set realistic expectations: Ensure that you develop agreement on the goal for each session. Attend to establishing and keeping agreement of the agenda for each session. Keep focused on the agenda and avoid jumping to different topics. PD patients have many problems and want the impossible solution of solving them all at once.

Which Aspects of REBT Don't Deliver the Most Benefit for Change?

1. Minimizing the importance of reviewing patient's early life: ST and CT approaches to treating PDs mentioned above describe the importance of reviewing PD patients' early life experiences concerning the events which they believe formed their underlying schemata. Because REBT advocates avoiding discussions of early life experiences, we were sceptical about this strategy. However, we tried this intervention and were surprised by the results. Patients easily recall the early life experiences that they believe inspired their dysfunctional schema and IBs, usually immediately. Although we cannot know whether these experiences actually happened or whether they were the first events that sparked their IBs, discussing whether their irrational schema was accurate, helpful, or represented reality helped patients develop more rational thoughts about their past and change.
2. Avoiding any examination of memories of the past: Again REBT advocates avoiding talking about memories of the past. PD patients often use memories of their childhood to justify their worthlessness or weak frustration tolerance. Examining such memories from an adult perspective rather than from the child perspective from which they recall them helps patients see that the recalled events are not so overwhelming or threatening as they recall them to be when examined form their present adult perspective. Although we agree that this intervention can be helpful, we do not maintain that it is necessary.
3. Flooding as behavioral homework: REBT has advocated exposure exercises that have patients face their fears by confronting the most feared stimuli first –such as in flooding- rather than use a graduate exposure hierarchy starting from the least fear provoking stimuli up to more intense fear arousing stimuli. Because PD patients usually have such weak frustration and discomfort tolerance and such poor emotion regulation, we have found this aspect of REBT difficult to use. We have found the use of graduate exposure procedures to be more likely tolerated with PD patients.

Summary and Conclusions

This chapter has focused on the principles for treating a category of disorders, PDs, within an REBT framework. PD patients tend to be less aware of their IBs. These patients' thinking patterns fall along one of the four main types of IBs: rigid demands, awfulizing beliefs, frustration intolerance beliefs, and depreciation beliefs, and helps to explain their difficulty in challenging their irrational beliefs and to engage in homework activities. The attempt to understand why patients with PDs tend to resist change has led the authors to focus on the assessment and treatment of their specific PD. Because by definition PDs are a chronic disorder, this chapter focuses on procedures

to reduce the relapse of symptoms. Some empirically supported treatments for PD exist and provide some strategies that are already included in REBT or can be used in addition to REBT.

References

American Psychiatric Association Peripheral Aspect. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: American Psychiatric Publishing.

Bateman, A. W., Fonagy, P., & Campbell, C. (2018). Mentalization-based treatment. In W. J. Livesley & R. Larstone (Eds.), *Handbook of personality disorders: Theory, research, and treatment* (pp. 541–554). New York, NY, USA: Guilford Press.

Beck, A. T. (2015). Theory of personality disorders. In A. T. Beck, D. D. Davis, & A. Freeman (Eds.), *Cognitive therapy of personality disorders* (3rd ed., pp. 19–62). New York, NY: Guilford Press.

Beck, A. T., Davis, D. D., & Freeman, A. (2015). *Cognitive therapy of personality disorders*. In A. T. Beck, D. D. Davis, & A. Freeman (Eds.), 3rd ed. New York, NY: Guilford Press.

Bernstein, D. P., & Clercx, M. (2018). Schema therapy. In W. J. Livesley & R. Larstone (Eds.), *Handbook of personality disorders: Theory, research, and treatment* (pp. 555–570). New York, NY, USA: Guilford Press.

Blum, N. S., St. John, D., Pfohl, B., & Black, D. W. (2017). Overview of STEPPS: History and implementation. In D. W. Black, N. S. Blum, D. W. Black, & N. S. Blum (Eds.), *Systems training for emotional predictability and problem solving for borderline personality disorder: Implementing STEPPS around the globe* (pp. 1–28). New York, NY, USA: Oxford University Press.

Budge, S. L. (2015). The effectiveness of psychotherapeutic treatments for personality disorders: A review and critique of current research practices. *Canadian Psychology/Psychologie Canadienne, 56*(2), 191–196. https://doi.org/10.1037/a0038534.

Clarkin, J. F., Cain, N., Lenzenweger, M. F., & Levy, K. N. (2018). Transference focused psychotherapy. In W. J. Livesley & R. Larstone (Eds.), *Handbook of personality disorders: Theory, research, and treatment* (pp. 571–585). New York, NY, USA: Guilford Press.

David, D., DiGiuseppe, R., Dobrean, A., Păsărelu, C. R., & Balazsi, R. (in press). The measurement of irrationality. In M. E. Bernard & W. Dryden (Eds.), *REBT: Advances in theory, research and practice, promotion*. New York: Springer-Nature.

DiGiuseppe, R., Ammendola, E., & Fisher, A. (2019). *A review of the REBT personality disorders research project*. Manuscript in preparation. The Albert Ellis institute.

DiGiuseppe, R., Doyle, K., Dryden, W., & Backx, W. (2014). *The practitioners guide to rational emotive behavior therapy*. New York: Oxford University Press.

DiGiuseppe, R., Leaf, R., Gorman, B., & Robin, R. (2018). The development of a measure of irrational/ rational beliefs. *Journal of Rational-Emotive and Cognitive-Behavior Therapies, 36*(1), 47–79.

Dryden, W. (2005). Rational emotive behavior therapy. In A. Freeman, M. H. Stone, & D. Martin (Eds.), *Comparative treatments for borderline personality disorder* (pp. 105–132). New York: Springer Publishing Co.

Dryden, W. (2009). *Rational emotive behaviour therapy: Distinctive features*. Routledge.

Ellis, A. (1994). *Reason and emotional in psychotherapy: A comprehensive method of treating human disturbance*. Revised and updated. New York: Birch Lane Press.

Ellis, A. (1999). Treatment of borderline personality disorders with rational emotive behavior therapy (pp. 475–496). In C. R. Cloniger (Eds.), *Personality and psychopathology*. Washington, DC: American Psychiatric Press.

Ellis, A. (2002). *Overcoming resistance: Rational-emotive therapy with difficult patients* (2nd ed.). New York: Springer Publishing.

Ellis, A., Abrams, M., & Abrams, L. (2009). *Personality theories: Critical perspectives*. Sage Publications.

Feldman, S. J. (2009). Relationships between type and number of personality disorders and outcome in rational-emotive behavior therapy. *Dissertation Abstracts International, 69,* 7808.

Hipson, W. E., & Seguin, D. G. (2017). The goodness of fit model. In V. Will-Ziegler & T. E. Schackleford (Eds.), *Encyclopaedia of personality and individual differences*. Basel, Switzerland: Spring International.

Lambert, M. (2007). What we have learned from a decade of research aimed at improving psychotherapy outcome in routine care. *Psychotherapy Research, 17,* 1–14.

Lenzenweger, M. F., Johnson, M. D., & Willett, J. B. (2004). Individual growth curve analysis illuminates stability and change in personality disorder features: The longitudinal study of personality disorders. *Archives of General Psychiatry, 61*, 1015–1024.

Maddi, S. (1996). *Personality theories: A comparative analysis*. Pacific Grove, CA: Brooks/Cole–Cengage Learning.

Marlatt, G. A., & Gordon, J. R. (1985). *Relapse prevention: Maintenance strategies in the treatment of addictive behaviors*. New York: Guilford Press.

Matweychuk, W. J. (1990, September). Personality variables and the prediction of treatment length in Rational-Emotive Therapy. Dissertation Abstracts International. ProQuest Information & Learning.

Millon, T. (2011). *Disorders of personality: Introducing a DSM/ICD spectrum from normal to abnormal* (3rd ed.). Hoboken, NJ: Wiley.

Millon, T., Grossman, S., & Millon, C. (2015). *Millon clinical multiaxial inventory-IV: Manual*. Pearson: New York.

Mitchel, D., Tafrate, R. C., & Freeman, A. (2015). Antisocial personality disorders. In A. T. Beck, D. D. Davis, & A. Freeman (Eds.), *Cognitive therapy of personality disorders* (3rd ed., pp. 346–365). New York: Guilford.

Ryle, A., & Kellett, S. (2018). Cognitive analytic therapy. In W. J. Livesley & R. Larstone (Eds.), *Handbook of personality disorders: Theory, research, and treatment* (pp. 489–511). New York, NY, US: Guilford Press.

Swales, M. A., & Heard, H. L. (2017). *Dialectical behavior therapy, 2nd Edition: The CBT distinctive features series*. Oxon, UK: Routledge.

Tafrate, R. C., Mitchell, D., & Simourd, D. J. (2018). *CBT with justice-involved clients: Interventions for antisocial and self-destructive behaviors*. New York, NY: Guilford Press.

Widiger, T. A., & Sweatt, S. N. (2009). Five-factor model of personality disorder: A proposal for DSM-5. *Annual Review of Clinical Psychology, 5,* 197–220. https://doi.org/10.1146/annurev.clinpsy.032408.153542).

REBT and Psychosis

Peter Trower and Jason Jones

Key REBT Theoretical Concepts in Working with Psychosis

Until comparatively recently, the idea of using REBT or any kind of cognitive psychotherapy for schizophrenia sounded like an oxymoron. The prevailing view in psychiatry and widely in the mental health field, was—and sometimes in routine practice still is—that psychological therapy for schizophrenia was inappropriate, even iatrogenic, in that there was a risk that it might cause as much harm as benefit. Current and more progressive views have shifted to at least emphasise that psychological therapies such as CBT might be useful as an adjunct to medication for controlling or reducing psychotic symptoms, but a recent and influential meta-analysis (Jauhar et al., 2017) argues that CBT has a disappointingly modest effect on symptoms, though the same is the case for antipsychotics, which also have serious side-effects (Morrison, Hutton, Shiers, & Turkington, 2012). One problem is that most research methodology has in our view mistakenly followed a biological rather than a psychological paradigm, placing symptoms rather than emotional and behavioural disturbance as the outcome variables. Within a traditional biological model of mental illness, which is now being strongly re-advocated by one group (Arbuckle, Travis, & Ross, 2017) symptomatology is the appropriate outcome to be

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targeted. But from an REBT perspective, reducing or eliminating symptoms is not the most appropriate target for intervention. On the contrary, it is more important to give priority to helping a person overcome their distress rather than reduce their voices. It is disappointing to have to report, however, that well-designed research based on REBT—in our view one of the most promising and fitting of all the CBT models for the spectrum of psychosis, is conspicuous by its absence. Only two methodologically well-designed randomized controlled trials have been undertaken that contain components of REBT (Trower et al., 2004; Birchwood et al., 2014), and as we show in the section on "The Do's and Dont's", are supportive of an REBT approach for command hallucinations, but these studies were primarily and conceptually CBT and not REBT-based and cannot be considered true tests of the theory, and studies specific to REBT await future research initiatives.

Clash of Paradigms

The clash of paradigms between the biological model and a CBT/REBT-based psychological model can be a difficult experience for the REBT practitioner, who on receiving a referral of a person with a diagnosis of schizophrenia, will feel under pressure in a medically dominated clinical service to work within the biological model, and it can be a struggle to see how to specifically apply REBT or indeed any CBT intervention to a 'disease of the brain'. But it is precisely this problem that the REBT approach can be most helpful. The appropriate targets for psychosis emerge very clearly from the elegant model of the person that Ellis proposed (Ellis, 1994) and is fundamental to REBT theory and practice, and though standing in stark contrast to the purely biological model it is in line with philosophically and empirically more valid and coherent models (Davies & Roache, 2017; Van Oudenhove & Cuypers, 2014). Ellis's model is a particularly valuable guide for both practitioners and clients when working with psychosis because, unlike the biological model, it is designed to bring the clients (and practitioners) back to the realities of what is needed for them (the clients) to return as far as possible to psychological well-being.

Ellis's trans-diagnostic person model is also preferable to the established diagnosis-oriented CBT model developed by Beck and colleagues (Beck, 1976) which targets the same symptoms in diagnostic categories as the medical model, rather than the person as a whole—their goals, inferences, beliefs, emotional and behavioural actions and reactions to other people and life events. The model is a perfect example of Ellis's ability to translate complex psychological processes into a form that has great clarity and simplicity, and which clients can quickly and easily understand and identify with. We will first describe the model, and then show how it can be applied to understanding, assessing and psychologically treating the problem of schizophrenia in its different manifestations.

Ellis's GACBD Model of the Person

This model of the person is based on the letters of the alphabet ABCDEFG though we will be describing the model in the shortened sequence and order GACBD.

G is for Goals, namely that people have goals, values and preferences in life, both short and long term, to thrive, to succeed, to have relationships, or as Ellis would often more colloquially put it, to work, to learn, to mate and have fun. Clients with psychosis *and* mental health professionals working within a medical model typically lose sight of these normal life values and goals and the REBT therapist needs to help bring them back into view or to help develop new ones. In our experience there is often a mismatch between the client's goals and the goals of the clinicians treating that person. Here, REBT can help to prevent therapeutic ruptures by ensuring that goals are shared, rather than imposed. For the REBT practitioner, there are some hidden dangers when working with psychosis, which we will come to later, but might be noted as early in the relationship as the opening discussion about goals for therapy. Some years ago JJ was treating an individual who was an inpatient. On the initial meeting the client revealed a goal to have a brain transplant. They remained persistent in this being their primary goal for some time. Therapy could only progress when some other secondary goals were agreed as initial targets for REBT (namely, anger towards a family member and guilt).

A is for Adversity, namely that people, when pursuing their goals, experience adversities that frustrate or prevent goal achievement or derail goal pursuit. Real negative events are subject to distortion and exaggeration, and are routinely challenged in standard Beckian CBT, but in psychosis these inferences become extreme and take on the illusion of concrete facts, in the form of hallucinations, delusions and other positive and negative symptoms. The REBT approach of focusing on the evaluations of these inferences *before* challenging the inferences themselves, is in our view, a better approach for a number of reasons, including significantly less risk of rupture in the therapeutic alliance.

C is for Consequences, namely that people experience negative emotional consequences as a result of being thwarted from achieving or pursuing their goals. These can be either healthy emotions, which motivate them to behave in ways that help them problem solve and pursue their goals despite the adversities, or unhealthy emotions which deeply disturb and de-motivate them, leading to self-defeating behaviour and failure to achieve or attempting to achieve goals. Such unhealthy negative emotions such as anxiety and depression are now known to be commonly experienced in psychosis (see Trower, 2003 for review), as are self-defeating and dangerous behaviours such as self-harm and obedience to command hallucinations. However, standard CBT approaches that follow a quasi-neuroleptic model approach may fail to target these unhealthy emotions and behaviours but instead target the symptoms, which are not the appropriate direct targets for any cognitive approach (Birchwood & Trower, 2006). REBT is distinctive in having always targeted unhealthy negative emotions and behaviours, and in our view provides the optimal framework for outcome research.

B is for the evaluative Beliefs about the Adversities, and which are the main cause of the emotional Consequences. In other words, people do not simply experience adversities and react emotionally directly to them, but they evaluate those adversities and respond emotionally and behaviourally as a consequence of those evaluations. As REBT practitioners know, rational Beliefs lead to healthy negative emotions and constructive behaviour, but irrational beliefs more likely lead to unhealthy negative emotions and self-defeating behaviour. The dominant beliefs in psychotic episodes are typically irrational, leading to some of the most extreme unhealthy Consequences including dangerous behaviours to self and others. A core feature of a dysfunctional thinking style in psychosis is belief inflexibility, and such inflexibility is the inevitable consequence of the irrational belief system—the rigidity of the demand and the extreme nature of the derivatives. Belief inflexibility leads not only to the very strong level of conviction in delusions, but a failure to consider alternatives. One of the most powerful features of REBT is the elicitation of the client's alternative rational beliefs, which brings these flexible and realistic beliefs into awareness at the *assessment* stage and can gently start a process of belief change *before* the more challenging intervention stage, which greatly facilitates the therapeutic alliance, which is especially crucial and difficult to maintain with clients with psychosis.

D stands for disputing, namely that people can learn to question, challenge and change their own beliefs, particularly when helped by the disputing process, and by imagery work and homework practice. Questioning and disputing is preferably targeted at the Beliefs first, rather than the Adversity inferences, and is particularly appropriate for clients with psychotic experiences, since these clients typically are very resistant to having their delusions and voices challenged, and to do so can lead to rupture in the therapeutic alliance as noted earlier. If disputation of Beliefs is successful moreover, the credibility of the Adversity inferences will be weakened, and therefore more susceptible to being questioned. Another reason for targeting Beliefs first is that this will help to improve the client's self-worth, and this is important because low 'self-esteem' (a concept frequently used in studies) in general and negative thoughts about the self, have been repeatedly shown in research studies to be strongly associated with increased psychotic symptoms.

Key Best-Practice REBT-Based Assessment and Treatment Strategies and Techniques in Working with Psychosis

In our view, the REBT approach as outlined above is highly applicable to and potentially effective for the psychosis spectrum of disorders. However, while strong in theory, it lacks an evidence-base in so far as, to our knowledge, there are currently no sufficiently rigorous outcome studies of pure, elegant REBT, in contrast to the many studies in generic CBT, though a few of these have been influenced by REBT. In this section therefore, we propose our own best-practice assessment and treatment strategies and techniques, drawing on REBT theory as outlined above, our own clini-

cal experience as REBT practitioners, and evidence-based CBT findings which have been modified by REBT theory.

The Syndrome

Despite controversy about whether or not 'schizophrenia' is a single, monolithic disease syndrome, routine diagnostic practice continues to formulate it as such, with associated assumptions as to cause and symptomatic manifestation. Medication is targeted at the symptoms with the aim of controlling or eliminating them, and this neuroleptic treatment model is often inappropriately adopted as the model of choice for CBT as noted earlier. This syndrome level approach would seem to be an unpromising framework for an REBT practitioner, but in fact Ellis's model of the person can be helpful so long as two important conceptual differences are recognised. The first is that, unlike the biological model goal, the REBT goal will not be to eradicate the symptoms and thereby hypothetically the underlying illness, but to help the individual sufferer overcome their emotional disturbance at being afflicted, not just with the symptoms but their negative appraisal of the diagnosis itself. So instead of putting psychotic symptoms at C, as consequences of an underlying causal schizophrenic 'illness' at A, the person model puts the diagnosis and symptoms at A, as an adversity, to which the sufferer responds with emotional disturbance at C. The second important conceptual difference is that the biological model is an A-C model, whereas the person model is an A-B-C model. In other words, in the biological model the hypothetical illness at A directly causes the symptoms and emotional disturbance at C because these are deemed to be a sequelae of the illness, whereas in the REBT model the symptoms and diagnosis at A lead to emotional and behavioural disturbances at C not directly, but through the mediating role of the evaluative beliefs at B. In summary, this approach does not necessarily challenge the validity of the diagnostic syndrome, so arguments about the medical model can be avoided! We take the position that if the client has accepted the diagnosis of schizophrenia, and further believes (IB) from this that they have thereby been stigmatized as a person, we then assess whether they are emotionally and behaviourally disturbed and dysfunctional because of this, and if they are, REBT focuses on firstly helping him identify, challenge and change their IBs about the diagnosis and secondly their inferences about it. Our aim will be to move the client, after ABC assessment and disputing, from the position: 'because I have symptoms I *am* now a schizophrenic and totally stigmatised and worthless', to 'even if I have symptoms and have been diagnosed as having schizophrenia, I am not a worthless schizophrenic but on the contrary, I unconditionally accept myself as a fallible human who has (might have) this illness'. There is a substantial literature on the stigmatising effect of a schizophrenia diagnosis (e.g. Wood, Byrne, Varese, & Morrison, 2016), and REBT offers one of the most effective psychological treatments for this problem in our clinical experience, though research is still needed to demonstrate this empirically.

The Symptoms

Hallucinations

Whether or not a client is emotionally disturbed *because* of the appraisal of their diagnosis, they may well also be emotionally disturbed by one or more of the symptoms *per se,* particularly hallucinations. The REBT person model is equally applicable to this; the symptom level of disturbance as well as the syndrome level in a way that the biological model, and to some extent the Beckian CBT model is not. For example, imagine that a client's presenting symptoms include voices, depression and suicidal ideation. The voices are malevolent, and tell him he is worthless and should kill himself. A biological, syndrome level formulation might infer an underlying schizophrenic illness at A causing the symptoms of voices and depression at C. This is an A-C model, namely A, an activating adverse event (the illness), directly causes C (the voices and affect), and which therefore gives little scope for any mediating variable at B. An REBT formulation, however, would formulate the diagnostic label and symptoms at A, the depression and suicidal tendency at C, but crucially at point B would identify evaluative beliefs *about* the diagnosis and symptoms, out of which comes the depressive consequence C. This is entirely absent from an A-C biological model, and misses the point completely that cognitive appraisal lies at the heart of the disturbance, which should be the main focus of therapy.

The REBT model also uniquely makes clear two types of mediating cognitions, namely inferences and evaluations, both of which are involved at the symptom and syndrome levels (though of course both are also ubiquitous throughout virtually all psychiatric disorders). On the face of it, REBT and Beckian CBT seem similar in that both appear to have a similar ABC rather than AC structure, however, in routine clinical practice Beckian CBT typically only utilises one type of mediating cognition, namely inferences, whereas REBT virtually always utilises both. In the example given earlier of the client with voices and depression, the Beckian formulation might add at B the client's mediating cognitions that the voice has an identity (e.g. the Devil), is malevolent in intent, is omnipotent and omniscient, and cognitive therapy might therefore be aimed at changing or discrediting these thoughts, and indeed research shows this inference-focused approach can be valuable and successful (summarized in Trower, 2003). In an REBT model these cognitions would also be identified, but as we have shown, they would be classed as inferences and grouped under A, and we would also make explicit the client's implicit irrational evaluative beliefs, and group these under B.

These often overlooked irrational Bs are important, not only because they, and not the inferences, are the direct cause of the disturbance at C, but they also have a mediating role in the development of those inferences. The IBs are also responsible for the client's self-depreciation (low self-esteem), low frustration tolerance (otherwise known as experiential avoidance or distress intolerance) and awfulising/catastrophising, all of which are known to have a causal contributory role to play in psychotic symptoms, such as voices and delusions (Freeman & Garety, 2014).

Yet another distinction in REBT which is crucial when working with voices, is that between different types of A, between those As which are actual anomalous experiences, like the physical sensation of the sound of the voice, which are experienced as facts and which we call the Activating events, and those that are the inferences about the actual voice, which we call the Adversity A. The distinction between Activating event and the Adversity inference is often overlooked because from the client's perspective they are both experienced as factual realities. So the client may refer to the physical topographic features of the voice and the identity and malevolence of the voice as equivalent, and the therapist may have to explain and illustrate the difference between a fact (as experienced) and an inference, to help the client make the crucial distinction.

When we come to questioning, challenging and disputing at D, by having carefully distinguished between two types of A and the beliefs at B, we are then able, firstly to challenge the validity of the beliefs at B, both the irrational and rational, in order to weaken the former and strengthen the latter, and secondly to challenge the inferences at Adversity A. Of course we do not challenge the anomalous experience itself, but only its meaning which is given at B and Adversity A. By disputing the irrational Bs at this point, our goal is to help to restore the person's sense of self-worth, reduce intolerance and improve acceptance, and reduce catastrophic and rigid and extreme ways of thinking, all and any of which is designed to help reduce the distress with voices. When successful, disputing (together with rational emotive imagery and homework assignments) will often also result in reduction of or even elimination of actual voice activity, although this is not the main target of the intervention.

Delusions

The REBT person model so far described, and illustrated for hallucinations, is equally applicable to the problem of delusions. Indeed, delusions can be understood in a similar way. While traditional psychiatry regards delusions much as it does hallucinations as symptoms of an illness and therefore best construed in an A-C model, the REBT person model uses a similar ABC formulation as with hallucinations, which opens up innovative therapeutic possibilities. In this formulation, the delusion itself is an Adversity inference A (e.g. that certain others are plotting to harm him), which is negatively (i.e. irrationally) evaluated at B, resulting in an unhealthy negative emotion and self-defeating behaviours such as avoidance at C. However, we do not recommend challenging irrational evaluations about an Adversity inference when the inference is a strongly-held and extremely harm-threatening delusion. For example, a client may express the persecutory delusion 'that evil looking man wants to rape/murder me' plus a demand that that absolutely must not happen, that would be awful and unbearable, with consequent high anxiety. It would obviously be inappropriate and counter-productive at this stage to challenge the irrational beliefs at B about that delusion ('where is the evidence he must not, that it would be awful and unbearable' etc). Instead it is important to explore the inferences that lead to

the formation of such a persecutory delusion. For example, Morrison et al. (2015) showed that clients moved from questionable suspicions about others to concrete delusions about evil others, as they deteriorated from a 'prodromal' pre-psychotic stage to frank psychosis. A substantial body of research shows that a persecutory delusion is likely to develop if the individual has low self-worth, believes they are vulnerable and a 'soft target', considers that they deserve to be harmed or considers other people to be threatening on the basis of previous experience (Freeman, Garety, Kuipers, Fowler, & Bebbington, 2002; Freeman, 2016). By identifying an inference related to low self-esteem, such as rejection and criticism from significant others, utilising a variety of methods such as the 'magic question' method developed by Dryden and adapted for this particular problem (personal communication), the practitioner can then identify and challenge the demands and derivatives at B that lead to low self-worth and consequent vulnerability cognitions. The goal here will be to help the client overcome the vulnerability cognitions, thus weakening the credibility of the delusion, which can then be more successfully challenged.

Negative Symptoms

Compared to positive symptoms, the group of negative symptoms are still relatively neglected with regard to CBT developments. This is regrettable as there is an even greater need, as negative symptoms are arguably more debilitating than positive symptoms—a fact long recognised, and even identified as early as Kraepelin's (1913) original description of them as showing 'destruction of the personality' (cited in Rector, Beck, & Stolar, 2005). Clients with negative symptoms characteristically show little emotional expression (flat affect), thus tend to speak in a monotone, to stare vacantly and appear unresponsive, with brief and 'empty' replies (alogia) and little goal-directed activity (avolition). Although no research from an REBT perspective has been carried out with regard to negative symptoms as far as we are aware, this presentation of social disengagement can be construed as a particularly severe form of self-defeating behaviour at point C (for Consequence) in an ABC formulation, given certain adverse challenges at point A (adversity) triggering irrational beliefs at B. Support for this assertion comes from Rector, Beck, and Stolar (2005), who found that clients commonly endorsed negative attitudes on the Dysfunctional Attitude Scale (DAS) such as 'taking even a small risk is foolish because the loss is likely to be a disaster', 'if I fail partly, it is as bad as being a complete failure', 'if I fail at work, I am a failure as a person' and 'if you cannot do something well, there is no point in doing it at all'. Such attitudes were significantly correlated with symptoms comprising the negative syndrome and were independent of positive symptoms, as measured by the Positive and Negative Syndrome Scale (PANSS). The authors suggest that such attitudes lead to avoidance, apathy and passivity, and that the consequent isolation protects them from the pain of rejection. In REBT terms, we can clearly see a B-C connection here and scope for intervention from an REBT perspective.

Psychosis and the Self

Self-esteem Versus Self-acceptance

A core theme inherent in all aspects of the schizophrenia spectrum that we have so far reviewed is disturbance, to varying degrees, in the experience of 'self', from low 'self-esteem' to more severe and widespread dis-organisation of the self. The concept of self-esteem is one of the most widely used concepts in theory, research and practice in schizophrenia (as well as many other areas of clinical and social psychology). Low self-esteem is commonly identified in a wide range of research studies as at least a major contributory factor to disturbance at the syndrome level (response to the stigmatising diagnosis) or the symptom level, including hallucinations, delusions and negative symptoms, and improvement in self-esteem often seen as one of the goals of psychologically oriented forms of intervention and particularly of standard Beckian CBT. However, a central tenet of REBT has always been that we should abandon the concept of self-esteem. Ellis (2005) is famed for saying that the goal of seeking high self-esteem is a form of disturbance, since it is a form of global self-rating which he rejects because it perversely promotes conditional self-acceptance. The goal of REBT, of course, is to promote quite the opposite, of unconditional self- and other- and world-acceptance. Whereas a standard CBT approach will usually be to challenge the adversity A, which is assumed by both therapist and patient to be the main 'cause' of low self-esteem, the REBT approach will be to cut the conditionality link. This is achieved by identifying, then discrediting and rejecting the demand belief which creates the conditionality ('to be worthwhile I must not fail') and leads to the derivative ('I am a failure because I failed'), and evaluating and accepting the preference (but not demand) belief ('I strongly prefer not to fail but accept I might'). The client can then discover that the adversity A is irrelevant to his worth as a person. For example, instead of 'failing (A) means *I* am a failure (global self-downing IB)', we move to 'failing (A) does not mean *I* am a failure but simply a fallible human failing at this task'. Given the implicit association between failing and the stigmatising label of schizophrenia ('failing proves I am a schizophrenic'), it is then a short step to global self-devaluation via the demand belief ('…I am therefore worthless'). This fundamental ABC format is relevant to most problems in the schizophrenia spectrum. Adversities at A can be voices perceived to be malevolent and all-powerful critics of the client, or persecutory agents plotting to harm the client, or highly critical, hostile and/or over-involved (high EE) family members constantly haranguing the client. Each of these Adversities would likely trigger a global self-devaluing derivative along with the demand, leading to anxiety, depression, avoidance, withdrawal, unhelpful safety behaviours and further cognitive consequences that may in turn become further magnifications of the original Adversity, so completing a self-perpetuating vicious cycle.

One of the consequences at C of the demand and global self-devaluation beliefs at B is the tendency to *in*voluntary action, so in unhealthy anxiety the threat to the whole self is linked with an involuntary escape and/or avoidance tendency, in

depression the devaluation of the whole self is linked with an involuntary action tendency to withdraw and lose motivation, and global other-devaluation can lead to unhealthy anger and involuntary rage behaviour. An explanation for this can be found in social rank theory (Gilbert, 2007). Global self-devaluation is a key feature of perceived low social rank—a consequence of an evolved mechanism that explains dominant-subordinate ranking in humans and indeed all group-living animals. A body of research now shows that subordination in a dominant-subordinate relationship or situation is a common feature of the lives of people with psychosis. Low perceived social rank in people with psychosis is associated with a variety of positive and negative symptoms, depression, anxiety and shame (Wood & Irons, 2016) and associated patterns of involuntary behaviour, particularly submissiveness to the dominant other, whether person or 'voice' or 'persecutor'. REBT is uniquely placed as a treatment, in first unravelling the problem by identifying the dominant other as the Adversity A as outlined above, the demand and self-depreciation beliefs at IB, and the unhealthy emotions and dysfunctional behaviours at C, but then second in overcoming the problem by preferring and negating the demand and generating the self-acceptance belief (rational beliefs at B), and if this is successful in producing healthy negative emotions and voluntary (as opposed to involuntary) approach behaviours such as positive assertion (healthy consequences at C).

The Process of Self-construction

Most self-focused research so far discussed has taken global self-depreciation as the self at threat in a wide spectrum of problems in schizophrenia. The traditional REBT perspective that has most relevance to this approach is that the problem the client has is believing his 'self' is flawed in its essence or at high risk of becoming so, that as a result he is helpless and the situation hopeless, or that recovery from this condition demands herculean efforts to reach some criteria that would make him acceptable to himself and others but which he doubts he can ever reach. This problem can be conceptualised as a block to self-construction. A theory put forward by the first author and developed further by colleagues (Fox & Harrop, 2015; Harrop & Trower, 2003; Trower & Chadwick, 1995) proposes that this is one of a number of blocks to self-construction, and that repeated and continuous failure in self-construction can result in symptoms of psychosis and relapse. Along with other similar theories such as Williams (2009), our theory points to ways to help the client overcome the blocks and restore the process of self-construction and aid recovery from psychosis. Harrop and Trower (2003) demonstrate how REBT can provide a powerful method for this task. The authors provide 21 detailed case studies where the ABC assessment method is used to analyse emotional episodes that resulted in blocks to self-construction and consequent psychotic breakdown. Using mainly REBT-based methods of assessment and intervention, the authors also provide practitioner guidelines for helping psychosis-prone clients, particularly those most at risk at late adolescence and early adulthood.

Treatment Guidelines from the Empirically-Supported Therapy Literature that Inform Best Practice in REBT with Psychosis

In contrast to the paucity of REBT-based research applied to psychosis, there is a large literature of outcome and other studies which have developed and evaluated a variety of psychosocial and CBT interventions for psychosis. In this section we will review a selection from among those best established developments for psychosis that can improve and be improved by REBT best practice in an integrated approach. A good example of one of a number of comprehensive reviews of approaches can be found at Dixon et al. (2009).

Family Intervention

One of the most well-established triggers of relapse in schizophrenia is the expression of hostility, criticism and emotional over-involvement (high expressed emotion (EE)) by family members, and an approach known as Family Intervention or Family Psychoeducation which aims to transform such communications has proved to be one of the most effective for reducing relapse, with a substantial evidence-base (McFarlane, 2016). This approach contains a variety of key components (reviewed by Gracio et al. (2016)), such as behavioural family therapy (BFT; (Falloon, Boyd & McGill, 1984)). This approach uses modelling, role play, rehearsal and discussion to educate and train family members to use positive rather than negative social interaction behaviour with the client. This is designed to change their hostile and critical comments to more affiliative ones, such as listening, showing understanding and caring. A traditional REBT approach in this problem area can be improved by integrating with Family Intervention in general and BFT in particular, by, for example, identifying the parents' unhealthy negative emotion (UNE) such as unhealthy anger at C that gives rise to associated hostile and critical behaviour, and helping the parents to make the transition to healthy negative emotion (HNE) such as healthy anger, by means of rational emotive imagery practice, which will facilitate the switch to more positive, low EE behaviour.

Social Skills Training

Poor social functioning has consistently been recognized as a fundamental feature of schizophrenia. Mueser et al. (1991) for example found that half of a group of patients diagnosed with schizophrenia showed worse social skills than the least skilled members of a group of non-psychiatric controls. There is substantial evidence that social skills training (SST) can produce significant change on proximal measures of social

skill and on social functioning, but mixed or weak on relapse and symptoms (Dixon et al., 2009). Poor social functioning is an area where traditional REBT can be beneficial, but there is likely to be a significant improvement by combining REBT with SST when poor social skills is an issue. For example, REBT can be used to help prepare a person for SST who has become isolated and avoidant due to shame about their poor social skills. The aim is to help a client shift from anxiety to healthy concern, and associated dysfunctional avoidance to functional social approach behaviour.

Cognitive Behaviour Therapy

As previously noted, REBT alone has in our view considerable potential as a psychological intervention for the whole spectrum of psychosis, but there is potential for increased effectiveness if used in conjunction with those other cbt approaches which have been shown to have a moderate effect size in research studies. One area where developments in generic CBT for psychosis have been most creative is at the level of inferences, and this is an area where REBT practitioners who may under-emphasise working with inferences in favour of evaluations, have most to learn. An integrated approach can ensure a greater emphasis on inferences where otherwise these might be neglected. Examples of the power of inference change alone were found in the outcome studies on command hallucinations by Trower et al. (2004), and the follow-up much larger multi-centre RCT on command hallucinations (Birchwood et al., 2014; Meaden et al., 2013) which built on the protocol developed for the first study (Byrne, Birchwood, Trower, & Meaden, 2006). The key inferences associated with command hallucinations (in these studies called the voice power beliefs) are targeted in both studies. Specifically, the inferences are identified about the power of the voice, the identity of the voice and the meaning of the voice. The results showed that there were significant, positive changes in the power beliefs (i.e. reduced power of the voices) and significantly reduced compliance to command hallucinations in the treatment compared to the control group. In our view, this outcome demonstrates that REBT practice can be enhanced by careful and detailed identification of inferences at A, always bearing in mind that their effect on C is mediated by the evaluative beliefs at B to which they are related (see section on The Dos for further discussion about this).

One of the key features of the studies on command hallucinations (Trower et al., 2004; Birchwood et al., 2014) was to use emotion and behaviour as the key outcome measures, and not symptoms. This, of course, adheres to the C in the ABC model, where C is the disturbed emotion and dysfunctional behaviour that is consequent upon the beliefs at B and the inferences at A. These two studies are among the few that have used affect and behaviour as outcome measures rather than symptoms.

Imagery Rescripting

One of the most important stages in any kind of CBT practice is to help the client move from intellectual to emotional insight, and one of the steps for achieving this 'head to gut' shift in REBT is to immediately follow the disputation stage with rational emotive imagery (REI), before then proceeding to behavioural homework assignments. The preferred procedure for REI is to first ask the client to bring to mind the specific adversity and the unhealthy negative emotion at C (e.g. anxiety), then secondly to switch to the corresponding healthy alternative emotion (e.g. healthy concern) without changing the adverse situation at A. The ideal outcome is where the client is able to achieve this change by replacing the irrational beliefs with the rational alternatives at B. When the client struggles to achieve this, by for example, changing the A instead of the B, they can be coached to bring to mind the RBs separately and then together.

A method independently developed in generic CBT with a substantial evidence-base called imagery rescripting is sufficiently similar in format to REI that it has the potential to be adapted to enhance this coaching aspect of REI. One form of imagery rescripting that can be readily adapted (Wheatley & Hackmann, 2011), starts by first asking the client to emotionally 're-experience' a specific adverse episode in detail, focusing specifically on the emotion-invoking imagery and thoughts. Second, the client comes out of the re-experienced episode and is asked to imagine alternative images and thoughts that would significantly reduce their distress. These alternatives are carefully noted for the third stage, when the client re-enters the imagined situation but introduces the alternative images and thoughts, thereby 'rescripting' the episode. An adaptation from an REBT perspective would be to bring together the healthy negative emotion, the rational beliefs, and imagery that these generate, into the REBT second stage. One of the strengths of imagery re-scripting approach is its specific emphasis on imagery rather than verbal content. The imagery constructed might therefore need to include an image of self that shows unconditional acceptance in some tangible, visual way, and/or an image of coping behaviour that would exemplify tolerance and persistence in the face of difficulty. The imagery can be in any combination of the sensory modalities, not just visual. Following this elaboration of an adverse episode, the client could use the rescripted material as preparation to enter the traditional REI second stage, for example by re-entering the Adversity A with a healthy negative emotion, but now better equipped to develop, maintain and follow through a completely rescripted episode. The application of the CBT-based imagery rescripting approach to psychosis shows considerable promise in early outcome studies (e.g. Ison, Medoro, Keen, & Kuipers, 2014) though of course the adaptation and integration with REI suggested here has yet to be evaluated.

Mindfulness-Based Intervention

The first fundamental task for the REBT therapist is to help the psychotic client gain the insight that it is not so much the adversity that is disturbing him, but his evaluation of it. This is no easy task. Typically, the client 'knows' his psychotic experiences are real, that they are awful and intolerable, that they are destroying his sense of self-worth or even his sense of self, and consequently he is deeply disturbed emotionally and behaviourally, and feels helpless to do anything about it. To tell him otherwise risks rejection of the therapy *and* the therapist. The therapist therefore needs great skill and sensitivity to facilitate insight. His task is to use the ABC assessment method to gently try to help the client unravel the dysfunctional emotional episode he is locked into, to uncover his inferential biases at A, to identify his irrational beliefs (IB) and discover the rational alternatives (RB), to get in touch with his unhealthy negative emotion and action impulses and alternative healthy ones (C), and to see clearly the relationship between A, B and C, but then even if this is successful, to avoid slipping right back into the old way of thinking, feeling and behaving. The question is, can mindfulness-based intervention (MBI) help with this process?

The two methods—REBT and MBI—although different in technique, are strikingly parallel and complementary in their emphasis on the importance of identifying subjective sensations, thoughts, feelings and action impulses. Kabat-Zinn, currently the most influential developer of MBI in Western practice, defines mindfulness as "paying attention in a particular way: on purpose, in the present moment and non-judgmentally" (Kabat-Zinn, 1994, page 4). Like REBT, mindfulness is based on the premise that disturbance is not inherent in the events we experience but rather is caused by our subjective appraisal of them. Mindfulness practice enables the client to allow such experiences to enter the mind and to experience them non-judgmentally with an attitude of acceptance, enabling the person to identify without distortion the As, Bs and Cs—the adversity inference, the evaluative reaction and the emotional response. In a qualitative study, Abba, Chadwick, and Stevenson (2008) found that participants with a diagnosis of schizophrenia who had completed a mindfulness-based program, reported being able to decentre from their experiences—'step back from your thoughts and feelings, become more aware of them' as one participant put it. Secondly, participants were able to free themselves from the habitual reaction to experiences, and thirdly they were able to objectively see the experiences as not realities but simply thoughts passing in the mind, and to realise that they did not define the self. Mindful attending also brings clarity, so that the meditator can more easily distinguish between the distorted and the realistic thoughts, which in REBT terms could include distinguishing rigid from flexible thinking, and extreme from relative thinking, which are the hallmarks of irrational and rational beliefs respectively. Finally, many MBI studies show that the mindfulness attitude and disposition is maintained for long periods after completion of the training, so long as minimal practice is continued (Van Gordon, Shonin, & Griffiths, 2015). This should help clients maintain their gains too, and not slip back into a deeply entrenched irrational belief system.

In sum, REBT and MBI are both effective forms of therapy independently of each other but can gain by being used together. For example, the REBT therapist will often find the client has difficulty in identifying his IBs *about* an adversity A (such as a malevolent voice), but even if this is successful, will then have difficulty in decentring from the IBs prior to identifying or recognizing the alternative RBs about the A in question. Having the client practice mindfulness of the adversity event can facilitate not only open awareness of the associated IBs but also the necessary decentring from the IBs and bringing into awareness the preferential RBs. Chadwick (2014) has shown that short periods of 10 min mindfulness practice with frequent gentle guidance works well for people with psychosis. Other creative uses of mindfulness can be explored.

Brief Case Example

Initially, David was reluctant to spend time thinking about his problems from an REBT perspective. However, he was keen to think about the shame he experienced for having been diagnosed with paranoid schizophrenia. For him, the shame meant that he avoided disclosing information about his experiences. David initially found it difficult to pinpoint examples of shame, experiencing anxiety about imagined shaming experiences and more often than not preferring to suppress experiences of shame and not identify them for assessment or further scrutiny. It took a number of sessions before he felt able to identify a specific experience that he could reflect further on, but once he had we were able to identify an ABC and associated intervention for an experience of shame. This helped socialise David to the model.

David and the Prophet

Once a trusting therapeutic relationship had been established and initial work had been undertaken (as above), David began to speak more about his relationship with the "Prophet". Like many people's experiences of hearing voices, the Prophet was initially experienced as a benevolent and caring entity that sought to support David's mission as he understood it (to bring "Old World" justice). Therefore, David had experienced a voice from no obvious source that advised him about the intentions of others and reassured him about his intentions for the future. However, over time, as David resisted the "suggestions" (or commands) issued by the voice, the Prophet began to be more commanding and critical. David felt anxious about and angry with the Prophet simultaneously leading him to be paralysed in terms of determining a course of action that might be helpful. He began arguing with the Prophet and not only when he was alone. As such he noticed others staring at him and also felt a sense of shame for his behaviours associated with the voice. At the time of the therapy, David was most concerned about his experience of anxiety associated with the voice.

David found it rather easy to identify a specific example of anxiety, as he experienced this every session, terrified that by talking to the therapist about his experience of hearing voices, the Prophet would speak. Box 1 summarises the ABC assessment of the example he identified.

Box 1. David's ABC formulation of his experience of anxiety about hearing the voice of the Prophet

Situational A Talking to my therapist about the Prophet **Adversity A** He will know we are talking about him, be monitoring it and this will excite him to make commandments and I don't know what he will want me to do and how I will react	
Irrational Beliefs I don't want to listen to the Prophet nor do as he says but I really (absolutely) should (ought) If I don't listen and obey, it will be awful and unbearable	**Rational Beliefs** I don't want to listen to the Prophet nor do as he says, and I don't have to do as he wants If I don't listen and obey it may feel very bad and frightening, but that is not awful (it is better than doing as he says) If I don't listen and obey it may feel difficult to bear, but I can bear resisting and it is definitely worth it as I stay in control
Consequences *Unhealthy Negative Emotion*: Anxiety *Action Tendency/Behaviour*: Avoidance/safety behaviours *Cognitive inclination*: I am not strong enough and Prophet is all powerful	**Consequences** *Healthy Negative Emotion*: Concern *Action Tendency/Behaviour*: Take a risk to try to seek help, a problem shared with people who understand is help *Cognitive inclination*: I can speak about this I can risk agitating the Prophet

We have found that in anxiety about voices the REBT disputation process is particularly straightforward and follows the core process for disputation of anxiety. We find this means that even beginning therapists can tackle complex issues such as voice hearing with relative ease. As always with anxiety, the key is keeping the emotion in the room and not indulging the urge to intellectualise.

David and Them

David's experience of the other, from childhood through to paranoia, was always difficult for him. He anticipates criticism and rejection in novel relationships and from strangers, and cannot see why the other might harbour any fondness for him. Even during the course of REBT therapy, the bond with his therapist was repeatedly tested and rejected (David rejects in anticipation of the hostile stance of the other). The key to this was to acknowledge the interpersonal differences (helped by the REBT emphasis on authenticity and genuineness) and the offer of philosophic empathy

about his distress. Because of the focus on emotions, in the same way we REBT therapists work with anyone, David commented that the therapeutic process and the underpinning therapeutic relationship was powerful, important and meant that he could take risks with another that he might otherwise have avoided.

In describing his dominant emotional response to the experience of hostility from others, David prioritized work on anxiety and anger. From the discussion it was evident that his immediate response to thinking that others were feeling hostile towards him was anger, which he then suppressed (for moral, i.e. guilt avoidance purposes; and anxiety, fearful that he could not overcome their threat if he revealed his anger). Box 2 describes the ABC formulation of his experience of anger towards others based on a paranoid (deluded) inference.

Box 2. ABC formulation of David's anger with Them

<table>
<tr><td colspan="2">Situational A
Noticing the new patient on the ward look at me as I walk past
Adversity A
He is one of them, he wants to attack me, to destroy me because he thinks I am beneath him (prey)</td></tr>
<tr><td>Irrational Beliefs
I really want people to be respectful towards me (not view me as prey) and therefore they have to be;
When they are not I cannot stand it and it proves that they are one of them (an evil predator = they are bad)</td><td>Rational Beliefs
I really want people to be respectful towards me, but they do not have to respect me
Even if they don't do as I want, I can bear it and it is worth tolerating the discomfort associated with this as it makes me stronger
That someone does not respect (if indeed they do not) then that proves nothing about them as a person, rather they remain a fallible human being capable of acting respectfully, disrespectfully and in whole heap of other ways</td></tr>
<tr><td>Consequences
Unhealthy Negative Emotion: Anger
Action Tendency/Behaviour: Suppress anger, avoid the other, remain vigilant and wary
Cognitive inclination: Everything about them shows they hate me</td><td>Consequences
Healthy Negative Emotion: Healthy Anger
Action Tendency/Behaviour: Courage to face the problem, get to know the other, or choose to let the issue go
Cognitive inclination: This life is hard enough without making more enemies (real or otherwise)</td></tr>
</table>

It was clear from the ABC formulation that David's anger was far-ranging and his tendency to suppress his feelings was also associated with a meta-emotional problem of shame (for having angry feelings). Therefore, although he was already familiar with the model the therapist had to be careful to continue to socialise David to the REBT process once more. In so doing, David could be helped to see the relevance of disputing the beliefs associated with his anger. This meant spending more time on the iB-C and rB-C connections than might be seen in ordinary practice, but was essential to enable David to have the psychological will to dispute his beliefs and seek

to change his emotional state. This process took repetition and encouragement, with the therapist being aware of the potentially 'protective' role his unhealthy responses were maintaining (by isolating ourselves we naturally reduce adversities associated with interpersonal problems).

What We Have Learned About Using REBT with Psychosis

Individual Differences

In our experience, we have not found significant differences in the application or effectiveness of REBT with regard to gender, ethnicity, or sexuality. The most striking set of individual differences relates more to personal morality. We have encountered distinct themes of ought-preferences (and so ought-demands) which we have formulated is an overlooked distinction in REBT (Trower & Jones, 2015). In short, we proposed in 2015 that despite the traditional vernacular in REBT, there is a clear distinction between a want-preference (and therefore a want-demand) and an ought-preference (and in turn an ought-demand). We argued that such a distinction enables REBT to more elegantly formulate problems where the key issue is a moral (or at least perceived to be) problem. In psychosis, we can evidently review cases of individuals who believed in a deity who might then experience the perceived voice of the deity commanding them to act in ways that they do not want to act. In such an instance it would be understandable for a person to believe they *ought* to (but not have to) obey the voice and at times experience distress when they convert the ought-preference into an ought-demand. Formulating these beliefs as *want*-preferences and *want*-demands makes little sense theoretically or to the individual.

This approach, of distinguishing between the ought-preference and the want-preference (and the associated demands), is of significant benefit in psychosis as it allows the individual to uphold their personal morality at times of significant confusion and internal challenge. Curiously, the same dilemma also occurs in shame and guilt (and anxiety about shame and guilt) and so we find that we return to the issue a number of times in working with people.

The Do's and Dont's

The Do's

People with a diagnosis of schizophrenia are not only demoralised and shamed by their diagnosis, but believe they are therefore victims of a disease process which they are powerless to do anything about. A theme that the REBT therapist needs to consistently adhere to is a normalising attitude to the problem, that they are ordinary

human beings capable of overcoming the problem. The therapist loses no opportunity to reframe diagnostic concepts into normal language concepts of perceiving, thinking, feeling and acting.

The reader who is familiar with the literature mentioned earlier on command hallucinations will note that in our case example we intentionally deviated from the suggested protocols for the assessment and treatment of voices. In the standard Beckian treatment literature, much is made of the importance of identifying the omnipotence and malevolence of the voice and encouraging the client to challenge these thoughts. Although we agree that identifying these inferences is necessary, it is not sufficient, and neglecting the evaluative beliefs about these inferences is a mistake, and certainly not in keeping with elegant and specific REBT. To be specific, judgments about omnipotence and malevolence (or impotence and benevolence) need to be clearly identified as nothing more than inferences, but then any associated evaluations (especially demands about the inferences) need to be looked for and made explicit. For example, a client's thinking may have evaluative (demanding) elements (e.g. we "must" comply with an all-powerful entity) but these are not necessarily explicit and may escape notice unless looked for. Any inference backed by a demand will prove very difficult to challenge and change unless the demand is drawn out and disputed. We have also found that clients rarely actually disturb themselves about the perceived omnipotence. Rather, in REBT terms we would consider this to be a cognitive consequence and, therefore, such beliefs will be experienced (at least initially) as immutable felt-truths that little genuine change will result from an analysis of their empirical truth. Therefore, we remain true to the REBT approach and help the client to move from a position of self-defeating distress (anxiety in the example for David) to feeling like they have more response choices (as comes from healthy concern).

One feature we have noticed in our clinical practice with people with psychosis and something we believe is often overlooked within the general literature is the importance of persistence. The people we have worked with who experience psychosis, commonly find it very difficult to develop a sense of trust and they might remain anxious about being forthcoming. Perhaps, therefore unusually for REBT (at least within the general literature) we do sustain a prolonged emphasis on developing a therapeutic relationship, where here and now processes can be attended to. In our experience, this takes time, should not be rushed, and requires persistence.

The Don'ts

Firstly, and in terms of priority, one of the top to be avoided with this client group is to try to challenge positive symptoms head-on. From the clients' point of view, the voices and the delusions are not strongly held inferences but concrete realities, and trying to challenge these directly and too early as 'merely thoughts in the head' will nearly always fail. We agree with the research that suggests positive symptoms often do serve a defensive function, and clients will be highly motivated to hang on to positive symptoms, especially when they are directly challenged by a therapist

who is supposedly there to help and support them. REBT has the advantage over other types of CBT in that disputing the irrational (and rational) evaluations and not the inferences avoids this problem, as the perceived reality of the voice is not being questioned at this point, and successful weakening of IBs will render the inferences more amenable to Socratic questioning.

Secondly, as noted earlier, more generic formulations of psychosis (e.g. CBTp) suffer from a lack of specificity, but this is also an area where even the most skilled REBT practitioners can fall short.

In general REBT practice, specificity is the key to accurate assessment and treatment. Take a typical example of a client defined problem of anger. In assessing this, one might find that the client (when feeling angry) quickly wants to introduce other examples of times they have felt anger about the same person or experience, almost citing their evidence for their defense or justification of their angry feelings. In simply discussing their problem, the client has introduced a variety of adversities and different experiences of anger. Without further work on specificity the process will become more generalised and less well-informed about the specific demand creating the unhealthy anger at that moment. In our experience as educators of REBT practice we have come to the view that this remains one of the most overlooked components of REBT practice. Even using a two-column form we have witnessed experienced practitioners including multiple emotional problems under Consequences, about which there will be multiple driving demands. This process error creates a particularly challenging set of circumstances when working with psychosis.

People with psychosis might resist the candid declaration of their specific experiences (such as hearing voices or experiencing delusional beliefs) because they experience a sense of anxiety that others will judge the, or that they will sound like they make no sense, or that they will have their vulnerability revealed. They also may be experiencing confusion about their experiences of reality because of their experiences of psychosis. Consequently, it is of utmost importance for the therapist to guide the client to work on specific and not general examples. Consider the difference between the following:

a. My brother does not like me and I don't like him. I suspect he is against me and wants to harm me
b. When my brother came into my room without knocking yesterday, he looked angry and was not friendly towards me. I suspect this is because he is against me and wants to harm me. I had been thinking about that just before he came to the door.

Both are ways of defining the A, but the second is more specific and therefore more likely to yield a useful formulation for intervention.

Which Aspects of REBT Deliver the Most Benefit and Which Don't

Aspects that Do Deliver Benefit

There are no specific aspects of REBT that stand out as delivering the most benefit for all clients with psychosis that we have treated, as the individual differences between clients is considerable. The diagnostic category and the formal listing of symptoms gives an impression of uniformity that does not reflect the reality. Our rule of thumb is always to design the therapy for the individual rather than try to rigorously apply a manualized version of REBT to everyone.

Aspects that Don't Deliver Benefit

There is one aspect that perhaps a majority of clients with a diagnosis of schizophrenia share, which is that they are exceptionally difficult to 'engage' in any kind of therapy. A greater proportion of time than in most other client groups needs to be spent on building the therapeutic alliance, and two aspects of this that needs emphasising is showing clients that the therapist genuinely understands the problem from *their* point of view, and that the aim of therapy is to help them achieve *their* goals. These two points should be obvious but in our experience are often overlooked by novice REBT therapists. REBT is seen as, and is often practiced as, a rapidly progressing form of therapy, but this approach is usually unhelpful with this client group. Having established the problems and goals from the clients' viewpoints, care always needs to ensure the client understands and embraces with some conviction every step in the assessment and intervention process. Failure to patiently follow this rigorous and often slow-paced methodical consultation process at any point risks rupturing the fragile alliance and the clients dropping out.

Conclusion

The bad news is that there is a paucity of REBT-driven research into the application of REBT to the problems of psychosis, so its potential is largely speculative and untested, and we lack a direct evidence base for practitioner-recommended interventions such as outlined in this chapter. The good news is that in our view REBT is an approach that does have an enormous and unique potential to break new ground with this spectrum of problems, which remain resistant to treatments of any kind. Not only does REBT have unique intervention methods, as discussed earlier, but the model generates a methodology for research which is more powerful and relevant than methodologies more commonly employed. Indeed one of the reasons why

CBT for psychosis outcome research continues to get disappointing result is that the methodology is inappropriate, focusing on the reduction of psychotic symptoms rather than emotional and behavioural problems. The REBT model not only specifies disturbed emotions and dysfunctional behaviour as the outcome (C in the ABC model), but specifies the exact process of change, which is a requirement of valid scientific methodology.

References

Abba, N., Chadwick, P., & Stevenson, C. (2008). Responding mindfully to psychosis: A grounded theory analysis. *Psychotherapy Research, 8,* 77–87.

Arbuckle, M. R., Travis, M. J., & Ross, D. A. (2017). Integrating a neuroscience perspective into clinical psychiatry today. *JAMA Psychiatry, 74,* 313–314.

Beck, A. T. (1976). *Cognitive therapy and the emotional disorders*. New York: International Universities Press.

Birchwood, M., Michail, M., Meaden, A., Tarrier, N., Lewis, S., Wykes, T., et al. (2014). (COMMAND): A randomised controlled trial. *Lancet Psychiatry, 1,* 23–33.

Birchwood, M., & Trower, P. (2006). The future of cognitive-behavioural therapy for psychosis: Not a quasi-neuroleptic. *British Journal of Psychiatry, 188*, 107–108.

Byrne, S., Birchwood, M., Trower, P., & Meaden, A. (2006). *A casebook of cognitive behaviour therapy for command hallucinations. A social rank theory approach*. London and New York: Routledge.

Chadwick, P. (2014). Mindfulness for psychosis. *British Journal of Psychiatry, 204*(333), 334.

Davies, W., & Roache, R. (2017). Reassessing biopsychosocial psychiatry. *British Journal of Psychiatry, 210*, 3–5.

Dixon, L. B., Dickerson, F., Bellack, A. S., Bennett, M., Dickinson, D., Goldberg, R. W., et al. (2009). The 2009 schizophrenia PORT psychosocial treatment recommendations and summary statements. *Schizophrenia Bulletin*, *36*, 48–70.

Ellis, A. (1994). *Reason and emotion in psychotherapy: A comprehensive method of treating human disturbances, revised and updated*. New York: Birch Lane Press.

Ellis, A. (2005). *The myth of self esteem*. New York: Prometheus Books.

Falloon, I. R., Boyd, J. L., & McGill, C. W. (1984). *Family care of schizophrenia*. New York: TheGuilford Press.

Fox, A., & Harrop, C. (2015). Enhancing social participation and recovery through a cognitive developmental approach. In A. Meaden & A. Fox (Eds.), *Innovations in psychosocial interventions for psychosis* (pp. 129–146). London: Routledge.

Freeman, D. (2016). Persecutory delusions: A cognitive perspective on understanding and treatment. *Lancet Psychiatry, 3,* 685–692.

Freeman, D., & Garety, P. (2014). Advances in understanding and treating persecutory delusions: A review. *Social Psychiatry and Psychiatric Epidemiology, 49,* 1179–1189.

Freeman, D., Garety, P., Kuipers, E., Fowler, D., & Bebbington, P. (2002). A cognitive model of persecutory delusions. *The British Journal of Clinical Psychology, 41,* 331–347.

Gilbert, P. (2007). *Psychotherapy and counselling for depression* (3rd ed.). London: Sage.

Gracio, J., Goncalves-Pereira, M., & Leff, J. (2016). Key elements of a family intervention for schizophrenia: A qualitative analysis of an RCT. *Family Process*, *55*, 79–90.

Harrop, C., & Trower, P. (2003). *Why does schizophrenia develop at Late Adolescence*? Chichester, West Sussex: Wiley.

Ison, R., Medoro, L., Keen, N., & Kuipers, E. (2014). The use of rescripting imagery for people with psychosis who hear voices. *Behavioural and Cognitive Psychotherapy, 42,* 129–142.

Jauhar, S., McKenna, P. J., Radua, J., Fung, E., Salvador, R., & Laws, K. R. (2017). Cognitive–behavioural therapy for the symptoms of schizophrenia: systematic review and meta-analysis with examination of potential bias. *British Journal of Psychiatry, 204,* 20–29.

Kabat-Zinn, J. (1994). *Mindfulness meditation in everyday life*. New York: Hyperion.

Kraepelin, E. (1913). *"Dementia praecox". Barclay RM, translator (1919). Psychiatrica* (8th ed.). Melbourne (FL): Robert E Krieger.

McFarlane, W. R. (2016). Family interventions for schizophrenia and thepsychoses: A review. *Family Process*, *55*, 460–482.

Meaden, A., Keen, N., Aston, R., Barton, K., & Bucci, S. (2013). *Cognitive therapy for command hallucinations: An advanced practical companion*. New York: Routledge.

Morrison, A. P., Hutton, P., Shiers, D., & Turkington, D. (2012). Antipsychotics: Is it time to introduce patient choice? *British Journal of Psychiatry, 201,* 83–84.

Morrison, A. P., Shryane, N., Fowler, D., Birchwood, M., Gumley, A. I., Taylor, H. E., et al. (2015). Negative cognition, affect, metacognition and dimensions of paranoia in people at ultra-high risk of psychosis: A multi-level modelling analysis. *Psychological Medicine, 45,* 2675–2684.

Mueser, K. T., Bellack, A. S., Douglas, M. S., & Morrison, R. L. (1991). Prevalence and stability of social skill deficits in schizophrenia. *Schizophrenia Research*, *5*, 167–176.

Rector, N. A., Beck, A. T., & Stolar, N. (2005). The negative symptoms of schizophrenia: A cognitive perspective. *Canadian Journal of Psychiatry, 50,* 247–257.

Trower, P. (2003). Theoretical developments in REBT as applied to schizophrenia. In W. Dryden (Ed.), *Rational emotive behaviour therapy: Theoretical developments*. Brunner-Routledge: Hove, East Sussex.

Trower, P., & Chadwick, P. D. J. (1995). Pathways to defense of the self: A theory of two types of paranoia. *Clinical Psychology: Science and Practice, 2,* 263–276.

Trower, P., Birchwood, M., Meaden, A., Byrne, S., Nelson, A., & Ross, K. (2004). Cognitive therapy for command hallucinations: A randomised controlled trial. *British Journal of Psychiatry, 184,* 312–320.

Trower, P., & Jones, J. (2015). Demanded wants and oughts: An overlooked distinction in REBT? *Journal of Rational-Emotive and Cognitive-Behavioral Therapy, 33,* 95–113.

Van Gordon, W., Shonin, E., & Griffiths, M. D. (2015). Mindfulness in mental health: A critical reflection. *Journal of Psychology, Neuropsychiatric Disorders and Brain Stimulation, 1,* 1–5.

Van Oudenhove, L., & Cuypers, S. (2014). The relevance of the philosophical 'mind-body problem' for the status of psychosomatic medicine: A conceptual analysis of the biopsychosocial model. *Medicine, Health Care and Philosophy, 17,* 201–213.

Wheatley, J., & Hackmann, A. (2011). Using imagery rescripting to treat major depression: Theory and practice. *Cognitive and Behavioral Practice, 18,* 444–453.

Wood, L., Byrne, R., Varese, F., & Morrison, A. P. (2016). Psychosocial interventions for internalised stigma in people with a schizophrenia-spectrum diagnosis: A systematic narrative synthesis and meta-analysis. *Schizophrenia Research, 176,* 291–303.

Wood, L., & Irons, C. (2016). Exploring the associations between social rank and external shame with experiences of psychosis. *Behavioural and Cognitive Psychotherapy, 44,* 527–538.

Part II
REBT with Diverse Populations

REBT with Children and Adolescents

Ann Vernon

From its inception, Albert Ellis pioneered the application of REBT with children and adolescents, stressing, in particular, the importance of teaching young clients positive mental health concepts that would promote their social, emotional, behavioral, and cognitive development. Although REBT has been practiced very successfully with young clients, one of the misconceptions is that it is simply a "downward extension of REBT adult methods" (Ellis & Bernard, 2006, p. xi). In fact, there are numerous specific techniques that have been adapted to complement the developmental levels of children and adolescents, helping them learn REBT concepts in their "own language" through unique approaches that enable them to apply the basic theoretical principles to address typical developmental challenges as well as more serious problems.

There are compelling reasons why REBT is especially appropriate for this population. First, it is generally a briefer form of counseling, which is very effective with young clients whose sense of time is more immediate. Consequently, the problems they present with today might not be problematic next week, which is why it is so important to help them in the "here and now." Second, this theory takes into account the developmental level of the client. DiGiuseppe and Bernard (2006), as well as Vernon (2009a), all stressed the importance of using concrete examples which are more developmentally appropriate, involving young clients in "doing" and "seeing" as much as "hearing" (DiGiuseppe & Bernard, 2006, p. 88). Third, children and many adolescents are still very concrete thinkers, which can become problematic in that their capacity for logical problem solving is limited. REBT promotes the use of specific techniques that help young clients distinguish between facts and assumptions, identify irrational beliefs, and learn perspective-taking in order to facilitate more effective problem solving. In addition, this theory and its therapy teaches young people what they realistically can and cannot change in their lives. Given the high

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preponderance of dysfunctional families, abuse, violence, bullying, and the increasing challenges in this contemporary society that negatively affect youth, learning how to control their thoughts, feelings, and behaviors can empower young clients to deal more effectively with problematic events and issues.

REBT has been shown to be highly effective with youth for a variety of presenting problems such as: anxiety and phobia (Silverman, Pine, & Viswesvaran, 2008), obsessive-compulsive disorder (Barrett, Farrell, Pina, Perls, & Piacentini, 2008), trauma (Cohen, Mannarino, & Murray, 2011), social phobia (Crawley, Beidas, Benjamin, Martin, & Kendall, 2008), depression (Vernon, 2006c), aggression (DiGiuseppe & Kelter, 2006), eating disorders (Phillips & Rogers, 2011) and ADHD (Doyle & Terjesen, 2006). For all of these more serious psychological problems, REBT has proven to be "best practice," and in addition, it is also widely regarded as a highly effective preventive approach in schools (Bernard, Ellis, & Terjesen, 2006; Vernon, 2009b).

Several scholars and practitioners have contributed to the REBT literature as it applies specifically to children and adolescents. Knaus (1974) developed a curriculum that teaches children the ABC's of REBT. Bedford (1974) wrote a short story emphasizing the connection between thinking, feeling, and behaving, and Waters (1979) created a coloring book that incorporates rational principles. Bernard and Joyce published a book in 1984 on REBT treatment strategies and preventative methods with children and adolescents, and in 2006 Ellis and Bernard and contributing authors wrote a comprehensive text on REBT approaches to childhood disorders. In addition, other curricula (Bernard, 2001, 2005; Vernon, 2006a, 2006b) have been written that teach children to develop critical thinking skills, differentiate between facts and assumptions, identify irrational beliefs and distorted cognitions, distinguish between healthy and unhealthy emotions, identify what causes emotional upset, and develop various ways to challenge irrational beliefs.

The purpose of this chapter is to describe specific applications of REBT with children and adolescents, including core theoretical concepts, assessment and treatment strategies, and treatment guidelines. A case example will illustrate the process of this theory, which has been proven to be highly effective with this population because it has a preventative emphasis and promotes skill acquisition. Not only does REBT teach young clients how to *think* better, which helps them *feel* better and also *get* better, but it can be readily adapted to children of most ages, cultural backgrounds, and intelligence levels.

Key REBT Theoretical Concepts When Working with Children and Adolescents

One of the distinguishing features of REBT as it applies to children and adolescents is the emphasis on teaching and prevention. Knaus (1974) described REBT as a therapeutic approach "by which children can be taught sane mental health concepts and

the skills to use these concepts" (p. 1), and Wilde (1992) emphasized the importance of "arming" young clients with knowledge and skills to use in the present as well as in the future. The basic core concepts that characterize REBT can be readily adapted so that young clients can comprehend the essence of the theory. Specifically, it is critical to orient children and adolescents to the following.

Emotional and Behavioral Problems Result from Irrational Beliefs

It is important to teach young clients that emotional and behavioral problems result from irrational beliefs about the event, not the event itself. This concept can be difficult for adults to grasp, which makes it imperative that it be presented to children and adolescents in a very concrete manner, personalizing it so it will be clear and relevant. For example, if I were working with a 9-year-old who had a sibling, I would ask him if he and his sister always feel *exactly* the same way when their parents won't let them do something that they really want to do. If he says yes, then I might ask: "So suppose you both want to watch a special TV show…what do you *do* when you dad says no?" "And does your sister act *exactly* the same as you do?" Depending on the developmental capability of the young client, it might be necessary to "come in the back door," so to speak, by asking about the behavior, which he or she can often relate to more readily than the emotion, and then have a discussion about how the behavior relates to the feeling. In other words, if the client threw a fit and his sister just shut herself in her room, he was probably angry and she might have just been annoyed or disappointed, which can be explained to the client, asking him if he indeed felt angry, or was there a different emotion? This concept could also be conveyed by using a brief example: "Suppose there are two cousins who are going to an amusement park. Their parents buy them tickets for the roller coaster. One of the cousins is jumping up and down because she is so excited. The other throws up because he is so scared. It is the very same situation—a roller coaster ride, but why are these two cousins feeling differently about it?" Generally with young clients this concept needs to be explained in multiple ways over time in order for them to clearly understand the connection between what they think, feel, and behave.

When Thoughts Change, Feelings Change

The notion that feelings can change when thoughts change is especially significant for young clients who in reality have little control over some of the events in their lives. As previously noted, they have no control over their parents who may decide to get a divorce, and they don't get to choose a stepparent or decide if the family is moving to another city or country. Therefore, helping them understand that while

they might not be able to change the event, they can change how they feel about it can have an important impact. This concept can be illustrated to an adolescent by an example such as the following: "Suppose you are at the shopping mall and your best friend suddenly grabs your arm and pulls you out of the main walkway into a narrow corridor. You get angry and tell her to stop pushing you around and are just about ready to push her back when she whispers that she saw a person with a gun coming out of the food court. Once you have that information, would you still feel angry or would you feel something different?" Reinforce this concept with other examples so that they clearly understand the concept.

Two Kinds of Beliefs

As Ellis (1962, 1994) has proposed, there are two kinds of beliefs: rational and irrational. This terminology can be confusing for younger clients, so terms such as "sensible and insensible" or "hot thoughts and cool thoughts" are more effective. The distinction between these two types of beliefs can be taught to young clients in several developmentally-appropriate ways such as through games, music, or stories. For example, in working with an 8-year-old, I would read a story entitled *I Have to Have My Way* (Vernon, 2006a, pp. 47–48) about a boy who was so demanding during a ball game that his friends didn't want to play with him. After discussing the concept of demandingness as reflected in the story, I would contrast demands with preferences by asking if it makes sense to *demand* that his friends always play exactly what he wants and if they don't he gets mad and refuses to play with them, or if it makes more sense to *prefer* that they play a game the way he wants it to be played but understands that he can't have his way all the time and keep his friends. To reinforce these new learnings I would then engage him in a bean bag toss, reading a statement that is either a sensible or an insensible belief. If sensible, he tosses the beanbag into a small box labeled "sensible" and if not, he tosses it into a similar box labeled "insensible" and then we would discuss why it is insensible and how he could change it to make it sensible. These same methods can be used to explain demands against self (the need to be perfect, to be liked by everyone), awfulizing, global evaluation of human worth, and frustration intolerance. Using the story of *The Little Engine that Could* (Piper, 1986) about persistence and frustration tolerance, coupled with the following song (Vernon, 2009a, p. 177) illustrate other concrete ways of conveying key REBT concepts to a 10-year-old who was easily frustrated by tasks that she didn't like to do.

(Sung to the tune of *Are You Sleeping*)
I can't stand it, I can't stand it, no I can't, no I can't
This is just too boring, I just feel like snoring,
I can't stand it, I can't stand it
The second verse portrays the rational belief:
I can stand it, I can stand it, yes I can, yes I can!

I don't have to like it, I just have to do it,
I can stand it, I can stand it.

Disputation

Although this can be a challenging concept to explain to young clients, there are many different interventions that concretely convey the essence very well. For example, use the metaphor "erase" the irrational with an adolescent who is struggling with self-demands. In one column have her write each of her irrational beliefs on individual lines, and in the next column, have her pretend to "erase" the irrational beliefs and replace them more helpful ways of thinking, such as: rather than thinking "I MUST always be perfect," the rational response could be: "I WANT to do well and I will try my best, but if it's not perfect, it doesn't mean I'm stupid". With younger children, play a game such as *Race to be Rational*, where the client draws a card and reads it, and decides it if is a rational (sensible) belief or an irrational (insensible) belief. An example might be an *awfulizing* belief: it is awful if I don't get my way. If the client is correct and says it is irrational, he must identify a rational alternative. If he is able to do this he then gets to move his toy matchbox car ahead on a race track (drawn on a large sheet of poster board) the number of spaces specified on the back of the card. If his answer is incorrect or he is not able to identify a rational belief, he stays where he is and draws another card when it is his turn. By playing with the client, I can serve as a role model by identifying rational/sensible beliefs when I draw an irrational/insensible belief card.

The A-B-C Model

Albert Ellis developed the A-B-C model as a way of conceptualizing the major constructs of REBT and the process of change. This model can also be explained to children and adolescents using creative approaches. With younger children, movement generally works well since many "learn by doing." An effective strategy is to write the letters A-B-C-D-E on large sheets of poster paper and place them on the floor. Ask the young client to stand on the "A" and explain that it stands for something that happened or might happen or what the client thinks happened. Then generate a recent example based on the client's experience. Next, have her hop over to the "C" and explain that it stands for the emotional and behavioral consequences, or how the client feels about the "A" and how she behaves in relation to it. Help her generate responses to the "C" based on the identified A. Then ask the client to hop to the B, explain what it is, and help her identify the beliefs associated with the A and the C. If the A that was identified was positive, the model can still be explained up to the point of irrational beliefs, but then it would be necessary to say something like,

"Let's pretend that instead of getting a good grade that you felt excited about and thought that you were pretty smart for getting it, let's pretend that the grade wasn't good. Then how would you feel, behave, and think?" In this way the D, disputation, can be hopped to and worked through even though the client didn't actually identify a negative situation. This is a helpful psychoeducational technique to use because as is often the case with younger clients, they may not want to admit that something is wrong, but by having them *pretend* that the situation was negative and not positive, it is possible to teach them the disputation process anyway. In my experience, clients sometimes "bend the truth" a bit and later admit that the event was actually negative. So referring again to the notion of pretending that the grade was bad, the counselor might say to the client, "how do you think you would feel if you had gotten a bad grade instead of a good one, and if you felt that way, how do you suppose you might react? After the client responds, the counselor would say, "Now, what might have been going through your mind when you got the paper back with a bad grade instead of a good one?" After eliciting the beliefs, the counselor would ask the client to hop to the D, disputation, and explain what this means, asking the client questions that challenge the irrational beliefs she identified in the hypothetical "bad grade" scenario. For example, the counselor could ask the client how one bad grade proves that she is stupid, how helpful is it to think she will never get good grades again, or if she can really prove that she is totally worthless because she got this bad grade. Finally, have the client hop to the E and ask how she feels and thinks after the D, explaining that this is the goal…to feel better, think more reasonably, and behave more appropriately. The A-B-C model can also be taught using stories such those found in *Rational Stories for Children* (Waters, 1980) or by having adolescents participate in the ABC activity (Vernon, 2006b, p. 37) which helps them understand more about core REBT concepts as exemplified in the ABC model.

Key Best-Practice REBT-Based Assessment and Treatment Strategies and Techniques in Working with Children and Adolescents

Although there has been considerable research focused on the effectiveness of REBT with adults, these findings cannot be generalized to children and adolescents because there are important differences between these two populations. To learn more about the impact of REBT on children and adolescents, Gonzalez et al. (2004) conducted a meta-analysis. They found that REBT had the most impact on disruptive behaviors and that REBT was equally effective for children and adolescents whether they had an identified problem or not, which suggests that this therapy is effective for prevention as well as intervention. Furthermore, they found that after REBT treatment, "the average child or adolescent scored better on outcome measures than approximately 69% of the untreated control group" (p. 232). While these findings are good, the

authors emphasized that there is a "paucity of and greater need for empirical studies using REBT with children and adolescents" (p. 233).

When working with children and adolescents, the assessment and treatment process is essentially the same as it is with adults except for the fact that developmentally-appropriate methods must be used because there are significant differences between the way adults and children present and process information. In the following paragraphs, examples of specific ways to assess the activating event, the emotional and behavioral consequences, and beliefs will be described, followed by examples of developmentally-appropriate treatment techniques.

The Therapeutic Alliance

As REBT therapists, we typically believe that we strengthen the therapeutic alliance by *working* on the problem. However, with most young clients it is important to spend time at the beginning of therapy doing some specific rapport building activities, for several reasons. First, they are usually referred by someone else and may not think they have a problem or even know what it is, so they may be more reluctant to engage. Second, attending therapy is most likely a new experience for them and they may feel quite anxious. In addition, therapists can learn a lot about the client by engaging in various get-acquainted activities and use this information in later sessions as metaphors or analogies or examples. I recall working with an 8-year-old who was very perfectionistic. During our first session we had played a game called *Who Are You* (Vernon, 2009a, pp. 26–27), in which we took turns asking: who are you and responding with something about ourselves that we were willing to share. In one of the examples she said that she loved to ride her bike and skate. So when it came up in one of the sessions that she thought she had to do everything perfectly the first time, I asked if she remembered the first time she rode her bike or tried to skate…did she do these things perfectly right away or did she learn to do them better with practice? Personalized examples such as this are very helpful because they convey the concepts in a more concrete manner which facilitates understanding. Using rapport-building activities such as games, movement activities, art or music also helps put younger clients more at ease and paves the way for a more productive therapeutic experience. Games and movement activities may not be appropriate for adolescents, but there are other ways to break the ice, such as inviting them to share a series of songs that are meaningful to them or to bring in their high school yearbooks and share pictures of their best friends, activities they are involved with, and so forth.

Assessment Strategies

In assessing the activating event, I might ask children to draw a picture of the problem, act it out, or pretend like they are telling me a story about the problem. Oftentimes

children and adolescents may be reluctant to share what the problem is because they may feel embarrassed or think that there is something really "wrong" with them, so it is important to explain that everyone has problems from time to time and the smart thing is to get some help so the problem doesn't get worse.

Once you have a sense of the problem, then ask how the child feels about the problem. This may be more challenging for younger children who may not have a well-developed feeling vocabulary, so it is often necessary to have the client select a feeling from a short list of feeling words, act out or pantomime the feeling, or draw a picture that portrays it. Psychoeducation may also be important—I might read a book about feelings or play a feelings game with younger children to help them understand more about feelings so that they can better identify their own emotions relative to an activating event. Although adolescents generally have a broader feeling vocabulary, they may be reluctant to admit to having certain emotions. In this case, I would use bibliotherapy, having them read about how other adolescents felt when experiencing a similar activating event. Similarly, cinematherapy is also an effective way to promote identification of feelings.

With young clients, it is especially important to assess the behavioral consequence as well as the emotional consequence because children often express how they feel through their behavior. Therefore, if they are unclear about the emotional "C," asking for the behavioral "C" is an effective way to assess it as well. If they have given you an emotion, then simply ask them how they behaved when they felt angry. If they weren't clear about the emotion, ask what they did in relation to the activating event and then infer the feeling, saying something like: "Since you said you hit your brother when he didn't let you play with his soccer ball, it sounds like you might have been angry?"

The next step is to assess beliefs, which can be challenging with both children and adolescents, so it is important to use very concrete strategies such as thought bubbles, sentence completions (when I felt anxious, I thought_____), or have puppets dialogue about the activating event. Inference chaining and the "think aloud" technique (Vernon, 2009a) are also helpful. *Supplying the inference as a hunch* ("Some kids might think they are total losers if they miss something on a test. Is that what you think?") or playing a game such as *Rational or Irrational* (Vernon, 2002, pp. 48–49), where young adolescents learn to distinguish between rational and irrational beliefs so that they can classify their own beliefs are age-appropriate assessment techniques. *Rational emotive imagery* may also be helpful in assessing beliefs.

Treatment Techniques

Given that disputation is the "heart and soul" of the REBT model, it is imperative to use techniques that are concrete and oftentimes psychoeducational, introducing young clients to the process through creative methods. As with adults, functional, empirical, and logical disputes are effective, but it is not good to rely solely on verbal

methods with this population. For example, a reverse role play is a very concrete way of helping young clients generate their own disputes. I used this with an 8-year-old who was quite perfectionistic and became very frustrated and upset when he performed less-than-perfectly on an assignment. I pretended to be him and he assumed the role of the teacher. When he handed me back my paper I got frustrated and threw it on the floor, verbalizing how horrible it was that I missed several and that I was stupid. His reply as the teacher was, "That's ok; you just made a few mistakes and it isn't worth getting upset about. You can try harder next time." In my role as the student, I said, "But I always have to get everything right because if I don't, it proves I am stupid." His reply was, "No, you are not stupid and you don't always have to get everything right." After several rounds of this type of practice he was able to generate quite a few rational beliefs to counteract his irrational thoughts.

Other age-appropriate techniques include the Best Friend technique ("If your best friend told you that you were a complete loser because her boyfriend broke up with her, would you agree with her or tell her something different?") and the Survey technique (Vernon, original). I used this with an adolescent who insisted that her parents were the worst in the world because they never let her do anything. Asking her for "evidence" that they were so horrible was not effective because she stubbornly insisted that they were, so I asked her to survey others her age, asking them questions about what their parents did or didn't allow them to do. We developed the survey in the session and she actually used it with ten of her friends, concluding that everyone else's parents were just like hers! With this understanding, it was easier to work with her to dispute her demand that her parents should always let her do exactly what she wanted to do.

Other effective disputing techniques include having young children pretend that they are "fact detectives," hunting for facts (versus assumptions) that are hidden throughout the room. After they have learned the difference between these concepts they can more accurately analyze their own problem to see if they are making assumptions and misconstruing the situation. *Stay Cool is the Rule* is a good strategy to help children replace their "hot thoughts" with "cool thoughts." They write their "hot thoughts" on tongue depressors that have red lines at the ends to resemble fire and for each one, they take a square of paper resembling an ice cube and write a "cool thought" replacement (Vernon, 2002, pp. 159–162). Having them perform rational puppet plays is another way of identifying disputes, as well as writing rational limericks, poems, and songs.

When working with this age group, it is especially important to reinforce rational thinking in many different ways. Having clients monitor movies or television shows for irrational beliefs and then writing rational replacements can be helpful, as well as writing rational endings to their own problems, making rational posters or banners, or using concrete analogies such as "changing the channel" when they are thinking irrationally and then identify rational replacements. Another strategy that helps adolescents understand the connection between how they think, feel, and behave is the *Chain Reaction* activity (Vernon, 2006b, p. 35). I used this with a client who didn't want to study for an exam. I took a strip of paper and labeled it "activating event—have an exam to study for. Then I took another strip and had the

client identify how he felt about studying for the exam (angry), wrote his beliefs on additional strips (I shouldn't have to waste my time, I should be able to go out and have fun and not study for some stupid test), and on another strip, what he did as a result of thinking this way (did not study and failed the test). Then I asked him to identify the consequences of not studying and failing the exam, using separate strips of paper for each one (had to stay after school, parents were upset and grounded me, I missed a party, etc.). Next, I stapled these together to form a chain and held it up so he could see how long it was. I then asked what the chain might look like had he thought differently about the same event; in other words, instead of thinking he shouldn't have to study and consequently didn't, he realized that even if he didn't want to study, the benefits might outweigh the costs. Concrete methods such as this one help make the point.

Rational coping self-statements are also very effective with this population. I used this technique with a young adolescent who was socially anxious, thinking that others did not like her or wouldn't work with her if she asked them to team up to complete a project. She identified several coping self-statements that she typed into her cell phone and referred to them prior to asking several peers if they could work together on the science experiment.

To summarize, the assessment and treatment phase of this approach can readily be adapted so that children and adolescents are going through the same process but in a slightly different way. Through stories, games, music, concrete analogies, and other creative interventions, young clients can learn to the REBT process.

Treatment Guidelines from the Empirically-Supported Therapy Literature that Inform Best Practice in REBT with Children and Adolescents

According to Fonagy et al. (2015), "somewhere between 10 and 50% of youth are likely to meet diagnostic criteria for a mental health disorder at any one time" (p. 1). This is especially concerning since adult mental health is clearly linked to childhood disorders, so identifying the most effective "best practices" for children and adolescents will also have a positive impact on adults if problems can be effectively dealt with in childhood through both prevention and intervention. Fonagy and colleagues stressed the importance of taking the following into consideration in implementing evidence-based practices with children and adolescents: brain development, the child as part of a system (family, school, friends), the need to network with systems that define the child's context, the importance of school as best place to introduce prevention, and the strong correlation between medical consultations and behavioral issues, making it imperative that medical practitioners know how to diagnose behavioral problems and not simply prescribe medication. Similarly, substance abuse service providers need to understand the link between mental health disorders and substance abuse problems in order to implement effective treatment.

Based on the above-mentioned suggestions concerning the child as part of the system, Cartwright-Hatton et al. (2011, as cited in Fonagy et al. 2015) discussed the effectiveness of working with parents on a CBT-based parenting intervention for helping children manage their children's anxiety, with impressive posttreatment results. Likewise, with respect to conduct disorders, the most common reason for referral in this population, parent training as a treatment was more effective than CBT for children, although another intervention that combined problem-solving skills training with parent management training showed promise in that the child's behavior improved and there was less family stress (Fonagy et al., 2015). Fonagy and colleagues also noted the effectiveness of a multimodal approach when working with adolescents with conduct disorders, focusing on the family and involving other parts of the system that influence the adolescent's behavior.

Fonagy et al. (2015) also stressed that brain development must be taken into consideration with regard to evidence-based practice, and REBT practitioners should strive to stay current with the developmental literature, taking into account the critical developmental tasks and characteristics particular to the young client's presenting problem. Specifically, cognitive development has a major impact on how young clients respond to events because formal operational thinking does not begin to develop until early adolescence, which has specific implications for how children process information. That is to say, their capacity for logical thinking and problem-solving is limited, they have a tendency to think dichotomously, and they do not consider a wide range of alternatives. They frequently take things out of context and are slowly developing the ability to see things from other perspectives (Glowiak & Mayfield, 2016). During early adolescence, ages 11–14, the rapid physical changes impact young teens in multiple ways, resulting in emotional volatility characterized by moodiness and strong negative emotions such as anger, depression, anxiety, and guilt. They also may feel embarrassed and confused about their physical and hormonal changes. Although they are gradually moving into formal operational thinking and can think more abstractly, hypothesize, and reason more logically, they often have difficulty with cause and effect. Consequently, it is important not to assume that they are capable of more mature cognition when the degree of abstract thinking is erratic (Scott & Saginak, 2016). It is not until mid-adolescence (ages 15–18) that they begin to think more abstractly and there is more emotional stability. At this stage they are better able to see things from other perspectives, and are able to think more abstractly, hypothesize, and consider alternatives and consequences. They also tend to be less impulsive and can manage their emotions more effectively (Scott & Saginak, 2016).

Taking into account developmental limitations, Bernard et al. (2006) noted that "REBT does little disputing of irrational beliefs in children younger than age 6 and reserves more sophisticated disputing of general beliefs until after the age of 11 or 12" (p. 7) because developmentally, most are not capable of comprehending the concept of disputing before formal abstract thinking has begun to develop. With this guideline in mind, I have spent years developing age-appropriate methods to help young clients understand fundamental principles that help them think more logically prior to when it is possible to actually use disputing techniques with them. For example, I was working with a 6-year-old who was very upset because she had

a new sibling and felt like her parents didn't love her anymore because they were paying more attention to the baby sister than they were to her. I read her a rational story with a similar theme, and then adapted the use of an empty chair technique in which she was first herself and "talked" to the empty chair about her problems, and then she switched chairs and pretended that she was giving herself some advice about this problem. So although she was not doing "disputing" as we typically think of it, when she was talking to herself she was able to say, based on what she had learned in the story, that just because her parents weren't paying as much attention to her presently, this just meant that her sister needed more care and that did not mean they did not love her. As this vignette illustrates, young children can learn rational concepts if they are modified to be developmentally-appropriate.

The REBT literature also guides best practice regarding the reciprocal relationship between mental and emotional development. Specifically, when children are very young, the way they experience emotions is limited by their ability to think clearly and understand the meaning of what they experience (Bernard et al., 2006). Consequently, it is very easy for children to acquire beliefs that are untrue and irrational and if these beliefs aren't addressed, they can have a major negative impact. Their incapacity for rational thinking manifests in thinking that is characteristic of preoperational and concrete operational thought, including dichotomous thinking, overgeneralization, magnification/minimization, arbitrary inference, and selective abstraction. These maladaptive thinking patterns were very characteristic of young clients I worked with in therapy and I developed many different techniques to help them correct them (Vernon, 2002, 2009a). One strategy in particular that has proven very helpful to children and also young adolescents is to use a continuum as I did with a 9-year-old who was convinced that her mother would get into a car accident and die, which was resulting in a great deal of anxiety. I drew a continuum on a sheet of paper and helped her see that the car accident resulting in death was one option, as well as there being no accident and no death, there were also many other possibilities in between on the continuum: being in a bad accident and getting hurt but not dying, being in an accident and getting some cuts and bruises but not being seriously injured, and so forth. Broadening her perspective and reducing her dichotomous thinking and magnification was an effective way to reduce her anxiety.

Another critical aspect of development relates to self, and REBT is well known for its emphasis on self-acceptance, which is a critical aspect of child and adolescent development (Vernon, 2009a). From an REBT perspective, helping young clients accept themselves with their strengths as well as their weaknesses and dealing with their irrational beliefs related to perfectionism is key. In addition, peers are extremely important to children and adolescents and are associated not only with pleasure but also with pain, as lack of other-acceptance and demandingness negatively impact peer relationships. Demandingness and the concept of other-acceptance are also central aspects of the theory which can be employed in developmentally-appropriate ways to help youth deal with these issues. In addition, it is a well-established fact that cognitive-behavioral approaches are considered "best practice" when it comes to dealing with strong negative emotions such as depression, anger, anxiety, and guilt,

all of which are very common among adolescents (Curry & Hersh, 2014; Seager, Rowley, & Ehrenreich-May, 2014).

REBT incorporates many techniques and concepts that help children and adolescents move beyond their concrete thinking tendencies that can become problematic throughout their development (Vernon, 2009a). In addition, REBT promotes skill acquisition and practical problem-solving techniques, which is so important for young clients who need to find ways to "grow up without giving up" when they are faced with challenging circumstances. Because they are prone to thinking illogically according to REBT theory (Ellis & Bernard, 2006), young clients are especially vulnerable because they can easily become overwhelmed and fail to put problems in perspective. The REBT literature (DiGiuseppe & Bernard, 2006; Vernon, 2002, 2009a, 2009b) identifies many developmentally-appropriate strategies which can be employed to teach children and adolescents how to think, feel, and behave in ways that enhance their development. The educative and preventative nature of the theory fits very well with the developmental theory which suggests that children and adolescents are not able to generate alternative ways of thinking or behaving without guidance, which can be provided under the REBT umbrella that adheres strongly to the notion that teaching skills is an integral part of this theory.

Brief Case Example

Marcy, age 17, had been a very good student who was planning to graduate from high school at the end of the year and attend a nearby university starting in the fall. Midway through her senior year she suddenly lost interest in school, stopped studying, and started skipping classes in order to hang out with her new boyfriend, a high school dropout who had a bad reputation in the community for using drugs and alcohol and getting into trouble with the law. Despite her parents' insistence that she stop seeing him, she didn't, and after the school called and expressed concern that she might not graduate, her parents referred her to therapy. Needless to say, Marcy didn't think she had a problem and was very resistant during the first session. It was quite evident that she would not identify a problem she wanted to work on, so I identified the "A" as her parents forcing her to attend therapy and trying to change her behavior. She readily agreed that this was a problem and that she was very angry at them for trying to get her to stop seeing her boyfriend and start going to school and studying, which she considered to be unimportant.

When asked how she was behaving in relation to her anger, she said that she was doing what she wanted to do and discounting her parents' concerns because she was 17 and old enough to make her own decisions. When asked about her thoughts when she felt angry, she identified a number of demands related to her parents' behavior. Although she admitted that there was no law that said her parents had to treat her exactly as she wanted them to, she still held onto the beliefs that at age 17, she should get to make her own decisions and that they shouldn't interfere with her life. Realizing that it might be difficult for her to give up these demands, I tried a

different tactic. I told her I understood that at her age she wanted to make her own decisions—this was normal. But I asked her to think about her choices, and if she was convinced that they were in her best interests, maybe we could figure out a more helpful way of discussing this with her parents rather than just defying them, which she admitted wasn't really helping because they were always "on her case." When she agreed, I said, "Suppose you decide not to change…that what you are doing right now is working for you and it is how you want to live your life. Imagine that it is 3 months from now (high school graduation) and take some pictures of what your life might be like if you decide not to change." At the next session she showed me pictures depicting a pyramid of beer cans, a wrecked car, a traffic ticket, a torn in half high school diploma, and other pictures that represented negative consequences of her current choices. When asked how she felt about this "picture" of her life, she still said she it was fine. I then casually asked her to suppose that she did decide to change, which was entirely up to her, and take pictures of what her life would be like in 3 months. This time her pictures depicted a diploma, a college campus, and a new car that her parents had promised her if she graduated. When asked which "picture" of her life she preferred, she referred to the latter and we began to discuss behavioral changes.

As this case exemplifies, adolescents are often resistant to therapy and need to come to their own conclusions about their choices. Initially disputing her demands against her parents was not very successful, but after helping her see the consequences of her behavior and letting her decide for herself if her current choices were helping her or hurting her, we were able to come back to the disputation and she was able to see that she couldn't change her parents and her demands getting her anyplace, but by changing her beliefs and recognizing that the choices she was making were not in her best interests she was able to focus on herself and make better choices, which in turn got her parents to back off.

What I Have Learned About Using REBT with Children and Adolescents

Having worked with children and adolescents for many years, I have learned that there are many different ways to help them learn REBT concepts and how important it is to take into consideration their developmental level as well as individual differences. Furthermore, I have learned from my young clients the importance of being flexible and creative.

Accommodating Individual Differences

One of the best ways to accommodate for individual differences is to use the creative or expressive arts. Because of the universal nature of the creative arts, they can be used with any client, "regardless of gender, ethnicity, ability, age, language, cultural identity, or physical functioning" (Degges-White & Davis, 2011, p. 5). These approaches attempt to facilitate change and they can expedite diagnosis, prevention, and intervention. When used in conjunction with REBT, there is a greater probability that the counselor and client will connect in a more meaningful way, which results in more effective outcomes (Vernon & Barry, 2013).

Although it is easier to teach the concepts to clients whose intelligence is average and above, with adequate modification, the concepts can be simplified so that they can at least learn basic elements of the model. This same principle applies to very young children. As an example, my 3 year-old granddaughter was taking a bath and said she needed more bath bubbles. I said, "Elia, you don't *need* them, you just *want* them. We went back and forth for a minute about whether she needed them or wanted them, and the subject was dropped. Several days later I was visiting her and told her that I had ordered a magazine for her with lots of games and stories. I told her that the mail carrier would bring it and I asked if she had gotten it yet. Her reply was, "No, Nanna, but I don't need it. I have lots of magazines." She seemed to get the concept, even at that young age. Two years later her brother told her that he needed something and she told him that he didn't really need it, he just wanted it! I think that is a good example of how rational concepts can be explained to young children, but if they aren't as quick to grasp the idea or aren't as verbal, it may be necessary to focus more on behavioral changes. While this approach may not be considered "elegant," it is nevertheless helpful.

As has been demonstrated with adults, REBT is very appropriate with clients from different cultural and socio-economic backgrounds, although it is necessary to modify the content at times to address contextual realities (Friedberg et al., 2014). Furthermore, the therapist needs to be sensitive to the fact that issues and beliefs that clients present will reflect their cultural norms and values. For example, when working with adolescents in the United States or other Western cultures, independence is valued much more than it is in Latin American countries, for example, where families are more close-knit and there is more of a dependent relationship within the family. For this reason, adolescents who are seeking independence in the U.S. are more likely to rebel against what they perceive as their parents' demands, while in Latin American countries, adolescents are more likely to feel guilty if they go against parental norms (personal communication, M. T. Parades, June 17, 2017). Consequently, REBT therapists working with youth from different cultures need to be aware of how cultural norms impact treatment.

The "Do's" in Working with Children and Adolescents

There are several factors that I consider to be important in working with children and adolescents, as highlighted in the following paragraphs.

Building rapport. This was discussed previously in the chapter, but the importance of building rapport cannot be underestimated. Because they are generally not self-referred, it is essential for young clients to sense that the therapist genuinely cares about them and takes their concerns seriously. Adolescents in particular are suspicious about whether they can trust the counselor to understand them. I recall asking a 16-year-old for feedback at the end of the first session. His response was, "For someone who's not a teenager, you seem to understand what it's like to be one!" Stepping into the shoes of the younger clients is an important aspect of rapport building.

Repeating concepts in multiple ways. Another important thing I have learned in working with younger clients is that it is critical to repeat concepts in multiple ways using a variety of different strategies in order for them to understand REBT. For example, in working with an adolescent whose boyfriend had broken up with her, I would address her self-downing: he wouldn't have broken up with me if I were smarter, prettier, more popular, and so forth, as well as the overgeneralization that she would never feel better or have another boyfriend. Although disputation was successful to a degree and she was able to see that life could go on and that she wasn't a loser, I wanted to reinforce this in different ways, so I asked her to write about her problem as if she was seeking advice from an advice columnist and to write a response to her problem as if she were the advice column expert. As a homework assignment, I asked her to interview her older sister and her cousins to see if they had ever experienced a break-up and if so, did they consider themselves losers, are they happy now, and have they had other boyfriends? Given that adolescents are egocentric and think nobody experiences things like they do, this was a helpful assignment. In a subsequent session I asked her to do a reverse role play, in which I played the role of the "worthless" girlfriend who would never be happy again and she played the therapist role. By incorporating these techniques into therapy sequence, the client ultimately was much more rational about this break up.

Using the creative arts. As mentioned previously regarding how to accommodate for individual differences, I consider it very important to employ the creative arts when working with clients of all ages, but children and adolescents in particular. Creative arts interventions are engaging and very appropriate for this age group who may not be able to verbally express what they are thinking or feeling or how they behave. Furthermore, these approaches put young clients at ease, reducing their anxiety about the therapy experience. And because children's attention spans are limited, it is much more effective to use interventions that are motivating and engaging. In addition, because their ability to remember concepts between sessions may be limited, it is important to use interventions such as the creative arts which are more concrete. Music, games, art, or metaphors help anchor the concepts in their heads more effectively than just relying on verbal methods.

I recall working with an adolescent male who was very angry at his girlfriend who hadn't called him at 10:00 pm the previous evening as she had promised. He assumed it was because she no longer liked him and wanted to break up with him because she was seeing someone else. Of course he hadn't checked out his assumptions, but rather, firmly held to the belief that the only reason she hadn't called him was because she no longer liked him. As he was talking about this situation, he was looking out the window where I had an electric machine that zapped bugs. I asked him what the zapper did and he said that it killed the bugs. I suggested that he think of his head as a giant bug zapper and that every time he started assuming things, he should "zap" those thoughts and check out the facts first in order to have a better handle on this. The concrete metaphor made sense to him and he used the zapper metaphor throughout high school and even as a young adult in college!

The "Don'ts" in Working with Children and Adolescents

What we don't want to do in REBT therapy with children and adolescents is assume that they will readily understand the concepts, which is why it is so important to repeat them in numerous ways using concrete examples as discussed more thoroughly in previous sections of this chapter. Another "don't" relates to disputing.

Don't assume that disputing is always feasible. Another thing that we don't want to do is to assume that disputing is always feasible with young children. As Bernard et al. (2006) noted, disputing of any kind is generally not possible with children younger than age 6, and more sophisticated disputing occurs after they have begun to think more abstractly, which usually occurs between the ages of 11-14 or later. But because abstract thinking develops gradually, it is a mistake to assume that preferential REBT is feasible with all adolescents. According to Bernard et al. (2006), it is typically suitable for many bright teens, but not for many average adolescents, and certainly not young children. In that case, non-preferential RET is employed and can be very effective. For instance, consider how important it is to simply teach young clients the difference between a fact and an assumption, as illustrated in the previous example about the "zapper" metaphor. Had this client stopped to consider the facts before making assumptions he could have avoided a lot of anguish. Additionally, teaching clients how to identify alternatives and evaluate consequences is extremely helpful as they make decisions about whether to cheat on a test, drink alcohol or use drugs, engage in unprotected sex, and so forth, especially because the consequences can have serious ramifications. Helping them learn how to reframe, which opens their minds to other possibilities, can be very useful.

While disputing is obviously a core REBT concept, we have to work harder to employ functional, logical, and empirical disputes with this population. As just noted, philosophical disputing may not be feasible for those who are not abstract thinkers. Consider the example of a 7-year-old whose parents got a divorce and his mother moved across the country. He thinks that she doesn't love him and that's why she moved, and while it could be true that she doesn't love him, this could

be a very difficult concept for a child this age to understand. As DiGiuseppe and Bernard (2006) noted, it is preferable to help the child deal with this reality rather than challenge his perceptions, but the therapist must be very cautious in doing so because the child may not have the ability to understand that even if his mother doesn't love him, he is still loveable. In these cases, it may be more appropriate to challenge inferences and automatic thoughts.

Don't just work with the child. **A**nother "don't" is to work exclusively with the young client and not include parents, who are a major influence in a young child's life and may be contributing to the child's irrationality. Thus, an important consideration is that the identified client (child) may not be the problem; the child may be reacting to the parenting style which may be inappropriate and detrimental. For this reason as well, parents must be an important part of the therapeutic process.

REBT Aspects that Affect Change

As has been discussed thus far in this chapter, the REBT model can readily be adapted to children and adolescents, but there needs to be a strong emphasis on "thinking outside the box" so that the strategies employed are best suited for this population. There are several key aspects of REBT that affect change with this age group.

What they can control. In my experience, perhaps the aspect that effects the most change is the notion that while they cannot control other people, they can control how they choose to think, feel, and behave. I often start with the behavior because it is something that is observable and more understandable to children than how they think of feel. I use the robot analogy with younger children who say that they can't help it…that's just the way they have to behave. I ask the client to stand up and I turn him around and pretend to wind him up, explaining that he is to pretend that he is a robot who is now programmed to do whatever I say. I then have him perform a series of tasks which he does, and then I ask him if he actually is a robot who has to do everything that others ask him to do. When he says no, I explain that if he isn't a robot, he has choices about how to behave. I follow up with specific examples applicable to his life: if he gets a paper back with a bad grade on it, does he *have* to throw a fit, or could he just accept the paper without such a strong reaction? Or if his mother asks him to clean his room, does he have to scream *I don't want to* or does he have other choices? This is a very important concept for children who need to learn that not only do they have choices, but that their choices have consequences.

How they behave is based on what they think. Once clients understand that they can control their behavior, another aspect that affects change is to help them see that how they behave is based on what they feel, which is related to what they think. I might illustrate this with the following example:

Suppose your parents inform you that they are going to move to a different city. At first you are really angry, thinking that this isn't fair, that it will be awful, that you can't stand to leave your friends and you probably won't make new ones. You yell and scream at them because you are so upset. But then you talk to your brother

about it and he is excited because he says it is a big city, there will be lots of cool things to do, and it will be an adventure! So after thinking about it, you decide that maybe he is right…it could be fun, it would be a new adventure, and you might make even better friends in a new school. Discuss with the client that when she changed the way she thought, she felt differently and probably didn't yell and scream at her parents because she wasn't angry anymore.

Self-help approach. The fact that REBT is designed as a self-help educative approach is also what delivers the most benefit for change. I use the analogy of a trampoline, explaining to clients that when they are on a trampoline and they jump up, they may also bounce pretty far down, but they never quite touch the ground. This is similar to what happens when they learn how to think rationally—they may experience a problem and it might get them down temporarily, but when they apply the rational thinking skills they have learned, they have "tools" that help them bounce back faster. I sometimes share the experience my son had as a young adult when his girlfriend broke up with him. At first he was really upset, blaming himself for doing things wrong and not being the kind of guy she said she wanted. But before long he realized that he was really personalizing things, allowing himself to think negative things about himself that his girlfriend had accused him of being, but in reality, he wasn't what she said he was. Because he was able to apply skills that he had learned over the years to help him deal with this problem, he began to feel better after a short while and got on with his life.

In summary, REBT can be very effectively employed with children and adolescents in meaningful ways that help them learn and apply the concepts. Parents and teachers play a key role in modeling rational beliefs and behaviors and keying in on the "teachable moment." For instance, when my son was 7 and hated to practice the piano, one day he said, "All I ever do is practice the piano." I replied by asking in an exaggerated fashion, "*All* you *ever* do is practice the piano? You don't eat, sleep, go to school, play, study, or watch movies?" After thinking about it, he admitted that he had been exaggerating. Learning this concept at an early age was something he continued to use as he was growing up.

As the old saying goes, "An ounce of prevention is worth a pound of cure"—and as emphasized throughout this chapter, REBT is a prevention model.

References

Barrett, P. M., Farrell, L., Pina, A. A., Peris, T. S., & Piacentini, J. (2008). Evidence-based psychosocial treatments for child and adolescent obsessive-compulsive disorder. *Journal of Clinical Child & Adolescent Psychotherapy, 37*(1), 131–155.

Bedford, S. (1974). *Instant replay*. New York, NY: Institute for Rational Living.

Bernard, M. E. (2001). *Program achieve: A curriculum of lessons for teaching students how to achieve success and develop social-emotional-behavioral well-being* (2nd ed., Vols. 1–6). Oakleigh, VIC (AUS): Australian Scholarships Group.

Bernard, M. E. (2005). *Program achieve: A curriculum of lessons for teaching students to achieve and develop social-emotional-behavioral well being* (3rd ed., Vols. 1–6). Oakleigh, VIC (AUS):

Australian Scholarships Group; Laguna Beach, CA (USA): You Can Do It! Education, Priorslee, Telford (ENG): Time Marque.

Bernard, M. E., Ellis, A., & Terjesen, M. (2006). Rational-emotive behavioral approaches to childhood disorders: History, theory, practice, and research. In A. Ellis & M. E. Bernard (Eds.), *Rational emotive behavioral approaches to childhood problems: Theory, practice, and research* (pp. 3–84). New York, NY: Springer.

Bernard, M. E., & Joyce, M. R. (1984). *Rational emotive therapy with children and adolescents: Theory, treatment strategies, and preventative methods*. New York, NY: Wiley.

Cohen, J. A., Mannarino, A. P., & Murray, L. A. (2011). Trauma-focused CBT for youth who experience ongoing traumas. *Child Abuse Neglect, 35*(8), 637–646.

Crawley, S. A., Beidas, R. S., Benjamin, C. L., Martin, E., & Kendall, P. C. (2008). Treating socially phobic youth with CBT: Differential outcomes and treatment considerations. *Behavioural and Cognitive Psychotherapy, 36,* 379–389.

Curry, J. F., & Hersh, J. (2014). Development and evolution of cognitive behavior therapy for depressed adolescents. *Journal of Rational-Emotive & Cognitive-Behavior Therapy, 32*(1), 15–30.

Degges-White, S., & Davis, N. L. (2011). *Integrating the expressive arts into counseling practice: Theory-based interventions*. New York, NY: Springer.

DiGiuseppe, R., & Bernard, M. E. (2006). REBT assessment and treatment with children. In A. Ellis & M. Bernard (Eds.), *Rational emotive behavioral approaches to childhood disorders: Theory, practice and research* (pp. 85–114). New York, NY: Springer.

DiGiuseppe, R., & Kelter, J. (2006). Treating aggressive children: A rational-emotive behavior systems approach. In A. Ellis & M. Bernard (Eds.), *Rational emotive behavioral approaches to childhood disorders: Theory, practice and research* (pp. 257–280). New York: Springer.

Doyle, K. A., & Terjesen, M. D. (2006). Rational emotive behavior therapy and attention deficit hyperactivity disorder. In A. Ellis & M. Bernard (Eds.), *Rational emotive behavioral approaches to childhood disorders: Theory, practice and research* (pp. 281–309). New York, NY: Springer.

Ellis, A. (1962). *Reason and emotion in psychotherapy*. Secaucus, NJ: Lyle Stuart.

Ellis, A. (1994). *Reason and emotion in psychotherapy: A comprehensive method of treating human disturbance*. New York, NY: Birch Lane Press. (Revised and updated).

Ellis, A., & Bernard, M. E. (Eds.). (2006). *Rational emotive behavioral approaches to childhood problems: Theory, practice, and research*. New York, NY: Springer.

Fonagy, P., Cottrel, D., Phillips, J., Bevington, D., Glaser, D., & Allison, E. (2015). *What works for whom? A critical review of treatments for children and adolescents* (2nd ed.). New York, NY: The Guilford Press.

Friedberg, R. D., Hoyman, L. C., Behar, S., Tabbarah, S., Pacholec, N. M., Keller, M., et al. (2014). We've come a long way, baby!: Evolution and revolution in CBT with youth. *Journal of Rational-Emotive & Cognitive-Behavior Therapy, 32*(1), 4–14.

Glowiak, M., & Mayfield, M. A. (2016). Middle childhood: Physical and cognitive development. In D. Capuzzi & M. A. Stauffer (Eds.), *Human growth and development across the lifespan*. New York, NY: Wiley.

Gonzalez, J. E., Nelson, J. R., Gutkin, T. B., Saunders, A., Galloway, A., & Shwery, C. S. (2004). Rational emotive therapy with children and adolescents: A meta-analysis. *Journal of Emotional and Behavioral Disorders, 12*(4), 222–235.

Knaus, W. J. (1974). *Rational-emotive education: A manual for elementary school teachers*. New York, NY: Institute for Rational Living.

Phillips, K. A., & Rogers, J. (2011). Cognitive–behavioral therapy for youth with body dysmorphic disorder: Current status and future directions. *Child Adolescent Psychiatric Clinics North America, 20*(2), 287–304.

Piper, W. (1986). *Little engine that could*. New York, NY: Platt and Munk.

Scott, S. D., & Saginak, K. A. (2016). Adolescence: Physical and cognitive development. In D. Capuzzi & M. A. Stauffer (Eds.), *Human growth and development across the lifespan*. New York, NY: Wiley.

Seager, I., Rowley, A. M., & Ehrenreich-May, J. (2014). Targeting common factors across anxiety and depression using the unified protocol for the treatment of emotional disorders in adolescents. *Journal of Rational-Emotive & Cognitive-Behavior Therapy, 32*(1), 67–83.

Silverman, W. K., Pina, A. A., & Viswesvaran, C. (2008). Evidence-based psychosocial treatments for phobic and anxiety disorders in children and adolescents. *Journal of Clinical Child & Adolescent Psychology, 37*(1), 105–130.

Vernon, A. (2002). *What works when with children and adolescents: A handbook of individual counseling techniques*. Champaign, IL: Research Press.

Vernon, A. (2006a). *Thinking, feeling, behaving: An emotional education curriculum for children (Grades 1–6)*. Champaign, IL: Research Press.

Vernon, A. (2006b). *Thinking, feeling, behaving: An emotional education curriculum for adolescents (Grades 7–12)*. Champaign, IL: Research Press.

Vernon, A. (2006c). Depression in children and adolescents: REBT approaches to assessment and treatment. In A. Ellis & M. E. Bernard (Eds.), *Rational emotive behavioral approaches to childhood disorders: Theory, practice, and research* (pp. 212–231). New York, NY: Springer.

Vernon, A. (2009a). *More what works when with children and adolescents: A handbook of individual counseling techniques*. Champaign, IL: Research Press.

Vernon, A. (2009b). Applying rational-emotive behavior therapy in schools. In R. Christner & R. B. Mennuti (Eds.), *School-based mental health: A pracitioner's guide to comparative practices* (pp. 151–180). New York, NY: Routledge.

Vernon, A., & Barry, K. L. (2013). *Counseling outside the lines: Creative arts interventions for children and adolescents*. Champaign, IL: Research Press.

Waters, V. (1979). *Color us rational*. New York, NY: Institute for Rational Living.

Waters, V. (1980). *Rational stories for children*. New York, NY: Institute for Rational Emotive Therapy.

Wilde, J. (1992). *Rational counseling with school-aged populations: A practical guide*. Bristol, PA: Accelerated Development.

REBT with Couples

Russell Grieger and Kimberly A. Alexander

In this chapter, we will discuss how we use REBT to treat couples—whether they be in love but experiencing conflict, have drifted apart and wish to rekindle their connection, or are at a crisis point where the survival of the relationship is at stake. With a few insights of our own interspersed, we give full credit to the genius of Albert Ellis (1913–2007), the founder of REBT and the grandfather of all forms of cognitive behavior therapy.

Key REBT Theoretical Concepts in Working with Couples

REBT with couples is grounded in seven core concepts. These provide reason and coherence to the clinical process and guide both the therapist and the couple to act purposely and intelligently to bring about desired relationship change.

This chapter is abstracted from Dr. Grieger's book, *The Couples Therapy Companion: A Cognitive Behavior Workbook,* published by Routledge in 2015.

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Humanism

REBT with couples places the highest value on the well-being and happiness of the individual. Therefore, relationships are seen as valid and valuable to the extent that they contribute to the fulfillment and satisfaction of the people in it.

The REBT couples therapist, therefore, does not labor to rescue troubled relationships. Rather, he or she holds two purposes: (1) to use REBT's ABC model to help rid the couple of strong, relationship-dysfunctional emotions (e.g., hurt, anger, insecurity) so as to determine if being in the relationship is wanted or desirable; (2) if so, to help the couple achieve long-range, mated happiness by (a) eliminating dysfunctional behavior patterns, (b) teaching needed skills (e.g., conflict resolution, communication), and (c) building practices that enhance harmony.

This humanistic posture takes the REBT couples therapist out of the role of being responsible for the survival of the couple's relationship to the role of freeing the couple to use reasoned rational thinking to determine what's in their individual and collective best interest. To say it another way, the goal of REBT with couples is to free the partners to make the best possible decisions going forward—whatever that may be.

Relationship Difficulty Versus Relationship Disturbance

REBT with couples makes a critical distinction between couple difficulties and couple disturbances. **A relationship difficulty** comes about when one or both of the couple partners dislike some behavior of their partner or some aspect of the relationship itself and rationally prefers it not exist. The emotional reaction would then include such appropriate feelings as frustration, concern, or annoyance, but the partners are still capable of relating harmoniously, communicating to resolve their issue, or uncouple without bitterness.

A relationship disturbance arises when one or both of the partners harbor such strong, negative emotions as hurt, anger, insecurity, jealousy, or guilt about their relationship difficulties, most often accompanied by a breakdown in trust and goodwill, communication, and problem-solving capability. The couple now struggles with two problems for the price of one: they first have a relationship difficulty; then, superimposed on top of that, they experience negative emotions toward each other and/or the relationship that leads to dysfunctional behavior.

When couples experience only relationship difficulties, the REBT therapist facilitates focused problem-solving and/or teaches the requisite interpersonal skills so that they can flourish going forward on their own. However, when couples are mired in relationship disturbances, the therapist first works to eliminate the disturbances and then addresses the difficulties. He or she does this for two reasons: one, with relationship disturbance in play, couples often find it difficult to work cooperatively together to find effective solutions to their problems; two, ridding the difficulty with-

out ridding the disturbance leaves the couple vulnerable to once again reacting in the same disturbed ways when new difficulties arise in the future.

The ABC's of Relationship Disturbance

Consistent with REBT practice in general, REBT with couples starts with the fact that disturbed couple relationships (at C) stem not so much from what happens between the couple (at A), but from the irrational beliefs (at B) they hold about their happenings (Ellis, 1986). Specifically, three major perfectionistic demands create almost all relationship disturbance:

1. Self Perfectionism: I must (have to, need to, got to) do perfectly well with and be perfectly loved and approved by my partner, otherwise it is so horrible that I can't bear it and it would prove me to be worthless and unlovable. This belief leads to insecurity, neediness, and dependency, feelings which prompt all kinds of relationship-defeating behaviors—whining, pouting, clinging, manipulating, controlling, and hysterics, to name but a few.
2. Partner Perfectionism: You, my partner should (ought to, must) always act right and treat me well, otherwise it is horribly unbearable and you are a terrible person for doing so to me. Holding this belief, the person thereby creates anger and resentment that inevitably prompts direct or passive-aggressive retaliation.
3. Relationship Perfectionism: My relationship must (should) always be easy, rewarding, and free of frustration, such that this relationship becomes unbearable when it's not and I've got to get away from it. Endorsing relationship perfectionism, one or both partners are likely to overreact emotionally when frustrated, avoid or run away from problem-solving, and denigrate the whole relationship as intolerable when in fact there is also good in it.

When there is a relationship disturbance, the therapist will apply the requisite range of REBT techniques to help the disturbed parties to uncover, surrender, and replace their disturbance-producing beliefs. Then, without the disturbance, he or she will focus on eliminating relationship difficulties, resolving couple disagreements, and building harmony and satisfaction between the partners.

Vicious Circle

It is common for couples in distress to have created a mutually- destructive vicious circle. A vicious circle exists when one of the couple partners presents a difficulty to the other partner, who then gets upset and acts in a difficult way in return, which reciprocally prompts both upset and more problematic behavior from the original partner, thus further stimulating the second person to again act badly, and on and on. Often mutual hurt, frustration, and disturbance builds, with each partner getting more

and more entrenched in their relationship-defeating behavioral patterns, blaming the other for the problems they have, and justifying one's own difficult behavior as warranted.

The REBT couples therapist works to get each partner to own responsibility for his or her own contribution to their never-ending vicious circle. Then, the therapist uses the requisite range of REBT tools to eliminate each partner's disturbance, opening the door to resolving relationship difficulties and building harmony.

Flexibility

In doing REBT with couples, it is wise to conceptualize that there are three intertwined but separate entities involved, each of which may need treatment: (1) partner one as an individual; (2) partner two also as an individual; and (3) the couple as an interactive unit. While the concept of "couple" is an abstraction that refers to the habitual patterns of interaction between two people, this tripartite distinction carries great weight when doing the relationship diagnosis and determining the best format for intervention.

We personally prefer to hold conjoint sessions with a couple that allows us to address their individual patterns of irrational and dysfunctional thinking, feeling and, behavior, as well as their dysfunctional interaction patterns. However, we find it wise to be flexible, that is, at times seeing one or both of the parties individually, at other times working with them conjointly. Here are some of the circumstances that argue for individual sessions: (1) when one of the partners has such a serious emotional problem that he or she needs focused individual attention; (2) when anger in one or both partners is so intense and/or trigger-happy that constructive communication breaks down; (3) when one or both partners harbors a hidden agenda; (4) when one or both partners finds it impossible to share important information with the other present; (5) when one or both partners feel so personally threatened they cannot take responsibility for their own role in the couple disturbance in the presence of the other.

Two words of caution with regard to conducting individual sessions within the context of couples therapy. One, to prevent the appearance of collusion, take great care to emphasize to both partners that you have no stake in the outcome of their relationship. You are only there to help remove relationship disturbance so that they can then make sound decisions as to how to behave going forward, whether that be to work together to build happiness and harmony or to gracefully separate. Two, to facilitate honesty and openness, emphasize that, when seeing one or the other partner alone, you will honor their confidentiality. After all, to be productive, the partner seen alone must be forthcoming.

Building Love, Connection, and Harmony

Without relationship disturbance, the couple is primed to eliminate their relationship difficulties and build a relationship filled with love, connection, and harmony. To do that, the couple partners need to understand the nature of love. According to Hauck (1984), "Love is that powerful feeling you develop for someone whom you believe will give you the qualities and experiences you most want and deserve from another person." So, he says, it is not the person himself or herself per se that directly stimulates your love, but your judgment of his or her value to you that does it.

The REBT couples therapist teaches that a person cannot actually give love itself to one's partner. What he or she does give are behaviors that are meant to be loving. So, to build couple love, connection, and harmony, the REBT couples therapist guides the couple through a three-step process designed for each partner to persist in acting loving in ways desired by the partner, helping them: (1) understand what each other wants and needs to feel loved and cherished; (2) develop the ability to act accordingly; and (3) relentlessly act to deliver what is wanted and needed by the other person.

Hard Work

All the insights and strategies explicated within sessions will be rendered useless unless the couple partners implement and practice them daily in their regular lives. The real work of REBT with couples, then, as with all REBT patients, takes place between the office sessions. The REBT couples therapist must therefore carefully assign therapy work to be acted upon between sessions. Furthermore, the therapist must see to it that each partner understands and appreciates that purposeful, sustained hard work to habituate the cognitive, emotional, and behavioral patterns in order for them to create a happy, harmonious relationship is necessary for success.

Key REBT Assessment and Treatment

Strategies and Techniques in Working with Couples

We think of REBT with couples to be a five-step process as described below. However, as communicated in *The Couples Therapy Companion: A Cognitive Behavior Workbook* (Grieger, 2015), it is important for a psychotherapist to be flexible. Think of the couple therapy process more as a basketball game than a golf match. In golf, the players progress lockstep from the first hole straight through the eighteenth with no deviation from start to finish. By contrast, the basketball players all know the strategy, but they must constantly adapt as the changing game situation unfolds. Like in

basketball, the REBT couples therapist may be focused on step three at one moment, find it necessary to divert back to steps one or two the next, then return once again to step three, and so on.

Step One: Relationship Diagnosis

With a willingness to be flexible, then, what follows is a template we carry in our heads as we conduct my couple diagnosis. Rarely does the diagnostic interview precede step-by-step down the list presented below. Most often, it comes from the natural flow of the conversation between the couple and the therapist, facilitated by careful listening, direct observation, and opportunistic questions.

1. **Relationship Difficulties**. The fact is that one inevitably mates with a fallible, flawed person who will at times act poorly, sometimes not doing what is wanted, other times doing what is not wanted. Similarly, there are inherent limitations and disadvantages to being mated that invariably lead to frustration and annoyance. That is the reality of living with another human being in a mutual relationship. Most couples thus come to therapy with a laundry list of complaints. These are the A's in REBT's ABC model. What are they? What does the "offending" partner think about his or her partner's complaint? The presence of these difficulties has the potential to erode love and provide the stimulus for relationship disturbance.
2. **Relationship Disturbance**. The REBT couples therapist stays alert for expressions of negative emotional reactions (e.g., hurt, anger, jealousy, insecurity, low frustration tolerance) and dysfunctional interaction patterns (e.g., acts of hostility, controlling behaviors, acts of dependency). These are the C's in the ABC model. If not volunteered, we make sure to follow-up couple complaints with four questions designed to uncover them:

   (1) How do you react emotionally when your partner does that?
   (2) Feeling that way, how do you typically respond?
   (3) When you act that way, how does your partner react in turn?
   (4) Does your reaction help the relationship or does it do harm?

3. **Irrational Beliefs**. It is central in the REBT diagnosis process with couples to uncover the irrational beliefs the partners' hold that cause their respective relationship disturbances. The therapist searches for any and all perfectionist demands—about oneself, the partner, and/or the conditions of the relationship itself. Without correcting these, thereby eliminating relationship disturbance, there is little chance for the couple to be able to communicate, problem-solve, and build harmony and happiness.
4. **Vicious Circle**. We particularly stay alert for the presence of a couple vicious circle. As explained earlier, this occurs when partner one presents a difficulty to partner two, who overreacts and thereby presents a difficulty back to partner one, who in turn overreacts and again presents another difficulty to partner two,

and on. Uncovering the vicious circle is critical for REBT to be successful with couples. It provides the necessary information to show each of the partners their responsibility for the ways they act/react that stimulate their partner to act/react in return.

5. **Additional Diagnostic Information**. As the diagnostic interview progresses, we find it useful to assess the following in order to formulate a workable treatment plan:

   - Does either partner suffer from an emotional disturbance that may negatively affect the process of couples therapy?
   - Do the partners love each other and are they committed to the relationship?
   - Does either partner have an impulse control disorder that would disrupt the productive use of the couple sessions?
   - What is the best format for the couple's therapy to proceed? Conjointly? Individually, then moving to conjoint sessions? Some combination of individual and conjoint?

Step Two: Couple Insight and Goal Setting

Armed with all the information obtained through the relationship diagnosis, the second step is to educate the couple about the dynamics of their problems and the therapy process itself. Being active, directive, and authoritative, we:

1. **Draw the distinction** for the couple between their relationship difficulties and relationship disturbances. Once distinguished, we take great pains to impress upon them that fixing the difficulty without fixing the disturbance may quiet their immediate dilemma, but will leave them vulnerable to a reactivation of their relationship disturbance in the future once another relationship difficulty arises.
2. **Teach REBT's ABC's** so that each of the couple partners understands that their own irrational beliefs cause their respective emotional and behavioral disturbance. The goal here is for each partner to understand and accept responsibility for creating his or her own disturbed reaction to their partner's "misbehavior," thereby creating the possibility for each of them to take responsibility for eliminating their own disturbed reactions.
3. **Explicate the couple's vicious circle**. We always outline this on the white board standing next where we sit. We show the couple how each of their overreactions, driven by their respective irrational thinking, serves as an activating event to stimulate both irrational thinking and then overreactions on their partner's part. The goal is to help each of the partners to see their role in helping to bring about the undesirable behavior they get from their partner, thereby motivating each to first focus on fixing their own relationship disturbance, not the relationship difficulties their partner presents to them.

4. **Set individual and couple goals**. Armed with the foregoing, the couple can now participate in setting elegant goals for change. These can include: (1) ridding the relationship disturbance one or both partners have; (2) learning necessary skills to enhance relationship harmony; (3) resolving relationship differences, disagreements, and conflict; and/or (4) developing strategies to build connection and harmony.

Step Three: Eliminate Relationship Disturbance

As stated earlier, relationship disturbance does not so much stem from the differences or disagreements between people, but from the irrational beliefs people hold about these difficulties. These irrational ways of perceiving and thinking can prompt negative emotional reactions and dysfunctional behaviors that are relationship damaging. They include:

(1) **Personalization**—Assuming the partner's behavior is purposely and coldbloodedly motivated by a desire to do personal harm, thereby causing hurt feelings;
(2) **Perfectionistic Demanding**—Demanding that the partner never act badly, thereby causing anger and resentment;
(3) **Neediness**—Believing that one needs to be loved in order to survive and have human worth, thereby causing insecurity, dependency, possessiveness, controlling this, and worry;
(4) **Catastrophizing**—Thinking that something unwanted or undesirable is so awful, horrible, or terrible that it is virtually understandable, thereby escalating difficulties in such catastrophes;
(5) **Low Frustration Tolerance**—Believing that one can't stand the inevitable frustrations that are part of any relationship, thereby causing the person to overreact to the normal deprivations, discomforts, and difficulties of relationship life; and
(6) **Self/Other Damning**—Rating one's self and/or the partner's self as all bad or worthless because of some difficult act or trait, leading to feelings of anger and resentment toward the partner and/or insecurity and inadequacy about oneself.

Whether done conjointly or in individual sessions, the REBT couples therapist uses classic REBT techniques to help each partner: (1) become mindful of the relationship disturbance and it's deleterious impact on the relationship; (2) take responsibility for creating one's own relationship disturbance by virtue of one's endorsed irrational thinking; (3) identify and own the exact irrational beliefs that create the disturbance; (4) resolutely dispute the validity and efficacy of the beliefs until their irrationality is revealed; (5) practice more rational ways of thinking until endorsed and habituated; and (6) act in new, constructive relationship ways.

Step Four: Build Relationship Harmony and Happiness

Once relationship disturbance has been overcome, some couples opt to discontinue their therapy. No longer upset with their partner, they gracefully lump their relationship difficulties as no big deal. Others choose to then work to resolve their difficulties or disagreements and/or deepen their bond. With the goal of building relationship harmony and happiness, the REBT couples therapist then teaches the skills to resolve differences and the techniques to deepen love. Described in detail in *The Couples Therapy Companion* (Grieger, 2015), we find that most couples can profit from using one or more of the following five strategies:

1. **Act on the Three Relationship Power Principles**: (1) be a giver, not a getter; (2) take 100 percent personal responsibility for the success of the relationship; (3) love is action, not feeling;
2. **Be a Relentless and Intelligent Giver**, by relentlessly displaying love to the partner in exactly the way he or she most wants and appreciates;
3. **Keep the Commitment to the Couple** alive and vibrant, by helping the couple acknowledge they have a committed relationship, work together to create the vision of how their relationship would look in its ideal state, develop a strategic plan to get from where they are to where they want to be, and finally act to make it so;
4. **Develop Frequent, Passionate Intimacy**, both with regard to communication intimacy and physical intimacy.
5. **Practice Win-Win Conflict Resolution**, whereby differences and disagreements are resolved in ways that neither party feels defeated and in which no resentment, bitterness, or hurt feelings linger.

Step Five: Ending

As the noted psychiatrist Kubie (1956) noted, "Men and women are infinitely ingenious in their ability to find new ways to be unhappy together, so that even with unlimited space it would be impossible to illustrate every variety of marital misery." It is little wonder that this is so when one notes the inherent disadvantages of being mated, the numbers of practical issues with which the typical couple will have to contend, the fact that when one always mates with a fallible individual who will be frustrating at times, the likelihood that two peoples' personal styles will at times clash, and the unexpected adversity that circumstances can provide.

Accordingly, to end REBT with couples, we take pains to review what has been addressed, being sure to highlight the correcting of the irrational thinking, feeling, and acting they accomplished, as well as the new skills that they've learned. We emphasize, however, that it would be a mistake to think of themselves as forever cured. Rather, we tell the couple that they can easily slide back into their former dysfunctional patterns if they don't consciously and purposely continue to think and

act on what they have learned in their therapy. Finally, we encourage the couple to check back with us, first in one month, then three months later. These check-ins provide both the couple and us closure, plus an opportunity to schedule a refresher appointment if needed.

Treatment Guidelines from the Empirically-Supported Literature that Inform Best Practice in REBT with Couples

It is beyond the scope of this chapter to present in detail the research that supports the efficacy of REBT with couples. Nevertheless, in brief, the overall results demonstrate robust improvement across a number of salient outcome variables for cognitive behavior therapy in general and REBT in particular (Epstein, 2001; Patterson, 2005). This includes both process research, which investigates what happens inside therapy sessions that is critical for successful results, as well as the predominate beliefs that elicit emotional disturbance among couples.

Central to REBT with couples is the correction of irrational beliefs that each partner may hold that drive relationship disturbance and prevent constructive communication, cooperation, and goodwill. In a thorough review of the literature, Friedlander, Wildman, Heatherington, and Skowron (1994) concluded that client changes in cognition (i.e., beliefs), among other things, significantly contributed to successful couple outcome. Similarly, Diamond and Diamond (2002) found that one of the hallmarks of favorable couple outcome was re-attribution/reframing. And, Sexton, Alexander, and Mease (2004) identified three critical change mechanisms related to couple therapy success, one of which was the reduction of blame.

While understanding that irrational beliefs drive relationship disturbance, research has also looked to identify which types of irrational beliefs are most strongly related to marital dysfunction. Addis and Bernard (2002) identified self-downing beliefs (i.e., "I must be loved to be worthwhile.") and the need for comfort (i.e., "The conditions of my relationship must always be rewarding and never frustrating.") as dimensions of irrational thinking most strongly related to marital dysfunction. Their results suggest that each partner's demands for approval and comfort can be exacerbated to the point of marital disturbance when the frustration of these demands are followed by lower frustration intolerance ones (i.e., "I can't stand it'itis."). Addis and Bernard (2002) further concluded that this irrational thinking can best be elicited when levels of reinforcement and acknowledgement fall below a threshold level. It should be noted that the idea of "threshold" can occur as an arbitrarily defined criterion across people that may themselves function to increase the potency of the unhealthy/unhelpful emotions driven by their irrational beliefs.

In addition to these beliefs, Ellis (1996) also describes the cognitive-behavioral process of morbid jealousy, as differentiated from rational, undisturbed jealousy. Typically, the irrational form of jealousy occurs when one demands that the significant other must not become emotionally involved with another and deprive one

of love. While it may be desirable or preferable for a partner to not become emotionally involved with another, morbid jealousy prompts disturbed emotions such as strong anxiety, depression, and/or anger which most often result in severe insecurity, hostility, and ultimately to the relationships demise.

One of the more significant moderators to marital satisfaction is the partners' intimate relationship. We have found this to be true in our clinical practices, for physical intimacy can and often is a bonding activity. Research has illuminated the impact that irrational beliefs about sexual performance has on the wear and tear of a relationship. Abrams (2012) specifically found that rigid and inflexible demands on oneself and on the significant other are the predominate irrational beliefs most associated with unstable relationships and unsatisfying sexual encounters. Abrams (2014) also found a strong relationship between irrational beliefs pertaining to sexuality and intimacy in relationships and more general life problems and distress.

Religion may also serve to moderate marital harmony. Johnson (2013) detailed the effects of using REBT with Jewish, Christian, and Muslim couples. Overall, religion was found to be both a protective factor and a stressor for couple health. He recommended that when addressing religious issues in session, focus should be placed on identifying if there is a demanding nature to the couple's beliefs about religious views. Johnson reported that when reframing demanding beliefs as preferences for the individual's religious views, the client was better able to assertively state their preferences to their partner and, when they do not get a satisfactory response to what they want, emotional consequences would appropriately be disappointment as opposed to more extremes such as anger and resentment.

As to the REBT couples therapy in-session processes, Addis and Bernard's (2002) research highlight the importance of focusing on each partner's irrational beliefs and emotional reactions rather than the dyadic relationship. That is, helping individuals address their demanding of perfection of themselves, their partner, and the relationship itself proves to be helpful in each partner's ability to self-regulate their emotions. Additionally, helping each partner to increase their capacity to tolerate discomfort can also serve the same purpose and assist in improving aspects of the relationship itself. Ellis (1996) also provides suggestions to develop tolerance for the feared outcome associated with morbid jealousy. He cites cognitive distraction, rational emotive imagery, and role playing as among many of the techniques that have proven to be helpful in couple treatment, in addition to REBT's traditional disputational strategy (Ellis, 1996).

Of particular importance to practitioners is the question of to whom it is best to focus the attention in session—the individual or the dyad. As Addis and Bernard's (2002) research suggests, the individual's irrational beliefs should be the primary focus. In support of that, Möller and Van der Merwe (1997) found that there is limited value for one partner to be aware of their partner's irrational beliefs. He suggests that the focus of therapy would be best placed on each individual's own irrational beliefs.

It should be clear at this point that REBT with couples has proven to be effective in helping couples both eliminate relationship disturbance and build relationship harmony. That has certainly been our personal experience in the clinical office.

Brief Case Example[1]

Sam and Nicole sat on the love seat across from me and told me that their biggest problem was poor communication. A second marriage for both, they explained that with their temperamental differences, he, laid-back and contemplative, she, high-energy and emotional, they often misunderstood each other's tone and mannerisms, thereby getting defensive and finding it impossible to reach consensus on several devilish issues. "Can you teach us how to communicate better?" Sam asked.

Having heard similar complaints from scores of couples, I knew the problems Sam and Nicole had went deeper than mere skill deficits. To get into the meat of their relationship problems, I asked them to share a recent example in which communication broke down.

That opened the floodgates. Without hesitating, Nicole voiced complaints about what she described as Sam's prejudicial treatment of her children in contrast to that of his, how they managed money so differently, and the dearth of quality time he gave her after he came home from work in the evenings. In response to my questioning, she admitted that she reacted with hurt and anger to her frustrations, feelings that prompted her to force a confrontational conversation.

Bringing Sam into the conversation, he complained that, despite all the efforts he made to please her, he felt he could never do enough. He said he felt "on edge" much of the time around her, expecting her to get upset about something no matter what. He reported that he got irritated when "she starts in on me." His responded then by withdrawing into himself.

So there it was. This couple's problems proved to not be a simple lack of communication skillfulness. Rather, they both harbored a relationship disturbance that had solidified into an ingrained vicious circle: the more frustrated and angry Nicole acted about her dissatisfaction with Sam, the more he withdrew into resentful silence; then, the more he withdrew from her, the more her hurt and anger deepened. With this in play, there was no way they could talk out their couple difficulties as teammates, even armed with the best of communication skills.

In typical REBT fashion, I took on an active, directive posture at this point. I explained to Sam and Nicole that they suffered from both relationship difficulties and relationship disturbances, illustrating what I meant with examples from what they had just shared. I then drew on the whiteboard standing next to me the self-perpetuating vicious circle in which they were trapped. I concluded by asserting that they'd never be able to communicate effectively to resolve their problems, no matter how many skills they may acquire, while ensconced in their debilitating vicious circle.

"Do you understand all this?" I asked.

"Yeah, but how do we break out of it and get back on track?" Nicole asked.

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[1]We will illustrate the process of REBT with couples through the treatment of Sam and Nicole, a couple treated by the chapter's major author, Russ Grieger. This section will thus use the pronoun "I" rather than the collective "we."

"By understanding what causes each of you to experience your respective relationship disturbances, taking personal responsibility for fixing what you do to cause your own disturbance, and then work your behinds off until you succeed to rid yourself of it."

"You can help us do that?" Sam asked.

"Yes," I said, "but only if you both work hard with me. Will you?"

After they nodded, I taught them REBT's ABCs, then helped each of them ferret out the irrational beliefs that drove their respective relationship disturbances. For Nicole, it was, first, personalizing what Sam did (i.e., "If he loved me, he would do X and not do Y."), and, second, perfectionistically demanding he act the way she wanted ("He should do this; he shouldn't do that."). For Sam, it was straight-out perfectionistic demanding ("I don't need this crap. She shouldn't be such a pain in the ass.").

The couple diagnosis completed, that set the stage for goal setting. Together, we three agreed to first work to eliminate their relationship disturbances of hurt and anger, then to work on learning conflict resolution skills so that they could work collaboratively together to eliminate their relationship difficulties.

All this pretty much exhausted the time available for Sam and Nicole's first REBT couples session. To conclude, I summed up their couple diagnosis and reinforced the goals we had set. Then I made three points before rescheduling:

1. The sequence of their work was important: it was critical to first rid their relationship disturbance, then work to resolve their relationship difficulties. I explained that, while at the resolution of their various conflicts was desirable, eliminating the irrational thinking that caused their relationship disturbance was a critical first step. Why? Because, resolving conflicts without ridding the disturbance would leave them vulnerable to future disturbance if and when future conflicts arose;
2. To make the desired changes, they'd have to work daily to both correct their thinking and their behavior patterns. This required them to think of their therapy as something to do daily, not just when they came to my office for their weekly session;
3. For their first between-sessions therapy work, I instructed them to read the Introduction, Chap. 3 ("Eliminating Relationship Disturbance: an Overview"), and Chap. 4 ("Premeditated Acceptance and Forgiveness: The Antidote Hurt and Anger") of my couples book, *The Couples Therapy Companion: A Cognitive Behavior Workbook* (Grieger, 2015). I told them to digest the content of all this so that we three would be on the same page when they returned to my office so that we could meet our therapy goals.

In the next four conjoint sessions, I led Sam and Nicole through REBT's working through process. First with Nicole, then with Sam, I helped them hold their irrational beliefs up to logico-empirical scrutiny—Nicole's personalization about and perfectionistic demanding of Sam; Sam's perfectionistic demanding of both Nicole and his relationship life in general. The goal was to reveal to them both the lack of validity and how self-defeating these beliefs were. Following this, I helped them formulate

more realistic, rational beliefs that would not cause them to experience hurt and anger toward each other, to whit:

1. My partner does not purposely and premeditatedly act in the ways I dislike just to do me in. Rather, he/she does so because of the way he/she is psychologically put-together. It's about him/her, not against me as a reflection of not loving me or as an act of disrespect or disloyalty.
2. My partner, being a fallible human being, must have flaws and must on occasion act in ways I don't like. Furthermore, he/she must have the flaws he/she has and act badly when he/she does, not just when I find it convenient or permissible. I don't have to like it, but I don't have to damn or judge him/her for simply acting human.
3. When my partner misbehaves, I have two good choices: (1) gracefully lump it, without hurt or anger, and get on with relating lovingly; or (2) without hurt or anger, work with him/her to resolve our difficulty in a mutually satisfying way.

As we write this chapter, Sam and Nicole have made significant progress in ridding their respective relationship disturbances. This has allowed them to begin to use win-win conflict resolution strategies to resolve their relationship difficulties. Following Stephen Covey's (1989) model, I (RG) am teaching them how to use a three-step conflict-resolution process: (1) endorse the win-win principle; (2) use sound listening skills in order for them each to fully understand what is a win for their partner; (3) armed with this information, incorporate synergistic brainstorming until a workable solution is found that can be a win for both.

It was fortunate that Sam and Nicole willingly cooperated with their therapist in their REBT couples therapy. But we have to also give credit to the theory and practice of REBT with couples that brought direction and order to the process. With all three of us being clear about was taking place, and by them working hard both in and between sessions, they successfully eliminated their relationship disturbance and are well on their way to resolving their relationship difficulties through the use of new problem solving and communication skills. Good for them.

What We Have Learned About Using REBT with Couples

Accommodating Individual Differences: Client Gender, Ethnicity, Socio-Economic Status, Intelligence, and Other Factors

While we always operate from the framework of REBT's ABC's in the couple therapy process, we do our best to never forget that we are conversing with people who bring their unique perspectives and experiences to this endeavor. As the leader, it is therefore our responsibility to do whatever it takes to help the couple partners enroll in the therapy process, hear and understand what insights and instructions we have to

offer, and commit to follow-through on assignments between sessions. Accordingly, it is critical that we be sensitive to and accommodate the individual differences they bring to the process as a result of their unique circumstances. With the perspective of bringing unconditional self-acceptance to each of the couple clients, we take care to parse our vocabulary, pace, illustrative stories, degree of directness, and the method of addressing them, among other things, to help them feel comfortable with us, hear our message, and cooperate with us. In this way, REBT with couples differs little with other methods of helping couples.

The Do's and Don'ts

At its core, REBT with couples is nothing more than a conversation between people. Yet, it is not one among peers, but rather a hierarchal conversation in which one party, the therapist, guides, teaches, and directs the other party, the couple partners, along a path from where they are to where they want to be. Being the authority figure, we have found it beneficial to keep the following do's and don'ts in mind as we conduct this conversation.

Elegance

We again remind the reader of the critical distinction between relationship difficulties and relationship disturbances. So many couple therapists prioritize helping couples alleviate relationship difficulties, while ignoring the irrational beliefs that cause the hurt, anger, insecurity, jealousy, and/or low frustration tolerance one or both parties harbor. Through this inelegant focus, the couple may indeed temporarily feel better, but they remain vulnerable to another breakdown should another relationship difficulty arise in the future. The long and the short of it is that the couple may temporarily feel and act better, but do not really get better at their core.

REBT with couples strives to always elegantly help couples rid their relationship disturbance first and then, if they want, tackle relationship difficulties. Without relationship disturbance, the couple can benefit in that: (1) they are better able to work together to solve relationship difficulties without the contamination of this emotional poison; (2) they can gracefully lump the relationship difficulties that are unresolvable and get on with the business of living in harmony despite them; (3) they can avoid the crisis of another relationship disturbance in the future once another relationship difficulty arises.

Between-Session Couples Work

Breaking dysfunctional relationship patterns of thinking, feeling, and acting requires strenuous, sustained effort. Emphasizing this to our couple patients, we make it a

point to assign them individual and/or conjoint therapy tasks to practice between each and every session. We make sure that they know that insight is never enough, that we have no magic, and that it's up to them to work to make the needed changes in order for them to have a happy, harmonious relationship. Hard work and sustained practice is the coin of the realm.

Unconditional Personal Responsibility

More often than not, the couple partners come to therapy complaining about something they don't like about the relationship and/or the behavior of their significant others. "Doc, fix him (or her, or it) and everything will be just fine" is what we hear, explicitly or implied, at the beginning of virtually every one of my couple cases.

While there may be some validity to the complaint each party voices, what they often don't understand is that their reaction to what they don't like about their partner is a problem in and of itself. Furthermore, it is counterproductive to what they want to change in their partner. What they may not see is their own role in perpetuating the vicious circle that most often is part and parcel of their relationship disturbance.

It is critical for the REBT couples therapist to see to it that each partner takes responsibility for their own dysfunctional reaction to what they find obnoxious in their partner, for their reaction often serves to stimulate their partner to continue to act in the dislikable ways they do. If you think about it, the ABC's of REBT at their core communicate personal responsibility, as does the concept of the vicious circle. Throughout our work with couples, we keep the principle of unconditional personal responsibility in the forefront of our minds so as to deter the couple from perpetuating a blaming, victim stance that helped to drive them to the office in the first place.

Be Active, Directive, and Authoritative

As with most individual patients, couples typically enter therapy with little insight into the causes and cures of their dysfunction. By and large, they are ignorant in that they don't know what they don't know, and, furthermore, they often don't even know that they don't know. Left to their own devices, they can mindlessly continue to act out what they dysfunctionally do to bring them into REBT couples therapy.

Knowing this, the REBT couples therapist takes an active hand in directing the therapy process. He or she teaches the couple what they need to know in order to recover, leads the conversation into productive directions, mediates differences of opinions, provides salient information, and confronts aberrant behavior. He or she unabashedly acts as an unbiased authority figure.

Which Aspects of REBT with Couples Delivers the Most Benefits for Change

All the REBT policies, practices, and procedures with couples presented in this chapter are important in delivering benefits for change. Yet, by far the most important is REBT's ABC model itself. It provides a simple but profound template for both the therapist and the couple to: (1) separate relationship difficulties at A from relationship disturbances at C; (2) understand and appreciate the power of one's self-talk, beliefs, and paradigms at B in creating the couple disturbances that can destroy relationships; (3) conceptualize the vicious circle that most couples create and that perpetuate their relationship dysfunction; (4) set the priority of first eliminating any relationship disturbances before correcting relationship difficulties; and (5) direct the attention of each person to focusing on disputing and replacing his or her irrational thinking at B as the first and most important step in positive change. Through the use of this profound ABC tool, once the couple is rid of their relationship disturbance, they are free to correct any relationship difficulties they may desire, as well as prevent relationship disturbances from arising if and when difficulties present themselves in the future.

Concluding Remarks

In this chapter, we have done our best to explain and illustrate the process of REBT with couples. It can be quite a challenging endeavor. After all, there are not one but two clients with whom to work, each of whom carry their own deeply engrained belief systems and behavior patterns, not to mention the complicated and oftentimes charged interactions between the two of them. At the same time, all this can be stimulating and quite a rewarding way to conduct one's professional life.

We close with one more observation. REBT with couples, as laid out in this chapter, can not only be applied to couple relationships, both heterosexual and homosexual, but also to parent–child relationships, sibling relationships, and dyads in the workforce. Its principles and practices contained herein are limitless.

References

Abrams, M. (2012). Helping couples deal with intimacy and sexuality. In A. Vernon (Ed.), *Cognitive and rational emotive behavior therapy with couples* (pp. 97–117). New York: Springer.

Abrams, M. (2014). A sexual irrational belief is associated with several measures of sexual and emotional problems and reports of life Trauma. *Transylvanian Journal of Psychology*, (2), 127–156.

Addis, J., & Bernard, M. E. (2002). Marital adjustment and irrational beliefs. *Journal of Rational-Emotive & Cognitive-Behavior Therapy, 20*(1), 3–13.

Diamond, G. S., & Diamond, G. M. (2002). Studying a matrix of change mechanisms: an agenda for family-based process research. In H. A. Liddle, D. A. Santisteban, R. F. Levont, & J. H. Bray (Eds.), *Family psychology: science-based interventions* (pp. 41–66). Washington, D.C.: American Psychological Association.

Ellis, A. (1986). Rational-emotive therapy applied to relationships. *Journal of Rational-Emotive Therapy, 4,* 4–21.

Ellis, A. (1996). The treatment of morbid jealousy: a rational emotive behavior therapy approach. *Journal of Cognitive Psychotherapy: An International Quarterly, 10*(1), 23–33.

Epstein, N. (2001). Cognitive-behavior therapy with couples. *Journal of Cognitive Psychotherapy: An International Quarterly, 15,* 299–310.

Friedlander, M. L., Wildman, J., Heatherington, L. & Skowron, E. A. (1994). What we do and don't know about the process of family therapy. *Journal of Family Psychology*, 8, 390–416.

Grieger, R. (2015). *The couples therapy companion: a cognitive behavior workbook*. New York: Routledge.

Hauck, P. A. (1984). *The three faces of love*. Philadelphia: Westminster.

Johnson, S. A. (2013). Using REBT in jewish, christian, and muslim couples counseling in the United States. *Journal of Rational-Emotive & Cognitive-Behavior Therapy, 31*(2), 84–92.

Kubie, L. S. (1956). Psychoanalysis and marriage: practical and theoretical issues. In V. W. Eisenstein (Ed.), *Neurotic interaction in marriage*. New York: Basic Books.

Moller, A. T., & van der Merwe, J. D. (1997). Irrational beliefs, interpersonal perception and marital adjustment. *Journal of Rational-Emotive & Cognitive-Behavior Therapy, 15*(4), 269–279.

Patterson, T. (2005). In M. Horway (Ed.), *Handbook of couples therapy*. New York: Wiley & Son Inc.

Sexton, T. L., Alexander, J. F., & Mease, A. L. (2004). Levels of evidence for the models and mechanics of therapeutic change in family and couple therapy. In M. J. Lambert (Ed.), *Bergin and Garfield's Handbook of psychotherapy as behavior change* (5th ed., pp. 590–646). Hoboken, N.J.: Wiley.

REBT with Families

Brooke E. Wachtler

A pioneer in the field of Cognitive Behavior Therapy (CBT), Albert Ellis helped shape the landscape of psychotherapy with his development of Rational Emotive Behavior Therapy. Starting his career as a psychoanalyst, Ellis later began introducing REBT approaches into his work with families, becoming one of the first psychotherapists to utilize cognitive behavioral interventions in the context of family therapy (Dattilio, Epstein, & Baucom, 1998). The cognitive strategies utilized in REBT lead clients to experience a philosophic shift in their pattern of thinking, and behaviorally based interventions help facilitate changes in the family's patterns of interacting (Ellis & Dryden, 1997). Around the same time that Ellis introduced REBT-based family therapy, behaviorists also began to apply behavioral interventions to the treatment of couples and families (Dattilio et al., 1998). By the 1970s, research studies emerged supporting the use of cognitive strategies, as an adjunct to behavioral interventions, to enhance couples therapy. Specifically, outcome studies support the efficacy of REBT in the treatment of families' emotional difficulties (Ellis & Dryden, 1997). Terjesen, Esposito, Kurasaki, and Kassay's (2009) review of the literature indicates that REBT is as effective as psychotherapy in general when treating children and adolescents. Moreover, Bernard, Ellis, and Terjesen (2006) explain that when parents are highly emotional about their child's actions, they are more likely to engage in ineffective parenting practices, which in turn leads to more negative interactions between the parents and child. Thus, REBT provides a framework to address the individuals' disturbed emotions, and then assist family members with problem solving and skill building to target the negative interactions. While the field was once primarily dominated by a psychodynamic orientation, the research supports Ellis's application of REBT, and points to the utility of applying CBT-based interventions in the context of family therapy (Ellis & Dryden, 1997).

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REBT Theoretical Concepts Within the Context of Family Therapy

Ellis and Dryden (1997) explain that, "Focusing on wholeness, organization, and relationship among family members is important but can be overdone. Families become disturbed not merely because of their organization and disorganization but because of the serious personal problems of the family members" (p. 141). Therefore, it is important to first address intrapersonal problems prior to tackling the interpersonal dysfunction occurring within the family unit.

The ABC Model

As would be done during an individual REBT session, the therapist works with each family member to identify the activating events ("A"), beliefs ("B"), and emotional and/or behavioral consequences ("C") about a recent or reoccurring problem. While assessment is focused on the individual, the process of identifying ABCs is central in better understanding the family dynamic. Specifically, identifying how each person's belief system can contribute to the overall discord and negative interactions occurring within the family. It is not the son missing his curfew that leads to arguing between the parents; rather, the parents argue due to what the father tells himself about his son breaking the family rules, and evaluating how his wife reacts to the situation. These cognitions lead to the father experiencing anger, and arguing with his wife and son.

The "A."

Epstein and Schlesinger (2003) explain that each individual holds beliefs about the other members of the family. Thus, it is these "Bs" that lead to an individual's emotional and behavioral reactions, not the situation. A situation, actual or perceived, may act as a trigger for one person's beliefs about the other members of the family, or the family unit. For instance, Epstein and Schlesinger (2003) note four events that can act as "As" within the family unit:

1. The individual's own cognitions, behaviors, and emotions regarding family interaction (e.g., the person who notices him- or herself withdrawing from the rest of the family).
2. The actions of individual family members toward him or her.
3. The combined (and not always consistent) reactions that several members have toward him or her.
4. The characteristics of the relationships among other family members (e.g. noticing that two other family members usually are supportive of each other's opinion). (pp. 305–306)

The "B."

Cluxton-Keller (2011) notes that when individuals rigidly hold on to unrealistic expectations and demands, these beliefs will lead to emotional disturbance and self-defeating behaviors. These beliefs are called Demandingness. According to Huber and Baruth (1989), demands are often about approval, achievement, treatment, and comfort. In regards to the family system, this way of thinking can perpetuate a cycle of negative interactions amongst the family. Consistent with applications of REBT to individual psychotherapy, family members may also hold evaluative beliefs about the "A." These beliefs are defined as: frustration intolerance, awfulizing, and self-downing, other-downing, and life-downing. Huber and Baruth (1989) discuss different types of irrational beliefs that may arise in family therapy. Specifically, they note that Awfulizing and Demandingness beliefs held by family members contribute to dysfunctional patterns of responding.

Irrational ways of thinking can be unique to the individual, as well as shared as part of the family culture. According to Joyce (2006), "REBT also recognizes that beliefs of both kinds [irrational and rational] can be shared by parents and children to create a family culture. Thus, parents and extended families may induct their children into shared ways of thinking that perpetuate irrational patterns across generations" (p. 180). Huber (1997) shares a similar position, such that during the assessment phase in Rational-Emotive Family Therapy (REFT), he works to identify the common "family belief" that is influencing how the family members interact with each other (p. 127). As Dattilio (2001) explains, each individual has a schema about themselves and the world, as well as about families in general. Additionally, people have a family schemata, which Dattilio (2001) defines as, "… jointly held beliefs of the family that have formed as a result of years of integrated interaction among members of the family unit" (p. 9). Taking this explanation a step further, Dattilio (2001) explains that the family schemata also develops as a result of the family of origin, such that the parents' are influenced by their family experience, which then plays a role in how they navigate the current family system.

One goal of family therapy is to help the individual family members to change their irrational ways of thinking that is leading to unhealthy negative emotions and maladaptive behaviors, and also to help family members learn to think more rationally and in turn engage in more adaptive ways of behaving and feeling. Rational beliefs are non-dogmatic, preferential, and flexible and unlike irrational beliefs are logical and based in evidence (DiGiuseppe, Doyle, Dryden, & Backx, 2014). As Dryden (1984) explains, "[Rational thinking] is generally understood to refer to thoughts that aid and abet individuals in achieving their goals and purposes. By contrast, *irrational* is understood to refer to thoughts which prevent or block goal attainment" (as cited in Huber & Baruth, 1989, p. 23). The categories of rational beliefs are: preferences, anti-awfulizing, high frustration tolerance, self-acceptance, other-acceptance, and life-acceptance (DiGiuseppe et al., 2014).

"Unconditional self-, other-, and life-acceptance."

While working with each family member to develop new rational ways of thinking about problems, the therapist also helps the clients move toward the practice of Unconditional Self Acceptance (USA), Unconditional Other Acceptance (UOA), and Unconditional Life Acceptance (ULA) as a means to change the current family dynamic (DiGiuseppe et al., 2014; Bernard, 2008). In teaching acceptance, REBT therapists help clients acknowledge what one may not like or is unable to change, and choose not condemn oneself, others, or the situation (i.e. I am worthless). Clients learn to separate behaviors from the person, and recognize the connection between globally rating oneself, others, or a situation as leading to disturbed emotions and behaviors (DiGiuseppe et al., 2014). For example, a child may engage in naughty behaviors such as yelling or hitting, but this does not mean he is a bad child. Rather, he acts defiant at times. Similarly, if an adolescent condemns the entire familial unit as "no good" after being grounded by her father, the adolescent will experience anger, which results in tumultuous interactions with her family members. Once the members of the family can learn to unconditionally accept each other, there will be less time spent disturbing oneself about how the family *should* function differently, or how a family member *should* behave, and efforts can be made to change what is within each person's control.

The "B-C" connection.

What is important to consider in family therapy is that despite the origin of each person's patterns of thinking and behaving, each family member has a choice in the way he/she reacts to any given "A." Whether or not patterns of thinking or behaving have been modeled or reinforced, family members *cannot* make each other feel, behave, or think in certain ways (Ellis & Dryden, 1997; DiGiuseppe et al., 2014; Bernard, 2008). Often times, individuals enter therapy with the goal of changing a situation, or another family member; however, not all "As" can be changed. By teaching this concept of emotional responsibility, the therapist can help enhance the clients' motivation to target their cognitions, rather than try to change the other family members. Once the family understands and adopts the "B-C" connection, and recognizes his choice in responding to the "A," the therapist can move forward in helping the clients identify, challenge, and change their irrational ways of thinking.

The "C."

Primary disturbances.

Consequences can take the form of dysfunctional behaviors or unhealthy negative emotions that are characterized as being self-defeating and maladaptive. Specifically, when family members are exhibiting Cs, it is these emotions and/or behaviors that lead to relationship difficulties (Cluxton-Keller, 2011). As in individual REBT, family members may present with a range of unhealthy negative emotions including: anxiety, depression, unhealthy anger, guilt, shame, jealousy, envy and hurt. The accompanying behavioral consequences may be: aggression, withdrawal, avoidance,

or underachievement (DiGiuseppe et al., 2014). More specifically, Huber and Baruth (1989) discuss the role of severe anxiety or apathy can play in inhibiting family members from engaging in adaptive responding, while disturbed emotions in general lead to an individual's resistance in attempting new strategies for problem solving.

Secondary disturbances.

When working with a client to identify their ABCs, the therapist will also want to assess for a possible meta-emotional disturbance, such that a family member may experience an emotional reaction about an emotion (i.e., anxiety about feeling anxious). Joyce (2006) explains that parents may experience guilt about the presenting emotional or behavioral difficulty associated with parenting, a child's challenging behavior, or presenting pathology. Thus, Joyce (2006) indicates the value in thoroughly assessing the beliefs leading to the presenting emotional reactions, as well as checking-in with clients about a possible meta-emotional disturbance.

Key Best-Practice REBT-Based Assessment, Treatment Strategies, and Techniques in Working with Families

The Family Dynamic

According to Cluxton-Keller (2011), Ellis agreed with aspects of family systems therapy, but differed in his approach in that he first targeted intrapersonal difficulties, and then addressed the family dynamic. In REBT-based family therapy, the therapist explores how each individual's reactions and beliefs can perpetuate and trigger negative interactions amongst the family (Cluxton-Keller, 2011). Specifically, irrational beliefs can lead to unhealthy negative emotions and self-defeating behaviors, which then act as an "A" for another family member. For example, take a child presenting with anger when he does not get what he wants, which then results in opposition toward his mother's requests. The mother may think to herself, "Children *should* do as they are told," leading the mother to feel angry. As a result, the mother yells at her daughter about not doing her homework. The daughter then feels depressed because she believes "I am not good enough." In his book *The Rational Management of Children*, Hauck (1967) discusses how parental beliefs contribute to whether a parent exhibits "unkind and firm patterns," "kind and not firm," and "kind and firm" styles of parenting (as cited in Joyce, 2006, p. 178). Hauck (1967) explains that the first two styles are marked by overly rigid and overly lax parenting styles. The latter style is most preferable in that parents are consistent, set clear limits and consequences, separate the child's behavior from the child, and utilize appropriate praise and punishment (as cited in Joyce, 2006, p. 178). Tackling each client's irrational beliefs is integral in changing unhealthy patterns of thinking and behaving that lead to negative interactions. Through this process, the family gains insight into how each person's reactions contribute to the family's overall difficulties.

Empathy

According to DiGiuseppe et al. (2014) and Ellis and Dryden (1997), demonstrating empathy is another integral strategy essential in treating clients. DiGiuseppe et al. (2014) explain, "The empathetic therapist attends not only to the words of the clients but also the nonverbal aspects of their behavior in order to perceive accurately their feeling state" (p. 82). During whole family sessions, the therapist is balancing two roles: attending to the client who is speaking and the target of interventions, as well as monitoring the reactions of the other family members (Friedberg, 2006). Over the course of the session, the therapist may shift her focus and attention many times to keep the other family members engaged, and acknowledge each individual's reactions to what is occurring in the therapy room. Being able to identify non-verbal and verbal reactions in family members allows the therapist to help clients work through disturbed emotions occurring in the moment, as well as display empathy to help foster the therapeutic alliance.

Gaining Commitment and Enhancing Motivation

While a therapist can highlight each family member's role in contributing to dysfunction in the system, this does not guarantee every family member will be motivated to change. Many times individuals enter therapy at the request of another family member, rather than a willingness to change or accept one's role in the dysfunction that is occurring. Therefore, the first step of therapy involves gaining commitment from each family member to actively participate in treatment. This process often includes orienting clients to what will be expected of them during therapy (i.e. attendance, homework, communication, confidentiality, etc.), examining what the clients expect from the therapist, and introducing clients to the therapeutic model. Ellis and Dryden (1997) also suggest asking the clients to take responsibility for their ability to change, whether or not the rest of the family is committed to the process. According DiGiuseppe and Kelter (2006):

> Because people learn emotional scripts from their families and some emotional scripts are culture-specific, it is possible that the disturbed child or adolescent has not changed because he or she cannot conceptualize and experience an acceptable emotional script in place of the disturbed emotion. (p. 264)

Thus, DiGiuseppe and Kelter (2006) suggest employing the "motivational syllogism," which can be utilized to enhance motivation and facilitate agreement on the goals of therapy (p. 263). This involves helping the client explore how her current behavior or emotion is unhelpful, and recognizing there is an alternative way of thinking, feeling, and behaving that will be more effective in reaching the goal.

Cognitive Interventions

After gaining agreement on the goals of treatment, the therapist will generate a case conceptualization to help guide intervention planning. Therapists are trained to practice with a flexible, non-dogmatic style, just as we teach our clients to think and behave in the same manner. This means therapists utilize ongoing progress monitoring and assessment to guide treatment and make necessary adjustments. This may include providing individual sessions to one family member, or referring the client to another therapist for individual work. Modifications may also include adapting interventions based on the developmental level of the child, as well as the cognitive abilities of the adult (Bernard, 2008; DiGiuseppe & Bernard, 2006; Terjesen et al., 2009; Joyce, 2006).

Disputation.

Through the process of disputation, clients learn how their current rigid and dogmatic way of thinking is illogical, lacking empirical support, and inconsistent with reality. By learning to question, and ultimately give-up their irrational beliefs, clients will be able to begin rehearsing more rational ways of thinking about the "A" (DiGiuseppe et al., 2014). As a result, the client remediates his emotional disturbance and is better able to effectively engage in skill building and practical problem solving. Think about the last time you tried to speak clearly and calmly when feeling angry. It is almost impossible to perform successfully when experiencing high emotional arousal. Thus, clients are first taught to change their emotional reaction, and then work on practical problem solving and skill acquisition.

DiGiuseppe and Kelter (2006) suggest that for younger children who have yet to develop meta-cognitive abilities, to focus on skill building rather than utilizing abstract interventions such as disputation. This may include direct teaching of prosaically skills, rehearsing rational statements, and developing an emotional vocabulary. Additionally, DiGiuseppe and Bernard (2006) suggests employing "deductive interpretation," in which the child is presented with hypotheses about what she may be thinking based on the presenting emotions (p. 101). Similarly, adults may present with skill deficits or minimal insight and require education on emotions or prosocial skills, as well as modified interventions to make sessions more salient and successful.

Working with Behaviors in Family Therapy

Behavioral interventions are also incorporated into treatment to help bring about changes in the family system. Ellis and Dryden (1997) discuss the use of contracting to assist family members in resolving arguments. This intervention involves each family member agreeing to change a behavior that may be contributing to disagreements. Thus, rather than working on changing the other, each family member takes responsibility for a behavior within his or her control (Ellis & Dryden, 1997). Therapists may also teach clients prosocial skills to facilitate behavior change. Such skills

include: assertiveness, problem solving, and relaxation techniques. In the case of families with children or adolescents, the therapist may work with the family to develop a behavioral intervention plan to target a child's disruptive, oppositional, hyperactive, or inattentive behavior. Additionally, in the case of a family member exhibiting avoidant or compulsive behaviors, the therapist may utilize exposure exercises (Ellis & Dryden, 1997). At the end of each session, family members are assigned homework assignments to help generalize skills learned during sessions into day-to-day life. Family members work collaboratively with the therapist to generate the weekly homework assignments to target cognitions, behaviors, and/or skills.

Throughout treatment the therapist will want to continuously assess each family member for negative unhealthy emotions or behaviors, which could lead to difficulty following through or utilizing the skills being taught in session. Similarly, the use of ongoing progress monitor is utilized to assess the current treatment plan and structure of the session. For example, if only one family member would benefit from exposure therapy, it is beneficial to meet with that individual separately, or recommend additional therapy sessions with another therapist.

Behavioral analysis.

As mentioned earlier in this section, during the initial session the therapist will orient the clients to therapy, which will include explaining different components of treatment. The therapist can take time to explain the role of both cognitive and behavioral interventions that may be utilized throughout the course of treatment. To better understand the family system, it can be helpful to conduct a behavioral analysis for specific target behaviors. This information may be used to create a behavioral intervention plan for a child or adolescent who is exhibiting behavioral or attention difficulties. In the above example, the therapist and parent may target the child's tantrumming behavior by conducting a behavioral analysis, and determining the function of the behavior. By understanding why the behavior may be occurring, the therapist can help develop proactive and reactive interventions to be used across situations at home, school, or in the community (DiGiuseppe & Kelter, 2006). When introducing behavioral strategies, the therapist will continue to assess and address any irrational beliefs that may be contributing to the maintenance of a family member's maladaptive behaviors, or difficulty implementing behavioral strategies (David, 2014; Terjesen et al., 2009; Gaviţa, Joyce, & David, 2011). For instance, if an adolescent engages in reassurance seeking in regards to obsessions about contamination from germs, the therapist will work with the adolescent and family to understand how providing reassurance helps maintain the anxiety, and interferes with the client's progress. Cognitive interventions would then be used if a family member has difficulty adhering to the intervention plan, due to his or her own irrational beliefs.

Role-playing.

Role-playing is another intervention that can help facilitate the learning and generalization of skills taught during sessions (Ellis & Dryden, 1997). Role-plays allow the clients to receive immediate feedback from the therapist, as well as other family members, and provide opportunities for practice when the client is not experiencing

an emotional disturbance. When individuals are experiencing emotional dysregulation, it is difficult to remember to use new skills, and ensure the skills are being executed effectively. Thus, practicing in more benign situations will better prepare the client to use these skills during more emotionally charged situations. One skill in particular that is often rehearsed and role-played in session is assertiveness (Ellis & Dryden, 1997; DiGiuseppe et al., 2014). After learning steps and scripts for ways to respond assertively, clients can be provided opportunities to role-play in session to work toward responding in an assertive rather than a passive or aggressive manner. Learning to communicate more effectively helps reduce miscommunications and escalations during arguments.

Treatment Guidelines from the Empirically-Supported Therapy Literature that Inform Best Practices in REBT with Families

This section will explore the literature on non-CBT and CBT-based family therapy approaches and discuss how these modalities can support best practices in a REBT framework for family therapy.

Family Problem Solving and Solution Focused Brief Therapy

Evans, Turner, and Trotter (2012) conducted a review of the family therapy literature and two models in-particular fit within the best practices of REBT-based family therapy. According to Evans et al. (2012), research suggests that family problem solving is an effective model to target parent-child relationships. Similar to problem-solving interventions utilized in REBT, family problem solving as described by Evans et al. (2012) involves an 8-step approach which includes first analyzing the problem, and then developing steps to resolve the problem. Evans et al. (2012) also note that a psycho-education intervention, which is often associated with family problem solving, can be beneficial in family therapy. In individual REBT-based treatment, initial sessions include providing clients with psycho-education about interventions, diagnoses, and therapy in general. In the context of family therapy, this psycho-education intervention can be utilized to not only help clients better understand treatment, but also their family member's diagnosis (Evans et al., 2012).

Solution Focused Brief Therapy (SFBT) is another family therapy orientation that can be adapted for use within REBT-based family therapy. Gingerich & Eisengart (2000) explain that SFBT is "… a brief goal-focused treatment developed from therapies applying a problem-solving approach and systemic family therapy" (as cited in Evans et al., 2012, p. 14). While there is limited research regarding family interventions, the studies reviewed suggest efficacious results with individuals. Aligning with

the REBT model, SBFT focuses on the here-and-now and posits that clients can solve their problems even without knowing the exact root of the issue (Evans et al., 2012). SBFT involves setting goals, engaging in problem-solving, and enhancing motivation making this approach consistent with interventions already being utilized in the context of REBT-based family therapy.

Systems Theory

Huber and Baruth (1989) developed a model of family therapy, REFT, which encompass much of the traditional REBT model, but applied to families. REFT emerged from Ellis' REBT model and The Mental Research Institute Strategy, a theory of change based in cybernetic theory. Specifically, Huber and Baruth (1989) explain that cybernetics views interactions within the family as circular rather than linear. Thus, family members' behaviors and reactions become activating events for the other members of the family. The therapist's goal is to help change the family's pattern of responding to each other by focusing on the beliefs leading to the current ineffective problem solving and interactions. Huber (1997) holds the hypothesis that no matter how bad the current family environment may be, the family will have at least one example in which they successfully handled the problem at hand. This information can then be used to teach the family the difference between the irrational thinking leading to the current difficulties and the rational way of thinking they employed when experiencing previous success. This intervention helps support the ABC model in that it facilitates family members' developing rational beliefs. The REFT approach integrates a systems therapy perspective while maintaining a REBT-based case conceptualization in that the family learns that by changing the "family beliefs" (i.e., the belief that is shared by all members of the family), they can change the way the system is functioning (Huber, 1997, p. 127).

Cognitive Behavioral Family Therapy (CBFT)

By the 1980s, the cognitive approaches of Ellis and Beck found their way into family therapy, and CBFT is now prominent alongside other family therapy treatments (Dattilio & Epstein, 2005). Similar to REBT-based family therapy, CBFT focuses on the present, as well as the influence a family member's behaviors and thoughts have on the rest of the family system (Spillane-Grieco, 2000). According to Friedberg (2006), CBFT sessions include components of Beck's Cognitive Therapy, such as mood check-ins, agenda setting, and assigning and reviewing homework. Additionally, interventions in CBFT include self-monitoring exercises, self-instruction, rational analysis, and behavioral enactment (Friedberg, 2006). Spillane-Grieco (2000) also emphasize the importance of teaching clients communication and problem-solving skills, as well as utilizing feedback, modeling, and role-playing to help facilitate

cognitive restructuring and behavior change. CBFT shares similarities with interventions that are often implemented in a REBT approach to working with families, and thus can provide a framework for the implementation of behavioral and cognitive strategies.

Dattilio and Epstein's (2005) review of the research regarding CBFT suggests mixed results. Specifically, Baucom et al. (1998) explain that when studies combine cognitive and behavioral interventions in CBFT "[t]he overall results of those studies indicate that combined CBFT was as effective as purely behavior treatment, although cognitively focused interventions tend to produce more cognitive change and behavior interventions tend to modify behavior interactions" (as cited in Dattilio & Epstein, 2005, p. 10). Furthermore, Sexton, Datchi, Evans, LaFollette, and Wright's (2013) review of the literature suggests that treatments incorporating behavioral strategies yielded positive results, while less specific approaches did not garner the same level of efficacy. Overall, these results support the combined nature of REBT-based therapy, which emphasizes the importance of both behavioral and cognitive change strategies.

Brief Case Example

Jake, a 7 year-old boy in the first grade was referred for individual therapy by his father Steve. Jake resides with Steve who maintains full custody. Jake's mother lives out of state and chose not to participate in treatment. Like Steve, Jake is oppositional and defiant, and presents with anger and aggression when he does not want to comply with a request. Steve is concerned that this pattern of responding is beginning to impede his son's ability to function socially and academically. Steve reported that at times he ignores Jake's disruptive behavior; however, he also finds himself getting angry and eventually giving-into Jake if the situation continues to escalate. Jake's teacher reported observing oppositional and aggressive behaviors when Jake is not motivated to complete a task, or is not receiving individualized attention. If asked to do something he does not want to do, Jake will temper tantrum by yelling or hitting himself. In these moments, he struggles to express why he is upset. According to Jake's teacher, when compliant and attending, he does not demonstrate any academic deficits.

Case Conceptualization

A behavioral analysis of Jake's behavior was conducted to better understand his aggressive behaviors, and develop an appropriate treatment plan. At home, the consequences of Jake's behaviors ranged from Steve becoming angry, attempting to pacify Jake, or ignoring Jake's behavior. At school, the consequences were Jake's removal from a situation he found aversive. It was hypothesized that due to the intermittent reinforcement of Jake's argumentative and aggressive behaviors, he continued this

pattern of acting-out since it led to obtaining desired objects, being removed from a situation he found aversive, or receiving attention. The therapist worked with Steve to develop a goal for treatment, which was defined as reducing Jake's non-compliant behaviors and frustration intolerance by targeting Jake's unhealthy anger and disruptive behaviors, through the teaching of adaptive behavioral and emotional responses. Initially Steven brought Jake to therapy with the intention of the therapist providing individual therapy. The research on treating children with aggression points to the efficacy of parent-based interventions as a component of therapy. Specifically, parents are taught behavioral strategies for addressing disruptive behaviors outside of session, and learn to challenge irrational beliefs about the child and situation that may impede their ability to follow through on the behavior modification techniques (DiGiuseppe & Kelter, 2006). Before treatment continued the therapist worked with Steve to understand the utility of family sessions, as well as individual parent management training sessions as a compliment to individual therapy with Jake.

Treatment Plan

Child sessions.

REBT-based interventions were incorporated into sessions with Jake to help him recognize the consequences of his anger and aggression, and help him develop adaptive emotional and behavioral responses (Bernard et al., 2006). The therapist focused on helping Jake develop an emotional vocabulary to better communicate his feelings, as well as learn about consequential thinking to understand how his current pattern of responding was actually self-defeating (i.e., getting in trouble in school, losing privileges at home). Due to Jake's age, rather than engage in inference chaining and abstract disputation, the therapist utilized a hypothesis-driven approach, which indicated the presence of dogmatic demands and frustration intolerance beliefs based on the presenting emotions and behaviors. Jake was taught rational self-statements to rehearse, such as "I can stand being told no, even though I do not like it when I do not get what I want" and "Just because I want something does not mean I have to get it." Additionally, Meichenbaums's (1977) self-instructional training (SIT) was used to teach Jake concrete steps to regulate himself when he was feeling angry (as cited in Bernard et al., 2006, p. 46). In session, Jake was asked to role-play different situations to practice these skills with the therapist, as well as his father.

Parent sessions.

During parent management training sessions, Steve learned that his current belief system interfered with his ability to engage in consistent limit setting, and follow through on behavioral strategies. REBT-based cognitive interventions were utilized to challenge and change his irrational beliefs and change his unhealthy anger to frustration when Jake began to display non-compliant behaviors (DiGiuseppe & Kelter, 2006). For homework, Steve practiced challenging his irrational beliefs and

replacing them with rational beliefs such as, "Even though I would like Jake to act differently, it does not mean he is going to and I can handle his temper tantrums." Once Steve learned how to regulate his emotional reaction, he was introduced to behavior modification techniques, and a behavior plan was created for use in the home. Additionally, the therapist collaborated with Jake's teacher to create a similar plan at school to help create consistency across settings. Family sessions were conducted so that Steve could practice the behavioral strategies he learned in individual sessions, and allow the therapist to model how to effectively and consistently deliver such interventions. Family sessions were also utilized to provide a multi-informant report of difficulties and successes over the previous week, and utilize role-plays to practice how to respond to problems more effectively in the future. These sessions also provided the therapist an opportunity to observe the family dynamic, explore additional irrational beliefs, and assess for skill or performance deficits.

Treatment Outcome

After three months of treatment, Steve noted that he observed inconsistent progress at home in regards to the target behaviors. It was determined that Steve was continuing to intermittently reinforce Jake's aggressive behavior, which resulted in Jake inconsistently performing the prosocial skills he learned in session. Additional parent management and family sessions were conducted to address Steve's difficulty following through with interventions. The therapist continued to work with Jake to practice behavioral and cognitive strategies, replace his frustration intolerance beliefs, and conduct in vivo exposures to situations Jake found frustrating so he could practice new ways of responding when he was experiencing feelings of frustration.

What I Have Learned About Using REBT with Families

Accommodating Individual Differences: Client Gender, Ethnicity, Socio-economic Status, Intelligence and Other Factors

Understanding past experiences and family culture.

Understanding and acknowledging past experiences can help a therapist be more empathetic in his approach and better prepare the client for future treatment suggestions. Many times a parent may enter therapy feeling fully responsibility for the current dysfunction, and referrals for individual treatment or parent management training may reinforce the belief that "I am a bad parent." Therefore, it is helpful to

understand the family's previous experience with therapy, whether it is in a clinical setting or interactions with a child's school counseling staff.

Learning about the family structure, cultural background, and family values can also help the therapist develop a case conceptualization and better understand the family members' core beliefs. Spillane-Grieco (2000) explains, "Elements such as race, ethnicity, culture, religion, class, gender, parent-child discipline, and so on inform the individual's schemata. Events are then given meaning by the individual based on this structure or schemata. Schemata can be problematic if they are influenced by prejudices and/or misinformation …" (p. 108). Thus, even though REBT-based family therapy emphasizes focusing on current issues, it can be beneficial to understand the development of core beliefs, as some may be rooted in the family culture and passed down through generations. This makes these viewpoints even more engrained in the shared family culture, and the underlying irrational beliefs are even more difficult to challenge.

The therapist will also want to explore if there are other individuals closely intertwined in the family's life. These individuals may be other adults residing in the home, and they can be invited to sessions, especially if he or she has a role in decision-making and child rearing. Recognizing the family's cultural beliefs about caregiving, mental health, and behavioral expectations of children are additional factors to consider during intervention planning. Such that, there may be cultural beliefs shaping expectations for the way a child behaves, or a family interacts. Therapists want to be culturally sensitive to their clients and utilize this knowledge to better understand the client and what may be maintaining irrational beliefs or self-defeating behaviors.

The Do's and Don'ts in REBT with Families

When working with families, there are a number of client and therapist factors to consider, which can either impede or facilitate treatment progress. This section will focus on the "dos'" and "dont's" of working with families, with the aim of providing clinicians recommendations to facilitate family work in clinical settings.

The "do's."

Confidentiality.

When working with families, it is necessary to establish rules of confidentiality during the first session. Helping each family member understand the therapist's legal and ethical obligations in regards to confidentiality can help reduce the chance of confusion or therapeutic rupture later in treatment. The parameters of confidentiality may differ based on the therapist's preferences. For example, if the therapist meets independently with a father and then sees the family, is the information from the individual session confidential? If a therapist believes that keeping this information

confidential could interfere with the family's treatment, the therapist may decide to only meet with the family as a whole. If individual therapy is indicated, the therapist can refer the client to a different therapist. Additionally, when working with adolescents and children, it can be helpful to discuss with the parents how information will be shared. The family may agree that if the therapist is going to share information from a session with their adolescent son, then he will be present during those conversations. These decisions are made collaboratively so the therapist is upholding legal and ethical obligations and so that the clients understand and feel comfortable with the decided parameters.

Agreement on the goals of therapy.

Another "do" is gaining agreement on the goals before delivering interventions. A parent may come to session intent on changing the "A," rather than working on an emotional disturbance. The therapist can use the motivation syllogism, as well as other motivational interviewing techniques, to help move the client toward working on the emotional problem. That being said, agreeing on the goal does not mean disregarding the client's wishes, and a plan can be developed that includes working on emotional and behavioral disturbance, as well as incorporating practical problem solving. Similarly, when there is disagreement on the goal between family members, the therapist will want to ensure all clients are on board with the stated goal before moving forward. Take for example a family with two parents and an adolescent and each wants the other to change. The therapist can point out that while the child wants to change the parents' behavior, and the parents change the child's behavior, it is impossible to control the others' reactions. Therefore, it is prudent to work on each person's emotional reaction and communication skills, so that they can begin communicating instead of arguing about how each person *should* behave.

Therapeutic style.

Most importantly, when considering best practices for REBT with families, therapists want to remain flexible in their approach. If an intervention is not successful, family members are exhibiting resistance, or a client is not ready to work on the primary problem the therapist may shift her approach. For example, if an adolescent is unwilling to attend individual sessions, the therapist can begin working with the parents to implement behavioral strategies in the home to address behavioral difficulties, and continue encouraging the adolescent to participate in treatment. Similarly, if parents are unwilling to attend individual sessions to work on their emotional dysregulation, the therapist can help the adolescent tolerate her parents' reactive parenting style, and teach prosocial skills to help manage arguments at home. The therapist can encourage the parents to at least attend some of the daughter's sessions to gain involvement.

The "dont's."

Treatment and intervention planning.

During a family session there are multiple clients in the room, but this does not mean the same intervention is appropriate for each family member. The therapist will want to take into account the client's ability to engage in metacognition, as well as their emotional intelligence, when choosing strategies. When working with an adult, the therapist may engage the client in Socratic questioning and abstract disputation; however, when addressing a child, the therapist may rely more on presenting and rehearsing rational coping statements. Similarly, one parent may respond very well to humor, however, the other may find it off-putting. During the teaching of specific skills, the therapist will want to consider whether or not the clients are presenting with a skill deficit or a performance deficit. This information can guide decision-making regarding whether the individual requires direct teaching of a skill, or work on irrational beliefs that impede the client from performing the skill. In the above example, the therapist may come to realize that the father is effective in his communication; however, when angry he delivers his message in an aggressive manner. The therapist may help the father work on his anger so that he is better able to perform the skill, while the son will benefit from being taught assertive responses and then provided opportunities for practice.

Progress monitoring is an integral component of family therapy, and encompasses both subjective and objective measures. By establishing short-term and long-term goals individual and family goals at the onset of therapy, the therapist has a clearer picture of how each person is progressing toward meeting the established the goals. Many times a family may enter therapy with hope of creating buy-in for one family member, who refuses to attend individual therapy. In these cases, the other family members may appear motivated; however, the root issue is not the family dynamic, but more so family concerns regarding the behaviors and emotional reactions of one person. In these cases, family therapy can begin to feel like an intervention, and one family member begins to feel attacked or targeted. In other cases, there may be family dysfunction; however, due to family members' individual difficulties, sessions begin to look like four or five individual sessions rolled into one. In a case where the therapist recognizes that family therapy is not clinically indicated at this time, it is prudent that the therapist be able to point to the data and the clients' progress, to help provide more appropriate treatment recommendations. Down the line, it may be beneficial for such cases to resume family therapy, however, another course of treatment may be necessary to resolve primary issues that are impeding pathways to change.

Which Aspects of REBT Deliver the Most Benefit for Change and Which Don't

Strategies that benefit change.

Thorough problem analysis.

During the initial session, REBT therapists are taught to assess, treat, and build rapport simultaneous. DiGiuseppe et al. (2014) suggest that the best way to begin building rapport is to actually do therapy, which can be incredibly helpful in creating buy-in from the resistant client if he/she experiences immediate relief. Since family therapy involves multiple people, this initial problem identification phase will include collecting information from multiple-informants. Problem identification may involve using objective measures, and collecting information from multiple raters, to better understand referral concern. DiGiuseppe and Bernard (2006) explain that problem analysis is on-going and helps dictate the case conceptualization and treatment plan (i.e. identifying the specific thoughts, feelings, and behaviors to target). Both of these stages are important in helping the therapist determine the structure of treatment. It is through this process, that recommendations be made for additional parent management training or referrals for a family member to receive individual therapy.

The elegant solution.

REBT provides a model for addressing clients' disturbed emotions and behaviors by targeting the client's underlying core beliefs for intervention (DiGiuseppe et al., 2014). Thus, rather than challenge the veracity of the client's beliefs, the therapist will work with the client to identify the core underlying irrational beliefs about the situation. Unlike in individual therapy where the therapist only has the client's reporting to rely on, family therapy involves the presence of multiple observers to help provide information. Thus, in family therapy it is possible to determine the veracity of most inferences, based on the reports of other family members. If a child states, "My brother doesn't like me and thinks I'm annoying," the brother will be there to confirm or deny the belief. If the older brother does find his younger sibling annoying and doesn't particularly like spending time with him, it is beneficial to help the child cope with this reality, rather than trying to convince him that there may be evidence supporting the contrary, because we know the belief is true!

Strategies that impede change.

As discussed above, utilizing the elegant solution can be very effective in addressing the primary beliefs leading to the client's presenting problem, and also provide the client relief. However, if the client is not prepared for this approach, or does not understand the rationale, the intervention may have an adverse effect. Take for instance a family coming to therapy due to a father and son's explosive anger. If the wife is experiencing guilt because she thinks "It is my fault they get angry and I am the cause of my family's dysfunction," asking the wife to consider this to be the truth could

come across as lacking empathy and rupture the therapeutic alliance. Additionally, asking the wife to assume this inference is true could come across as colluding with the father and son, who tend to blame her for their aggressive responses. In this case, the therapist may want to begin by disputing the inference, establish rapport, and familiarize the client with the REBT approach. As the therapeutic alliance grows, the therapist may then tackle the underlying irrational belief that "I am a failure as a parent and spouse and therefore a worthless person" (Bernard et al., 2006). As discussed above, interventions are not one-size fit all, thus it is important to consider the context of therapy when delivering interventions.

Conclusion

Since Ellis' induction of REBT into the practice of family therapy, therapists gained a new model for conceptualizing emotional and behavioral disturbance within the family unit. While the treatment interventions remain similar to REBT with individuals, there are various factors to consider with the addition of family members to the therapy room. Understanding the individual, as well as the family dynamic, is integral in developing a strong case conceptualization and guiding the interventions that are implemented. Respecting and understanding the family's culture and values, as well as the interpersonal relationships within the family, can help guide the integration of both behavioral and cognitive strategies. On-going progress monitoring and assessment is critical in addressing new issues that arise over the course of treatment. Maintaining flexibility in one's approach, and considering each client's needs, can lead to positive results in addressing intra- and interpersonal difficulties, as well as the overall family dynamic.

References

Bernard, M. E. (2008). Albert Ellis and the world of children. In *43rd Annual Conference of the Australian Psychological Society*, Hobart, Tasmania.

Bernard, M. E., Ellis, A., & Terjesen, M. (2006). Rational-emotive behavior approaches to childhood disorders: History, theory, practice and research. In A. Ellis & M. E. Bernard (Eds.), *Rational emotive behavioral approaches to childhood disorders: Theory, practice and research* (pp. 3–84). New York, NY: Springer.

Cluxton-Keller, F. (2011). Rational emotive behavior therapy. In L. Metcalf (Ed.), *Marriage and family therapy: A practice oriented approach* (pp. 129–145). New York, NY: Springer.

Dattilio, F. M. (2001). Cognitive-behavior family therapy: Contemporary myths and misconceptions. *Contemporary Family Therapy, 23*(1), 3–18.

Dattilio, F. M., & Epstein, N. B. (2005). Introduction to the special section: The role of cognitive-behavioral intervention sin couple and family therapy. *Journal of Marital and Family Therapy, 31*(1), 7–13.

Dattilio, F. M., Epstein, N. B., & Baucom, D. H. (1998). An introduction to cognitive-behavioral therapy with couples and families. In F. M. Dattilio (Ed.), *Case studies in couple and family therapy: Systemic & cognitive perspectives* (pp. 1–36). New York, NY: The Guilford Press.

David, O. A. (2014). The rational positive parenting program for child externalizing behavior: Mechanisms of change analysis. *Journal of Evidence-Based Psychotherapies, 14*(1), 21–38.

DiGiuseppe, R., & Bernard, M. E. (2006). REBT assessment and treatment with children. In A. Ellis & M. E. Bernard (Eds.), *Rational emotive behavioral approaches to childhood disorders: Theory, practice and research* (pp. 85–114). New York, NY: Springer.

DiGiuseppe, R. A., Doyle, K. A., Dryden, W., & Backx, W. (2014). *A practitioner's guide to rational emotive behavior therapy* (3rd ed.). New York, NY: Oxford University Press.

DiGiuseppe, R., & Kelter, J. (2006). Treating aggressive children: A rational-emotive behavior systems approach. In A. Ellis & M. E. Bernard (Eds.), *Rational emotive behavioral approaches to childhood disorders: Theory, practice and research* (pp. 257–280). New York, NY: Springer.

Ellis, A., & Dryden, W. (1997). *The practice of rational emotive behavior therapy*. New York, NY: Springer Publishing Company LLC.

Epstein, N. B., & Schlesinger, S. E. (2003). Treatment of family problems. In M. A. Reinecke, F. M. Dattilio, & A. Freeman (Eds.), *Cognitive therapy with children and adolescents: A casebook for clinical practice* (2nd ed., pp. 304–337). New York, NY: The Guilford Press.

Evans, P., Turner, S., & Trotter, C. (2012). *The effectiveness of family and relationship therapy: A review of the literature*. Melbourne: PACFA.

Friedberg, R. D. (2006). A cognitive-behavioral approach to family therapy. *Journal of Contemporary Psychotherapy, 36*(4), 159–165.

Gaviţa, O. A., Joyce, M. R., & David, D. (2011). Cognitive behavioral parent programs for the treatment of child disruptive behavior. *Journal of Cognitive Psychotherapy, 25*(4), 240–256.

Huber, C. H. (1997). Rational-emotive family therapy. In J. Yankura & W. Dryden (Eds.), *Special applications of REBT: A therapist's casebook* (pp. 1010–129). New York: NY: Spring Publishing Company, Inc.

Huber, C. H., & Baruth, L. G. (1989). *Rational-emotive family therapy: A systems perspective*. New York, NY: Springer.

Joyce, M. R. (2006). A developmental, rational-emotive behavioral approach for working with parents. In A. Ellis & M. E. Bernard (Eds.), *Rational emotive behavioral approaches to childhood disorders: Theory, practice and research* (pp. 177–211). New York, NY: Springer.

Sexton, T. L., Datchi, C., Evans, L., Lafollette, J., & Wright, L. (2013). The effectiveness of couple and family-based clinical interventions. In M. J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (6th ed., pp. 587–639). Hoboken, NJ: Wiley.

Spillane-Grieco, E. (2000). Cognitive-behavioral family therapy with a family in high-conflict divorce: A case study. *Clinical Social Work Journal, 28*(1), 105–119.

Terjesen, M. D., Esposito, M., Kurasaki, R., & Kassay, K. (2009). Rational emotive behavior therapy (REBT) with children and adolescents: Theory, applications, and research. *NYS Psychologist, 20*(2), 13–20.

REBT with Women

Monica O'Kelly and Kathryn Gilson

Key REBT Theoretical Concepts in Working with Women

Introduction

There are social factors as well as mental and physical health issues that women, as a group, have higher risk than men of experiencing or are specific to females. The World Health Organisation (WHO) reports that women have significantly more mental health issues than men in addition to escalating rates of substance abuse. Environmental factors contributing to women's poor mental health reported by the WHO (2017) include gender based violence, socioeconomic disadvantage, low income and income inequality, low and subordinate social status and unremitting responsibility for others. Women are under pressure as a result of multiple roles and gender discrimination. The long-term impact of women's vulnerability is not yet understood.

Women also have biological factors that can create challenges to their mental health (WHO, 2009). In particular women can struggle with biological factors associated with reproduction, hormonal changes with the menstrual cycle and biological changes over the life cycle. Fertility difficulties, postnatal issues, and changes in mothering over the life cycle can present issues. Cancer, particularly of the uterus or breast, and the associate procedures can have gender specific implication.

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The lives of women have also been undergoing immense change over the past decades, hence the social context for many women has changed. World War II saw women in the western world move into the work force and they continued to work outside the home to expand their role and reap the personal benefits that paid employment offered. With increased education women climbed the occupational ladder taking on higher level positions and more responsibility with its associated stresses.

REBT View

Ellis, in his seminal work on Rational Emotive Behaviour Therapy (REBT) (1994), clearly stated that individuals are not disturbed by events but the view they take of them. Within this REBT framework the sociocultural and biological challenges of women mentioned above would not be the cause of women's mental health issue. It would be the view the women take of them.

In the 1980s women's role as wife and mother was given particular attention in the REBT field. The REBT focussed book "Why do I think I am nothing without a man" (Russianoff, 1982) was clear in its claim that the beliefs of women were such that they lacked self acceptance without a male partner. They saw their main roles were to be their husband's support person and to produce and nurture their children. It was suggested that this repeatedly seen lack of self-acceptance in women was the result of a tendency of many women to have a pervasive negative view of themselves leading to relatively high rate of mental health issues in women.

Ellis' theory was developed further in reference to women by Wolfe and Naimark (1991). It was their contention that if a woman held rigid, demanding views of her role, she would be emotionally distressed. Stressing the influence of social context they presented a model of how subtle attitudes about sex roles become part of an automatic repertoire of cognitions, thus influencing behaviour. Wolfe and Naimark (1991) used the terms "sex role messages" and "belief systems". They proposed that girls internalise sex role messages as they grow, developing a gender role belief system. They suggested that such stereotyped beliefs were often unexplained and unconsciously held assumptions about the appropriate sex role and frequently had demand like properties. "In the case of women, beliefs are common that they 'should' or 'must' talk, behave, feel, look, and think in certain ways if they are to be accepted by men" (p. 268). Wolfe and Naimark (1991) listed demands women placed on themselves in four dominant areas of Western society: sex-love relationships, physical image and sexuality, work and career, and victimisation and self-sacrifice.

For a number of years this contention, that women's sex role beliefs contribute to women's mental health issues, was simply a theory without empirical evidence to support it. A major study of the beliefs, stress and wellbeing of 974 women was, however, carried out (O'Kelly, 2011) producing evidence to support this theory. The O'Kelly Women's Belief Scales (OWBS) were developed for the study based on the sex role demands outlined by Wolfe and Naimark (1991) in the four areas mentioned above. The REBT processes of demandingness, awfulising, low frustration tolerance

I must have someone stronger on whom I can rely.
I must satisfy the wishes of others - particularly the men in my life.
I must not act in such a way that it upsets others.
I must have a husband/male partner.
As a woman I should not try to have senior positions at work.
I should do everything I can to make myself look attractive.
I should be responsible for the care of my children at all times.
I should not rock the boat or be pushy
I should act passively in front of men.
I should care for myself only when everyone else is taken care of.
My children should not have any problems since it would be my fault if they did.
It is my responsibility to keep the house clean and tidy, do the washing and prepare the meals.
I should not try to get better pay/work conditions.
I should not put my desires or wishes first.
Things should go well in my family.
I must have a child to be fulfilled.

Fig. 1 Demandingness beliefs from the O'Kelly Women's Belief Scales (OWBS) (O'Kelly, 2011)

and negative self rating were reflected in the scales. The 16 demandingness items are shown in Fig. 1. The scales had good psychometric qualities and once constructed enabled the study of the impact of sex role beliefs on women's well being.

We now know that Wolfe and Naimark (1991) were right. The OWBS were used in a study of the relationship between sex role belief and wellbeing in multirole women who were working in employment outside the home, living with a male partner and had children under the age of 21 years. High scores on each of the scales, Demands, Awfulising, Low Frustration Tolerance and Negative Self Rating, were related to poor wellbeing (O'Kelly, 1999). This research did provide evidence that rigid and unhelpful sex role messages contributed to a lack of well-being in women with Negative Self Rating having the most impact. This supports the notion previously expressed that many women have a pervasive negative view of themself.

The sex role messages, however, were not unhelpful for women who had roles that were congruent with their sex role messages, such as cleaners and kitchen staff, however, were unhelpful for the women who worked in roles that were previously male dominated, such as medicine, allied health and management. Women now have flexibility in their choice of professions, however, if women do not have the same flexibility in their sex role beliefs, such rigid beliefs will impact on their emotional well-being.

Wolfe and Naimark (1991) have pointed out a woman's beliefs about herself and her role and place in society are present from the "day dot", having been inculcated from birth and reinforced by society. They are like other well-entrenched beliefs or schemas. As such they can be a challenge to change. From a conceptual level the beliefs can exist and be reinforced at three levels.

1. Individual Irrational Beliefs (IBs) that are the individual beliefs or schemas that a woman has about herself, with regard to her appropriate roles and behaviour. e.g. I must be slender to attract a man.
2. Family Irrational Beliefs (FIBs), which are the beliefs, held by all members of the woman's immediate family including herself. In systems theory these would be regarded as the myths of the system. e.g. Mum is responsible for the care of the children.
3. Cultural Irrational Beliefs (CIBs) which are the predominant beliefs held by people in the wider culture. e.g. Men are better leaders.

A particular belief may be held by a woman and also reinforced by the family system as well as by her culture in general. Challenging the familial and cultural beliefs requires particularly persistent, elegant and skilled forms of therapy. With women, REBT places emphasis on challenging the demands that a woman has. With sex role beliefs there may also be a need to challenge the demands at a family and culture level. The task is challenging if the beliefs are covert rather than overt and even more challenging if the therapist does not recognise the belief as unhelpful because he/she shares the cultural IBs.

Strong claims have been made that REBT is a truly feminist therapy (Wolfe, 1995). Traditional psychoanalysis was considered oppressive to women using phrases such as penis envy or masculine protest and interpreting the lack of vaginal orgasms as immaturity. Others considered it an ideal therapy for women as they are "…trying both to overcome psychological problems associated with the sex-role stereotyping of their early childhood years and for achieving happiness and a sense of self-worth in their struggle for independence and autonomy" (Bernard, 2011, p. 306). With our new knowledge about the relationship between sex role beliefs and women's well being REBT remains in a strong position to help women.

Key Best-Practice REBT-Based Assessment and Treatment Strategies and Techniques in Working with Women

Assessment

In general there are more similarities between women and men regarding mental health issues than there are difference. The starting point in working with women is a good basic clinical assessment. There are, however, a number of additional factors that need to be taken into account when assessing women in a clinical interview.

1. It is standard practice to assess suicidality or risk to self when a client, either male or female attends. In addition when working with women there is a need to assess a woman's risk of being abused by others; physical, sexual, emotional and financial abuse need to be considered. This vulnerability of women is considered to be a significant contributing factor to poor mental health in women (WHO, 2017). The therapist's ethical and possible legal ramifications need to be considered.
2. A women's biology, in particular her reproductive biology and her place in the life cycle, may impact on a woman's mental health (WHO, 2009). This needs to be taken into account when assessing women. Particularly difficult times might be at menarche or menopause, being pregnant and giving birth, adapting to being a mother or no longer having an active mothering role or dealing with the frequent cyclical changes of the menstrual cycle. Surgery, such as a mastectomy or hysterectomy, can also have a significant impact on a woman's mental health. Of most importance however is not to assume that the woman's problems are due solely to the biological changes. The changes can at times be accompanied by environmental changes (WHO, 2009). These need to be assessed. When a woman has a child for example and suffers from postnatal depression it may be possible that it is not biologically based. The impact of having a child on a woman's life needs consideration. She may have previously worked in a socially and intellectually stimulating environment. These may have been lost after the birth of her child. The mental health issue might be best regarded as adjustment disorder and respond well to REBT rather than a biologically based treatment.
3. When assessing a woman her social context needs to be considered as such factors impact on mental health and can have an influence on sex role messages. Factors include socioeconomic status, low and subordinate social status and responsibility for others (WHO, 2017). Additional factors to explore include the ethnic group to which she identifies, whether she is employed and her role or profession, relationship status, number of children and their ages, and whether she has support.

The above-mentioned aspects of assessment can be done in the initial assessment. Sex role beliefs, however, may not be obvious during the initial assessment although the information obtained may alert the therapist to be more aware of the presence of certain sex role beliefs. Sex role beliefs are like a blanket overlay to standard REBT beliefs that become apparent as therapy progresses. From the writers' experience it is up to the therapist to have a heightened awareness of sex role messages, to look for them and bring them into the woman's consciousness. They can be deeply imbedded and a woman may not be aware of them. They really are the way a woman defines herself and her role and worth as a woman. Assessment and eliciting of sex role beliefs is an on-going process. Sex role messages can be identified particularly when the therapist is eliciting beliefs during therapy, listening intensely to what the woman is saying, and from observing a woman's response to recommended behavioural interventions and then exploring the associated cognitions.

Take for example a situation where the therapist is treating a woman who has a gap in her two front teeth and regards this as being unattractive. She is depressed about

the situation and worries that her husband will leave because of it. In stating the A. as "Having the gap in your teeth" and the C. as "Depressed" the therapist could elicit the cognitions asking what goes through your head when you are depressed when you think about the gap in your teeth. She may think my husband might leave and state demands such as "I should do everything I can to make myself look attractive to my husband or he might leave me" and then evaluate herself along the lines of, "I am nothing without a husband/male partner".

Another example might relate to the behaviour of a working mother who presents as anxious and depressed. The client is advised to do some activity scheduling and plan pleasant activities for herself on a regular basis to help lift her mood. When she returns to therapy, she reports that she has not had time to do anything for herself as she has been busy, when not working, getting her children to their after school activities. From this observation the therapist hypothesised that the following beliefs blocked the woman from caring for herself.

I should care for myself only when everyone else is taken care of.

I should not put my desires or wishes first.

The beliefs could be elicited from the client by having A. "Having the children in after school care while you do something for yourself" and C. "Guilt" (or other emotion stated by the client) and then asking, "What would you be thinking that makes you feel guilty?"

Intervention

As with assessment issues research indicates that REBT is effective for both men and women. In a thorough synopsis of REBT (David, Szentagotai, Kallay, & Macavei, 2005) it was indicated that REBT was effective and efficacious with a range of clinical diagnoses common to both men and women. Meta analyses of REBT also indicated that REBT was effective with men and women (David, Cotet, Matu, Mogoase, & Stefan, 2017).

In the areas of dealing with their vulnerability to abuse, dealing with their biology and managing life in general in demanding roles, which in many cases means juggling multiple roles, using standard REBT can be helpful to women. A number of studies have shown that standard REBT is helpful in treating problem specific to women such as dealing with premenstrual syndrome (Morse, Bernard, & Dennistein, 1989) and for treating problems with a relatively high prevalence in women, such as eating disorders (Moller & Bothma, 2001). Our experience suggests that you need to *go beyond* standard REBT when working with women. *Going beyond* standard REBT involves identifying, challenging and changing the sex role beliefs. This is particularly so with regard to challenging the sex role demands and the negative self-evaluations to which women are prone.

Sex role beliefs differ from idiosyncratic beliefs held by one person. Idiosyncratic beliefs can be relatively easy to challenge because the therapist is challenging the beliefs of one person. Sex role beliefs however can be a challenge to change as they

are often reinforced by the woman's family and her culture. The therapist is out numbered. In addition to empirical, logical/philosophical and pragmatic challenges more sophisticated and complex challenging approaches are necessary.

Challenging Sex Role Demands

In challenging a woman's sex role demands, guided discovery with Socratic questioning, placing the woman's demands into the historical context, as shown below, is helpful.

T. I wonder where the demand that you must have a male partner came from?
C. That is just the way it is. All the women in my family have a husband except me.
T. What was life like for you mother?
C. She went to school until she was 12 years old and then left school to help her mother in the house. When she was twenty she married dad and I was born soon afterwards followed by my 4 siblings.
T. So did your mother ever go to work?
C. No she didn't.
T. So who provided for your mum?
C. Dad did of course as well as for the 5 of us. Things weren't good between mum and dad. After we all left home mum told me she wanted to leave dad but knew it wasn't possible financially.
T. So what you are saying is that your mum needed a male partner to support her and then her children. How is your life different to your mothers'?
C. I went to school and then to university and I have been working since and earning a decent living.
T. So you are pretty independent and supporting yourself. So why must you have a male partner? Just because your mother and the other women in your family have a husband does that mean that you must have one if you don't need one.

This approach can be applied across the board to many sex role demands.

If it is the case that a woman's partner, and possibly her older children, have the same sex role beliefs as the woman it may be necessary to work with the woman and her partner together or even with her partner and children. If this is not done, when the woman returns home after therapy, her new beliefs will be challenged by others in the system. Socratic guided discover as outlined above can be engaged to change their familial sex role beliefs. In addition psycho education discussing the origins of gender roles, dating back to hunter-gatherer times, the past advantage of male superior strength, and the changes over time can help the partner and family see that times have changed and the need for the past roles and beliefs has also changed.

Of additional concern is sending the woman not only back to her family but back into the wider world in which she developed her limiting sex role beliefs. That is back into her culture. Changing can be a difficult task if the woman perceives that every one around her believes the traditional, unhelpful sex role beliefs. Creating a

therapy group that acts as a new cultural group for the woman supports her change to more liberating sex role beliefs and can guide and reinforce her efforts to change.

Behavioural tasks can reinforce the change to more flexible sex role beliefs. Such tasks include behavioural experiments in which the woman acts on the more flexible and less demanding beliefs, observing or having discussions with women who she considers live less traditional lives, and learning to be assertive to express herself and ask for what she wants.

Challenging a Woman's Negative Self Evaluation

It is understandable that if women are not as strong as men, not as well educated as men, do not earn as much as men, are not encouraged as much as men, and are not given the same respect as men, both as adults and when they are developing, that they will see themselves as inferior. However even when most of these factors are equal many women still have a pervasive negative attitude toward themselves and lack unconditional self acceptance. Over the many years as therapists we still find it amazing that clients say "No" when asked, "Have you ever thought about what makes a person worthwhile?" What makes a person worthwhile is a philosophical discussion that therapists need to have with women. This is particularly the case if they have sex role demands that are not met and then condemn themself.

The following didactic dispute by Ellis could be applied when any sex-role demand is not met and a woman devalues herself.

> Some women threaten weak males. And men have their own problems. They think they're shits for not being good nor strong enough. So you see, no women is worthless because of any reason including her not mating. Because to be worthless, she'd have to be good at nothing. So if you'd go through these things; one, there is no reason I have to be married, although it's desirable; two, it's not terrible, it's just a real pain in the ass, a great inconvenience, maybe; three, I can bear the pain, the lack of pleasure, from not mating; and four, I'm never a worthless individual, then you'd start to overcome this problem. You'd still be alone and have some difficulties in mating, but you'd be in much better shape to get more of what you want. (Ellis therapy session, in Bernard, 2011, p. 305)

Further examples of how a woman's negative self-evaluation can be challenged are below.

i. Direct logical challenge

T. Does it logically follow that because your marriage broke up and you no longer have a partner that you are therefore not a worthwhile person?
C. Well I guess it is a leap of logic.
T. Maybe you are right there.

ii Exploring worth dispute

The aim of this dispute is to get the client think about whether you can really rank and rate people, particularly herself. It needs to be done Socratically allowing the client time to think about the issue.

T. Do you think that a prostitute is worthwhile?
C. I guess so.
T. Why do you think that?
C. I guess she is doing her best to support herself.
T. Do you think that a very handicapped person is worthwhile? They are your age and just lie in a beanbag, have their nappy changed and are spoon fed soft food.
C. No.
T. Well we could put them in the gas chamber and get rid of them.
C. Oh I don't think you could do that.
T. Why not?
C. Well they are a person.
T. What about some like the Angela Merkel or Michelle Obama? Would you think they are worthwhile?
C. Oh yes.
T. Of the three, the prostitute, the handicapped person and Angela Merkel, which one has the most worth?
C. Angela Merkel.
T. I did not say "Who does the most worthwhile things? As a person, which one has the most worth?"
C. I guess they are all really the same then.
T. Well does it make sense to have one rule for everyone else and a separate one for yourself?

iii. Pie chart dispute

In this dispute the therapist draws a pie chart and asks the client to talk about their characteristics and write each characteristic in a different section. Figure 2 demonstrates this technique. It is usually the case that the client will tell you some good features about herself and some not so good features. This information can help you have a conversation about her complexity and whether she needs to negatively evaluate herself totally because of some negative features .

Fig. 2 Pie chart dispute

iv. Pragmatic dispute

T. Where does it get you having a philosophy of life about yourself that doesn't help you?
The purpose of these challenges is to help the woman develop unconditional self-acceptance. After the challenges you might say, "Given our discussion what could you say to yourself that would be more helpful?"

Treatment Guidelines from the Empirically-Supported Therapy Literature that Inform Best Practice in REBT with Women

General Guidelines

1. There is a need to acknowledge and be aware that women are in a more vulnerable position in society (WHO, 2017). When making an assessment of women's mental health issues it is important not only to assess their risk to self but also assess whether they are in an abusive situation which can be emotional, verbal, physical, sexual or financial.
2. With multicultural communities being common in many countries a therapist needs to be aware of the woman's culture of origin or that to which she identifies. This is particularly relevant when the therapist is from a different culture to the client (Australian Psychological Society, 2017).
3. Be aware and assess where a woman is at with regard to her stage in her biological life cycle and how she is managing (WHO, 2009).

4. Whilst women's biological cycles associated with child bearing and rearing create challenges for women it should not be assumed that the problems experienced are all associated with the women's biology. Psychosocial factors need to be considered (WHO, 2009).
5. With changes in women's roles over time there is great diversity, opportunities and choice for women. Because not all women now have the same role there is a need to assess the woman's confidence and security in her role particularly if they see themselves as being different to the norm (O'Kelly, 1999). If in the paid workforce, the presence of glass ceilings, inequalities of treatment, and dealing with the boy's club need to be ascertained.

Specific Guidelines to REBT with Women

For most mental health issues there is no difference between men and women with regard to the efficacy and effectiveness of standard REBT practice (David et al., 2005). Overall there is little research on the use of REBT with women. However, the following guidelines collated from the literature can increase effectiveness of REBT with women:

1. *Go beyond* the standard practice of REBT, which elicits demands and evaluations. Continuously identify and challenge limiting sex role beliefs and schemas of the female client in the four areas of: sex-love relationships; physical image and sexuality; work and career: and victimisation and self-sacrifice. Both research and theory indicate this to be a major factor in working with women (O'Kelly, 1999).
2. Be aware of the different layers of sex-role beliefs; individual, familial and cultural, as such an approach takes into account the social context from which the beliefs developed (Wolfe & Naimark, 1991).
3. Use REBT to empower women to address the imbalance that leads to their sociocultural vulnerability, which is a major contributing factor to women's poor mental health (O'Kelly, 1999).
4. Consider the use of REBT in treating biological based issues. For example, research has indicated that premenstrual tension can be effectively treated with REBT (Morse et al., 1989). Similar benefits may occur with other biological issues for women.
5. Use REBT practices to increase a woman's flexibility and reduce demandingness with regards to sex role beliefs. This can help women embrace the opportunities and choices and confidently manage their chosen role in a world of constant change (O'Kelly, 1999).
6. The therapist, either male or female, needs to monitor his or her own sex role beliefs and schemas (Wolfe & Naimark, 1991). Regular supervision with awareness of sex role beliefs is recommended.

7. Work with women in REBT groups (Bernard, 2011). This enables the development of a micro culture that facilitates the shift to more flexible sex role beliefs. This may be away from traditional familial and cultural beliefs.
8. Be aware of the ripple effect of change once the woman becomes more flexible and less demanding regarding traditional roles (McHale, & Crouter, 1992). Interventions such as assertive communication, problem solving skills, making wise and safe choices, building self-acceptance to cope with criticism from others, including family members, who hold traditional sex role beliefs are a few such approaches.
9. Consolidate more effective sex role beliefs with relevant homework tasks that reinforce more flexible sex role beliefs (DiGiuseppe, Doyle, Dryden, & Back, 2014). Tasks that promote exposure to a range of helpful behaviours and sex role beliefs could involve researching, networking, surveying and observing role models.

Brief Case Example

Mary was a 38-year-old married woman with two children aged 4 and 7 years. Mary worked full time in a large multi national company. She was promoted into a senior, high-pressure role. Mary considered her husband was not helpful with domestic duties and he did not initiate activities with the kids at home. She considered that she was responsible for the majority of home and parenting duties and found it difficult asking her husband to help.

She presented with low mood most days, had poor motivation, was not enjoying activities, woke in the early hours of the morning and felt tired in the day. She had difficulty concentrating and making decisions. She reported binge-eating behaviours, made poor food choices, and was overweight. She became upset over trivial things and was angry when the children did not do as they were told. She found it hard to wind down and experienced chest tightness. She tended to be a perfectionist and placed great pressure on herself to meet deadlines at work and uphold her unrelenting standards regarding home duties and parenting. She complained of having no time to herself. Her goals for treatment were to improve mood, reduce stress at home and work (to manage better), and improve self-care.

It was considered that Mary was depressed and anxious. Mary had typical beliefs associated with depression and anxiety. When feeling depressed, she had demands for perfection and negative self-appraisal evaluations that she was not good enough and worthless. When she felt stressed or anxious, she had demands that others must approve and demanded that she should manage easily with little discomfort. When these conditions or demands were not met, she considered it to be a catastrophe and believed she could not cope (*I can't stand-itis*), respectively.

Interventions commenced behaviourally with Mary to treat her depression by suggesting the standard treatment approach that she exercise for half an hour and

plan a pleasant activity each day. Standard REBT techniques were used to challenge common demands and evaluations associated with depression and anxiety.

However, as therapy proceeded ***an overlay*** of unhelpful sex role beliefs became apparent. It was considered that the ***layer*** of sex role beliefs further contributed to distress and blocked Mary from progressing with treatment.

Mary considered that it was inappropriate to set time for herself. She had the sex role demand *I should care for myself only when everyone else is taken care of* (victimisation and self-sacrifice, Wolfe and Naimark, 1991). This demand and the associated negative self-evaluation (self-downing) had to be addressed and challenged to liberate her so that she could achieve her treatment goal and make life changes.

Once Mary's mood had lifted as a result of the behavioural interventions, therapy shifted to focus on challenging the negative evaluations she had of herself. However, at this point Mary revealed she could not manage all household and parenting duties as well as her mother did and as she believes she "should". She was demanding perfectionism. This demand was challenged individually with Mary exploring where the belief came from and whether it was realistic to hold that belief given the change in her roles and women in society. Mary could see this, however it was hard to change given that her mother, mother-in-law, and husband were critical of her lack of housekeeping skills and career aspirations, thereby reinforcing the traditional sex role stereotype and belief. She was worried these people in her life would not approve (demand—*I must be approved).*

Therapy used a multi-prong approach to challenge her beliefs at different levels: individually (as shown above), familiarly and culturally/society.

1. She had perfectionistic demands that she be the one to do it all as her mother did which interfered with effective problem solving and delegating to others. Mary developed more self-accepting helpful beliefs to apply when she relinquished or delegated some responsibilities.
2. Her demands for approval from others were challenged and she was encouraged to accept their different opinion without self-downing. It was identified that Mary held a sex role belief that "*I should not rock the boat*", which impeded Mary from asking for help from her husband and mother. She was fearful of potentially upsetting or offending others. Mary's catastrophising beliefs about not gaining the approval of the matriarchs and her husband regarding house keeping were challenged using a catastrophe scale. The catastrophe scale was also used to help her learn to live and work with people who hold opposing views. She developed self-acceptance as a woman who could tolerate being challenged by others.
3. She also had demands that she should manage easily. Standard REBT practice challenged Mary to consider a more flexible and realistic definition of coping that involved accepting discomfort. Whilst Mary could acknowledge that coping involved hard work, with continuous awareness and monitoring of sex role stereotypes, it became apparent that Mary had an image that women are always graceful. This sex role belief was challenged with a homework task targeted to test this belief. She surveyed friends and women at work who she perceived as

"coping well" and asked them about their coping experience such as did they have moments of frustration, were they ever uncomfortable when juggling their roles, and the like.

Standard REBT techniques of challenging Mary's typical demands and evaluations associated with depression and anxiety were helpful to put out the "spot fires" in her life by improving coping. However, addressing and challenging the layer of sex role beliefs appeared to overcome blocks to treatment progress, evoke more enduring and stable changes and importantly, liberate Mary from limiting, long-held sex role beliefs.

Other aspects that enhanced Mary's treatment outcomes included teaching Mary assertive communication skills and providing her with skills to manage the reactions of others such as her husband whom she asked to take on more domestic duties. Mary was also encouraged to join a local businesswoman's network to expose her to more flexible beliefs about gender roles and present her with evidence of non-perfect, capable women in the community. Such a group allowed Mary to appreciate greater diversity of gender roles. The women's group also taught Mary that some professional women juggle work and home by outsourcing cleaning, ironing, and some meals.

Mary's husband was invited to attend sessions to assess and respectfully challenge his sex role stereotyped beliefs. He was questioned about his beliefs relating to men and domestic house duties and aspects of parenting.

Due to changes in exercise, diet, and self acceptance as a result of therapy Mary could go on to pursue other important life goals such as weight management without feeling depressed or anxious about making this one of her priorities. She was now more self-accepting. The belief that she should be attractive to men was also no longer a significant issue. For health reasons, however, Mary had decided she would continue to exercise and eat well to pursue personal goals relating to weight.

Using REBT principles to help Mary let go of the demandingness that she should be perfect, approved of, and graceful in her coping with regard to the overlaying sex roles, helped her to develop flexibility and appreciation that she can be different to her family, culture, or society. She was at last, liberated. It enabled her to create her own identity as a woman and help reduce her depression and anxiety. Using REBT principles she was empowered to challenge the sex role beliefs of herself (i.e., individual), the family, culture and society.

What We Have Learned About Using REBT with Women

Standard practice of REBT helps women to manage demands and unhelpful evaluations about their challenges whilst also living under gender stereotypes and social norms. There are ways of practicing and aspects of REBT that make it even more effective when working with female clients.

Accommodating Individual Differences: Client Gender, Ethnicity, Socio-Economic Status, Intelligence and Other Factors

Female clients may feel more comfortable talking to a female therapist and may prefer seeing someone who, in their opinion, can understand them because of gender similarity. Women are more likely to state preferences regarding therapist characteristics, and when reporting preferences regarding the gender of the therapist, women prefer a female therapist (Dancey, Dryden & Cook, 1992). The nature of the presenting problem such as a history of abuse can also influence a female client's preference. There may also be cultural reasons why female clients prefer to work with a female therapist.

This chapter has highlighted how REBT can assist female clients to challenge the gender stereotypes that they personally hold or are held by their family or culture. What about the sex-role beliefs of the therapist? Therapists may hold rigid and traditional gender stereotypes or alternatively may be completely liberated from such beliefs. Clinicians have an ethical obligation to be aware of bringing their own sex-role beliefs, values, and ideas to therapy. The clinician must not steer a female client to their own prejudices about how women should behave, think, or react. This is no different to our standard practice, for example, relating to bringing religious beliefs about divorce, fidelity, or abortion to therapy. However, the therapist may not be as aware of their gender stereotypes and may need to self-monitor or address these through peer supervision.

It is also helpful for therapists to be aware of and examine generational differences between the client and themselves. If the therapist is significantly younger than the client she/he may hold certain views and stereotypes about older women in terms of their roles, abilities and place in society. The younger therapist could also be unaware of the sex-role stereotypes prevalent in different times of the client's past eras. Similarly, a therapist who is significantly older than the female client is likely to have observed eras of changes to women's rights, equality, and roles. The 'older' therapist may or may not have agreed with or internalised these changes. An older female therapist may have endured difficulty challenging sex role stereotypes in much less flexible and accommodating times as is present today. She may hold beliefs such as "I learned the hard way and so should you" and "why should you cruise through life".

Both male and female therapists will likely achieve greater therapeutic success by demonstrating open-minded, flexible and non-gender specific stereotypes. In particular, the therapist might appropriately share examples of gender equality to help demonstrate his/her awareness and active participation in sex-role equality and open-mindedness.

Other important issues to consider when delivering REBT with female clients include being culturally sensitive, collaborative, consistent, adhere to ethical standards, form a healthy therapeutic relationship, and test out your hypotheses rather than make assumptions.

The Dos and Don'ts

The Do's

- Do use traditional REBT with women.
- Do continuously assess and address the sex-role stereotypes of the client and those of her family, society and culture.
- Do assess for clashes between: the client's internalised gender-schema beliefs and the social norms that she resides in.
- Do raise awareness of traditional stereotypes such as *I should stay home to care for the children* even though women in professions are now more widely accepted (evolved stereotype) or *society prefers thin women* (traditional, non-evolved stereotype) and therefore *I am worthless*. Some questions to raise awareness and elicit stereotypes include: Where did your belief come from? Where might you have learned this belief? What are the gender expectations of your family, culture, profession, society? Who enforced these beliefs? Do you need to have the same beliefs as… (your parents, elders, society, other women) in order to be liked/accepted? What might happen if you thought differently to other women, your family, society? Is it ok if you think or behaved differently to your family, society, culture? What were some of the messages you received in your upbringing about women's roles?
- Be aware that any changes that the client makes can have a ripple effect in her world. In an ideal world, when a female client makes changes that challenge the gender stereotype beliefs, her family and/or society would also embrace these changes. But unfortunately, this is not always the case. REBT would be more effective if female clients are provided with the necessary skills to manage any such consequences. Assertive communication skills may need to be part of standard practice for women in therapy. For some individuals, major life changes such as divorce may be a consequence and the client may need skills to problem solve, execute decisions, and manage adjustments.
- Consider whether the client's partner may also need to be involved to address some of the ripple effects. Inviting a partner to therapy can provide an opportunity to examine the partner's sex-role stereotypes and help the couple to challenge and push through stereotypes that might be hindering the female client and the couple.
- Do give homework tasks and create homework tasks that challenge existing gender stereotypes and expose the client to alternate sex role beliefs. One such example is to ask the client to join a women's group. Groups provide female clients with evidence that they are not alone with some of their challenges (Brody, 1987). Joining a women's social group or a local women's professional network can expose the female client to different lifestyle arrangements. Exposure to other women in various career roles, with/without children, different body sizes, and the like can help the female client learn alternates to home duties, childrearing, relationships, career, and lifestyle balance. There is an opportunity to observe and gain evidence of alternate arrangements and strategies at work. For instance,

a female client attending therapy to learn life-balance and coping skills might learn from her peers to normalise hiring a cleaner, asking for help and sharing responsibilities. Another homework task can be to have the female client survey a role model about their thinking and coping styles when faced with the same activating events as the client. For example, the female client can ask their role model, who appears to manage their work stress, "what goes through your mind when you're dealing with work stress (be specific e.g., confronting a colleague). This homework task will give the female client a glimpse into alternate thinking styles and behaviours. The connection between thoughts and feelings (B-C link) is also re-affirmed here.

The Don'ts

- Don't see women as weak and vulnerable and can't tolerate challenging.
- Don't reinforce sex role stereotypes.
- Don't see women as incapable of changing their sex stereotyping.
- Don't see the sex-role stereotypes as incapable of changing.
- As a therapist don't be influenced by your own sex role stereotype.

Which Aspects of REBT Deliver the Most Benefit for Change with Women and Which Don't

Which Aspects of REBT Deliver the Most Benefit for Change with Women

REBT is an effective therapy for treating a range of mental health conditions in women. When therapists elegantly challenge the client's demands and evaluations, there is a shift in the client's experience of distress. REBT's focus on challenging demandingness and evaluations enable female clients to be freed from ideas that they *must* or *should* be a certain way as a woman and free themselves of self-downing, poor self-acceptance and approval seeking if they don't. In other words, when REBT is used to challenge the sex-role stereotypes and their evaluations if they do not meet the gender stereotype demand, this leads to the greatest benefit for change in women.

REBT also encourages congruence between newly formed rational beliefs or gender schemas and actions outside of therapy. REBT's emphasis on testing out newly formed beliefs by doing homework that can challenge sex-role stereotypes is likely to enhance treatment outcomes. Shame attack exercises targeted at gender schemas could help the female client deal with being "different" or deal with embarrassment about not fitting into the expected gender norms. Low frustration tolerance (LFT) (or frustration intolerance) tasks can serve to build up tolerance to being uncomfortable such as hiring help around the house. Designing LFT tasks that develop frustration

tolerance to persist with the changes in the face of pushback from others may also be helpful.

Ellis strongly promoted REBT group programs specifically for women because of the unique circumstances and gender stereotypes that women face (Bernard, 2011). Group therapy or workshops address aspects of womanhood in ways that individual sessions cannot. Wolfe and Naimark (1991) note that women are highly likely to have a dependence on others' approval and poor self-acceptance. Group work can add benefit by providing reassurance, acceptance and support especially when challenging or experimenting with new beliefs and behaviours that challenge traditional female norms.

Bernard (2011) notes how group work with women can lead to positive reinforcement and independence when traditional gender stereotypes are challenged. Bernard (2011, p. 305) suggests including the following agenda in REBT women's groups to maximise outcomes: *consciousness raising* through discussion groups and feminist literature; *goal setting*; *REBT* to change an 'I'm helpless' belief system to one of optimism and self-acceptance; *assertiveness training*; *positive self-messages*; *self-pleasuring assignments* designed to reinforce the idea that' I have a right to do nice things for myself'; *encouragement of female relationships*; *focus on environmental resources and societal change* which involves showing women how to use community resources and organizations (women's shelters, women's professional organizations, non-sexist gynaecologists), and *problem solving*.

Which Aspects of REBT Do not Deliver the Most Benefit with Women

If REBT therapists only challenge beliefs and evaluations about the activating event and do not go further to uncover gender-role schemas then they may be not change the client beyond "coping" under the conditions they are presenting.

The research supports the application of REBT for both men and women. However, whilst REBT is seen to be of benefit to women, the personal style of *how* REBT is delivered may be important here. Albert Ellis in action at Friday night live sessions may be overwhelming for some women. Therefore, consideration needs to be given to manner in which REBT is delivered.

The effectiveness of REBT with female clients for a range of presenting issues has been demonstrated in the literature. There is an emphasis to assess and raise awareness of gender-specific issues before elegantly disputing demands relating to sex role stereotypes and the evaluations. Applying the REBT elegant practice can liberate the female client from their unhelpful gender schema beliefs and help them navigate through their family, social or cultural traditional sex-role stereotypes that so many women carry and have carried for generations.

References

Australain Psychological Society. (2017). *Code of Ethics*. Melbourne, Vic: Author.

Bernard, M. E. (2011). *Rationality and the pursuit of happiness. The legacy of Albert Ellis* (p. 305). London: Wiley-Blackwell.

Brody, C. M. (1987). White therapist and female minority clients: Gender and culture issues. *Psychotherapy: Theory, Research, Practice, Training, 24*(1), 108–113.

Dancey, C. P., Dryden, W., & Cook, C. (1992). Choice of therapeutic approaches as a function of sex of subject, type of problem, and sex and title of helper. *British Journal of Guidance & Counselling 20*(2), 221–230.

David, D., Cotet, C., Matu, S., Mogoase, C., & Stefan, S. (2017). 50 years of rational-emotive and cognitive-behavioral therapy: A systematic review and meta-analysis. *Journal of Clinical Psychology*, 1–15.

David, D., Szentagotai, A., Kallay, E., & Macavei, B. (2005). A synopsis of rational-emotive behavior therapy (REBT): Fundamental and applied research. *Journal of Rational-Emotive & Cognitive-Behavior Therapy, 23,* 175–221.

DiGiuseppe, R., Doyle, K., Dryden, W., & Backx, W. (2014). *A practitioner's guide to rational emotive therapy.* New York: Oxford.

Ellis, A. (1994). *Reason and emotion in psychotherapy: Revised and updated*. New York: Birch Lane Press.

McHale, S. M., & Crouter, A. C. (1992). You can't always get what you want: Incongruence between sex-role attitudes and family work roles and its implications for marriage. *Journal of Marriage and Family, 54,* 537–547.

Moller, A., & Bothma, A. (2001). Body dissatisfaction and irrational beliefs. *Psychological Reports, 88*(2), 423–430.

Morse, C., Bernard, M., & Dennerstein, L. (1989). The effect of rational-emotive therapy and relaxation training on premenstrual syndrome: A preliminary study. *Journal of Rational-Emotive and Cognitive-Behavioral Therapy, 7*(2), 98–110.

O'Kelly, M. (1999). *Multirole women: Their beliefs, stress and wellbeing* (Unpublished doctoral dissertation, Monash University, Melbourne, Australia).

O'Kelly, M. (2011). Psychometric properties of the O'Kelly Women's Belief Scales. *Journal of Rational Emotive and Cognitive Behavior Therapy, 29*(3), 145–157.

Russianoff, P. (1982). *Why do I think I am noting without a man*. New York: Bantam Doubleday Dell.

Wolfe, J. (1995). Rational emotive behaviour therapy women's groups: A twenty year retrospective. *Journal of Rational-Emotive of Cognitive Behavior Therapy., 13*(3), 153–170.

Wolfe, J., & Naimark, H. (1991). Psychological messages and social context: Strategies for increasing RET's effectiveness with women. In M. E. Bernard (Ed.), *Using rational-emotive therapy effectively* (pp. 265–301). New York: Plenum Press.

World Health Organisation [WHO]. (n.d.). *Gender and women's mental health*. Retrieved October 25, 2017 from http://www.who.int/mental_health/prevention/genderwomen/en/.

World Health Organisation [WHO]. (2009). *Mental health aspects of women's reproductive health: A global review of the literature*. WHO Press: Geneva Switzerland. Retrieved from http://apps.who.int/iris/bitstream/10665/43846/1/9789241563567_eng.pdf.

REBT with Religious People

Steve A. Johnson

Introduction

About the use of CBT and REBT with religious clients, theorists have expressed optimism and caution.

Albert Ellis wrote in 2000:

> Although I have, in the past, taken a negative attitude toward religion, and especially toward people who devoutly hold religious views, I now see that absolutistic religious views can sometimes lead to emotionally healthy behavior. As several studies have shown…people who view God as a warm, caring, lovable friend, and see their religion as supportive are more likely to have positive outcomes than those who take a negative view of God and their religion.
>
> Rational emotive behavior therapy (REBT) has been found by many religiously oriented therapists, including Jewish, Christian, and Islamic practitioners, to be quite compatible with religious views. (p. 31)

About an REBT intervention, Ellis (2000) wrote, "….it [REBT] can be used by clinicians who accept their clients' religious orientations and show them how their disturbance-producing beliefs can be religiously disputed." (p. 29)

Other theorists (Probst, Ostrum, Watkins, Dean, & Mashburn, 1992) have expressed a more cautious tone:

> …CBT may not be equally effective for religious patients. One reason is that CBT, with its emphasis on such values as personal autonomy and self-efficacy as necessary for mental health…may clash with the cultural values of some religious individuals who may regard such values as alien to their assumptive world of dependence on a divine being.
>
> Indeed, there is evidence that this value discrepancy may result in underutilization of mental health services by highly religious individuals…resulting in a segment of the U.S. population in need of but not currently receiving psychiatric treatment. (p. 94)

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As one author wrote, "In the practice of psychotherapy it is often observed that psychological problems are closely related to the religious experience of the patient" (Schaap-Jonker, Eurelings-Bontekoe, Verhagen, & Zocks, 2002, p. 55)

In light of the optimism and caution, what would constitute best-practices REBT with religious clients, and what is the current state of the field in developing and implementing those best practices? At this time, it is difficult to find research conducted on effective interventions for religious clients that integrate religious content into the therapy.

Key REBT Theoretical Concepts in Working with Religious People

Among the REBT concepts that have proven to be foundational in working with religious people are those that are fundamental to REBT and overlap areas about which religious individuals typically disturb themselves. Some of those fundamental concepts include those such as, unconditional acceptance of the self, differences between inferences (religious dogma) and beliefs, and that irrational beliefs largely cause dysfunctional emotions and behaviors. The following list goes into more detail on these concepts.

1. **Unconditional acceptance of self, others, life, and the world; and high frustration tolerance**. Most of the disturbance religious people have about religious dogma and behavior is not about the content of religious dogma or behaviors associated with, or motivated by religious dogma, but the demandingness that the self and others must believe what the believer believes, believe perfectly what the believer believes, does what the believer demands, and/or does perfectly what the believer does.

This rigidity of belief is consistent with a meta-analysis by Gartner (1996) on the relationship between religion, mental health, and prosocial behavior in which it was found that while religion may moderate problems of undercontrol, such as delinquent behavior, addictions, suicide, etc., it can contribute to problems of overcontrol, such as, authoritarianism, dogmatism, intolerance of ambiguity, and rigidity, which from an REBT perspective are problems grounded in demandingness.

Associated with the lack of unconditional acceptance and the presence of demandingness is often inadequate frustration tolerance, and thus the tendency for religious persons to frustrate themselves that others and the self are not believing and acting according to their rigid demands.

2. **Unhelpful inferences and beliefs**

Within REBT theory, beliefs are viewed as evaluative cognitions that more directly contribute to emotional disturbance than do inferences, which are non-evaluative cognitions. Since many, if not most, religions even within their sacred texts contain commands and demands, such as thou shalt not covet the goods or spouse of others,

believers in those commands often employ them against others. While it might be a category mistake to hold that since God has the right to command and demand others, the believer also has the right to use those "God-like" demands against others, believers do have demands on the self and others and disturb themselves when reality doesn't correspond to their demands.

The inferences of believers can also be problematical in that the words within those inferences are linked to evaluative terms that directly cause emotional disturbance. For example, a believer might hold the inference, "Sally sinned against me." The content of this inference isn't necessarily evaluative, but it may often be linked to terms that give rise to negative evaluations. In this instance, the term 'sinned' may be associated with the term 'sinner,' which connotes an individual who engages in terrible, horrible, unforgiveable behavior. Terms can be entrenched within a web of inferences and beliefs such that the presence of a given term embedded within an otherwise nonevaluative inference is directly linked to an evaluative belief.

3. **Unhelpful motives about the self and others**

Many religions hold theological beliefs about human ontology that are negative about self and others. For example, some interpretations of Christianity hold a literalistic belief that through the rebelliousness of Adam and Eve toward God in the Garden of Eden, i.e., acting against the command of God not to eat the fruit of the knowledge of good and evil, all humans have inherited a 'sin nature' which involves thinking evil thoughts and acting sinfully upon those thoughts. There can be a tendency for Christians who subscribe to this doctrine to attribute negative motives and potentially negative actions toward the self and others. This contributes to a confirmation bias that combs the environment for sin.

Religions that do not embrace such a human ontology (e.g., some interpretations of Islam, would take a different view less prone to attributing such motives to humans). Some versions of Islam teach that humans are created in the best form and that while Adam and Even sinned, this did not result in a 'sin nature' in humans. Therefore, when humans do sin, it is not attributed to a sinful nature giving rise to sinful motives, but is simply part of being a human and a cue to correct the sin by doing something good.

4. **The B-C connection**

The ABC model within REBT is about the relationships among events/situations (A), beliefs about those situations or components of those situations (B), and emotions, behaviors, and even physiological responses (C). The B-C connection reveals an awareness that emotions, behaviors, and physiological responses are to a large degree influenced by the beliefs one holds about the A. Most religions, except perhaps Buddhism, believe in the sovereignty of God. If this sovereignty is believed to be such that God is sovereign over, or causes, life situations, this may not be emotionally problematical for the believer. However, if the believer generalizes the sovereignty of God to include the belief that God causes all A's, then the believer might hold that suffering is externally caused, and the believer has no power to control it. In this situation, therapy may involve how not to disturb the self about one's fate. However,

if the religious client can embrace that God causes A, but humans are responsible for the B, then one can change the C. This position would dislodge pain from suffering and could help the client maintain the sovereignty of God while maintain a belief in the goodness of God, i.e., God does not cause suffering.

Key Best-Practice REBT-Based Assessment and Treatment Strategies and Techniques in Working with Religious People

There can be major challenges assessing religious individuals, especially for those religious clients who are skeptical about "secular" psychology and tend to believe that the Bible, the Qur'an, etc., are all that is needed to make an assessment and function as an intervention. This section of the chapter will focus on techniques for assessing religious clients and additional techniques for working with them that differ from techniques typically used for clients who do not self-identify as religious.

1. **Assessment techniques**

a. **Distinguishing the senses of the word 'belief'**: Some theological beliefs are understood as beliefs within REBT (e.g., "God is good"). Other theological beliefs are understood as inferences, e.g., "Jesus is the second person of the Trinity." Still other theological beliefs are understood as descriptions, e.g., "There were 500 eyewitnesses to the resurrection of Jesus." Some agreement on terminology between the therapist and client would be helpful to distinguish disturbance producing evaluative cognitions and those cognitions with less potential for disturbance, i.e., descriptions and meaning-attribution cognitions.

Making this distinction between senses of belief may minimize the possibility that religious clients erroneously assume REBT challenges religious dogma that are inferences or descriptions, but not beliefs as the word 'belief' is defined in REBT.

b. **Assessing the sabotaging of spiritual goals**: REBT therapists typically assess the frequency, intensity, and duration of symptoms with an emphasis on the degree to which these symptoms sabotage a client in reaching his/her personal, interpersonal, and professional goals. It is simple to assess the degree to which these symptoms sabotage a religious client in reaching spiritual goals. For example, a therapist could easily ask the client whether her social anxiety sabotages her spiritual goals of attending corporate worship or talking to non-Christians about her faith. Perhaps the realization that one's symptoms sabotage spiritual goals might make it easier to have the client consider other non-spiritual goals sabotaged by dysfunctional emotions.

c. **Using prayer as both an assessment tool and intervention**

In a later section of this chapter, I will discuss how prayer can be used as an intervention for some religious clients for whom it would be helpful, relevant, and desired. However, prayer can also be used in conjunction with the ABC model as a

diagnostic tool. For example, should the client want to pray at the beginning of the session, the therapist can note within the content of the prayer any irrational beliefs, the presence of activating events, and even dysfunctional emotions and behaviors. The irrational beliefs and dysfunctional emotions and behaviors can be tracked within prayer over the course of the therapy as one tool in assessing progress.

2. **Interventions**

a. **Non-cognitive interventions**: Some religious clients, especially conservative religious clients who tend to take sacred scripture as the only source of authority may think that scriptural verses are the only legitimate challenges to inadequate or dysfunctional beliefs. Thus, therapy can be reduced to dueling verses. This can be problematical when behavioral activation might be a more effective means to change dysfunctional beliefs.

One way in which the belief that Scripture can function as the only legitimate challenge to dysfunctional beliefs can be challenged within therapy is for the therapist or client to identify instances within sacred scripture in which a religious authority commanded an action to help someone change behavior.

For example, in the Bible (John 5:2-8) there is a story describing Jesus commanding a paralyzed man to walk to help overcome the latter's belief that he was helpless.

> Now there is in Jerusalem near the Sheep Gate a pool, which in Aramaic is called Bethesda and which is surrounded by five covered colonnades. Here a great number of disabled people used to lie—the blind, the lame, the paralyzed. One who was there had been an invalid for thirty-eight years. When Jesus saw him lying there and learned that he had been in this condition for a long time, he asked him, "Do you want to get well?"
>
> "Sir," the invalid replied, "I have no one to help me into the pool when the water is stirred. While I am trying to get in, someone else goes down ahead of me."
>
> Then Jesus said to him, "Get up! Pick up your mat and walk." At once the man was cured; he picked up his mat and walked.

This kind of intervention often opens the door to consider other behavioral and emotive interventions other than resorting to dueling with scripture.

b. **Scriptural inferential debates**: While REBT emphasizes debating beliefs rather than inferences, at times it can be quite helpful to debate inferences, especially when an inference tends to be rigidly associated with a belief. For example, as previously mentioned in this chapter, the inference, "Humans sin because of their sin-nature resulting from the fall," is often associated with the belief, "Humans are depraved by nature," or "I am depraved." The inference, "Humans are created in the image of God," could be used to debate an overgeneralization about the sin-nature and complexify an otherwise reductionistic position on human ontology.
c. **Exposure to those who hold alternative theological beliefs**: A therapist can use exposure of a believer to someone who holds alternative theological beliefs with the directive to pay close attention to the content of the different theological beliefs and to describe those beliefs in detail but without judging the person

who holds the alternative beliefs. One method in which this can be done is a variation on the REBT intervention, Rational Role Reversal. The therapist could ask the client to debate the therapist when the latter is playing the role of downing someone because of their "errant" belief while the client agrees with the criticism of the belief but upholds the value of the one who holds the "errant" belief.

d. **REBT structured traditional religious practices**: Since many religious clients value the religious practices within their faith tradition, it can be powerful and effective when those practices are used in therapy but structured using the ABC model. For example, if agreeable to the client, the therapist could ask the client to pray using an ABC structured prayer. Such a prayer might involve having the client include within the prayer a description of the "A" and the relevant "C's" followed by the naming of the unhelpful beliefs causing the C's. Also included in the prayer would be scriptural verses or other religiously grounded statements that debate the unhelpful beliefs.

This modification of the prayer could not only function to debate the unhelpful beliefs, but also disrupt prayers that might reinforce the unhelpful beliefs. For example, if a client held the belief that her boss was a horrible person, this belief could be repeated numerous times in prayer asking that God change the boss. The prayer would be repeatedly focused on a change in the A rather than a more powerful change in the client's B that could be contributing to anger. A quick survey by the author of over a thousand prayers revealed that individuals typically pray about the A and the C rather than a change in B. An REBT structured prayer might be more effective in getting a more fundamental change in belief that might help the client in similar such situations lower the incidence of dysfunctional symptoms. An example of just such a prayer is as follows:

> Heavenly Father,
>
> Today my boss fired me and I am feeling very angry. I am thinking over and over again that my boss is no good and that he shouldn't have fired me because I have been a loyal worker for nearly fifteen years. I realize that is an ungodly way to think about my boss, but I am having difficulty changing those thoughts and my anger to something that would glorify You. I know that in the Bible you say that we are all created in your image, so I really have no right to put my boss down in the way that I am doing. I also know that in the Bible you say that our anger does not bring about the righteous life that You desire, so I want to stop my anger. I pray that Your Holy Spirit helps strengthen me to hold to your teachings in the Bible and change my ungodly thoughts to more godly ones that help me unconditionally accept my boss.

In addition to prayer, practices such as fasting and meditation could be structured using the ABC model. For example, a client with frustration intolerance could, after being assessed as medically capable of fasting, could fast. The client could be directed to monitor her/his thinking for thoughts that would have her/him sabotage the fast prematurely and replace those unhelpful thoughts with thoughts that help maintain the fast in the face of the felt frustration.

Meditation could be used in much the same way rational emotive imagery is used within REBT. For example, the client could visualize a scene about which the client experienced a dysfunctional emotion. The client would be directed to try to

experience the dysfunctional emotion while visualizing the scene. Once in touch with the dysfunctional emotion, the client would stop the imagery and calm down. Once calm, the client would be directed to visualize the same scene, but this time include in the visualization that Jesus is speaking to him/her to have him/her experience a more helpful negative emotion.

e. **Self-doubt without black/white thinking**: Because religious faith is about non-empirical matters, e.g., belief in a transcendent God, the presence of true repentance of sin, purity of soul, complete reliance on God in all matters, etc., doubt is common, but often viewed as unacceptable. Often there is a black/white dichotomy regarding faith and doubt rather than viewing faith along a continuum. One intervention to weaken the dichotomous thinking would be to place doubt about a belief along a continuum from 0% doubt to 100% doubt and perhaps even include brief descriptions about what the grades or shades of doubt would look like. For example, if the believer was doubting the mercy of God, then when this doubt was placed on a continuum, then 100% doubt would be to act as if God is never merciful, e.g., despair about doubting; whereas, 50% doubt might entail feeling more hopeful and not focusing on the doubt so much during the day.
f. **Rating progress in attaining religious goals in terms of process rather than reaching the goal**: Often religious individuals have ultimate concerns and goals that are regulative ideals that may never be fully attainable, e.g., fully glorifying God in one's thoughts, words, and actions. While such goals might help create unity among lower level life goals, they may be so transcendent that one never experiences the joy of attaining the goal. Emmons (1999) has noted that depressed individuals often have such unattainable goals without the presence of sufficient lower level religious goals, e.g., going to temple three times each month. One way REBT therapists can help clients maintain the transcendent goals, as well as enjoying the attainment of goals is to shift the focus from the end of the goal to the steps toward attaining the goal and help the clients celebrate those intermediate steps. This can be further helped if the attainment of such a goal is viewed as a cyclical process rather than a strictly linear one.
g. **Reframing failures or setbacks in attaining religious goals**: Since clients, religious or non-religious, often globally rate the self based on performance or progress toward a goal with all the attendant negative consequences of such self-rating, it can be helpful to reframe failures. For example, instead of believing, "I sinned, so I am a failure," a religious client could be taught to think, "Awareness of my sin is evidence of my love for God and my seriousness about glorifying God through my actions. If I didn't love God and want to glorify God, then I would be so hard-hearted that I wouldn't even register my sins."
h. **Using words and images**: Cognitions can take the form of either words or images. Images can have implicit meanings and evaluations that can contribute to dysfunctional emotions. However, images can be used in therapy in ways that they do not cause dysfunctional emotions. Harris (2009), using Action and Commitment Therapy, uses a sky image to help clients visualize differentially the changeability of emotions with the unchanging nature of self-as-context. I use the

same metaphor or image with religious clients to help them employ their belief in an unchanging God to deal with times when emotions are experienced as chaotic. I ask clients to view their changing emotions as the weather below the clouds, i.e., that is sometimes as raining, snowing, wind blowing, tornadoes, blizzards, hurricanes, ice storms, etc. They are then to imagine they are flying through the clouds and to notice that once they get above the clouds, they experience blue sky, which represents the God who is unchangeably present above the vicissitudes of weather. In this way, the clients bypass the negative cognitions about their emotions.

i. **Self and Other Focus:** Ellis and Bernard (1985) listed thirteen criteria of psychological health. The first criterion on the list was "self-interest," which was described as, "emotionally healthy people tend to be first or primarily interested in themselves and to put their own interests a little above the interests in others." This view is inconsistent with some religious views that others are to be put first or are necessary to understand the nature of the self, i.e., the work of Emmanuel Levinas, the Jewish existential philosopher and Talmudic scholar; or in one of the traditional interpretations of the Bible (Philippians 2:3), "Do nothing out of selfish ambition or conceit, but in humility consider others as more important than yourselves."

Rather than discussing the merits of self-interest over other-interest, the therapist might shift the focus to the "fact" that if valuing the self and others is a necessary condition of mental health, then regardless of the logical primacy of self-interest or other-interest, pragmatically both are necessary.

Treatment Guidelines from Empirically-Supported Therapy Literature that Inform Best Practice in REBT with Religious People

While there is a growing body of research on CBT for religious persons, little has been written about using REBT with religious individuals; and what has been written about REBT and religion has focused on proposed ways to integrate principles of REBT and religious doctrine, e.g., short-term hedonism and Christianity; research on the compatibility of principles of REBT with principles and values of religious individuals; using religious scripture as debates of the irrational beliefs of believers; using religious content in REBT with religious individuals; using the ABC model in REBT to structure traditional religious practices. There is virtually no research on whether such strategies are effective with religious individuals.

Taylor (2006) in a critique of Andersson and Asmundson (2006) claims:

> Although there have been many efforts to integrate CBT into Christian pastoral counseling (e.g., Lipsker & Oordt, 1990), it is clear that CBT has imported interventions from various religions of the world, rather than merging with them. There are many examples. Mindfulness

exercises and methods for tolerating or accepting emotional distress have deliberately been imported into CBT from Buddhism (e.g., Linehan, 1993).

Most of the work in REBT has been in integrating religious content and interventions from the original secular form of REBT. For example, Nielsen, Johnson, and Ellis (2001), appealing to the work of Probst (1980), discussed using religious imagery in REBT to address symptoms or using imagery in addition to scripture to address symptoms in REBT. Johnson (2006) has developed interventions for Christian clients that use traditional Christian practices, such as prayer, fasting, and meditation but structuring these practices using the ABC model of REBT. Similar work has been done on the Jewish foundations of REBT in an effort to demonstrate that principles within Judaism are congruent with REBT principles (Pies, 2011).

Effort has also been expended to determine whether the principles of REBT are compatible with the values of religious clients. For example, Naeem, Gobbi, Ayub, and Kingdon (2009) studied university students in Pakistan on the compatibility of CBT with their religious values. Also, some researchers have discussed the potential ethical risks of using religiously sensitive forms of REBT (Nielsen, Johnson, & Ridley, 2000).

However, virtually no known work has been completed testing the effectiveness of these REBT integrationist interventions for religious clients beyond mere anecdotal evidence. More work has been done in looking at outcomes of CBT interventions with religious clients by either religious or non-religious therapists, or CBT interventions with religious and non-religious compared to non-CBT-based pastoral counseling (Probst et al., 1992).

Recently, a Christian University in the United States, Columbia International University, completed a research study comparing an REBT-structured prayer (as described earlier in this chapter) to psychoeducation about anxiety to treat mild to moderate anxiety in university students. While yet to be published, the study found the REBT-structured prayer more effective in lowering mild to moderate anxiety than psychoeducation about anxiety.

Brief Case Example

A 26-year-old Caucasian pregnant wife (Holly) presented in therapy with depression, anxiety, and marital conflict. She was a practicing evangelical Christian and her 28-year-old husband (Samuel), was Jewish, but attended a Reformed temple only during high holy days with his parents. Holly had no history of depression, but had grown increasingly depressed as she and her husband discussed in what religion their child would be raised. Holly had assumed that since religion was not very important to Samuel that the child would be raised an evangelical Christian, but her husband felt that since religion was not important to Holly's family and it was to his family that the child would be raised Jewish.

Holly decided that her depression was more problematical for her at the time of therapy that she should address it first in therapy and then consider the marital conflict. At the intake session, several of Holly's irrational/unhelpful beliefs were voiced:

1. We must raise our child in evangelical Christianity, otherwise, the child might not be saved.
2. It would be horrible if our child was not saved.
3. While I don't mind if our child attends Jewish schools, the child must also attend Sunday school to get a Christian education, especially about Jesus and his role as Lord and Savior.
4. I couldn't stand it if Samuel and I experience conflict about this throughout our marriage, or worse, if it causes us to get a divorce.
5. I can't stand the thought of our child not being saved.
6. I would be a terrible mother if I failed to raise my child as a Christian.

Samuel attended two of the sessions and revealed some of his disturbance-producing beliefs:

1. I am fine if our child attends Sunday school at a church, and I will even attend church with Holly and our child, but I must make an effort to make sure that our child attends Hebrew school enough to know Jewish practices, so she can share the Jewish faith with my parents.
2. I feel that our child should decide what religion he or she should practice after having been exposed to both our faiths or any other faith he or she is interested in, or even no faith.
3. I believe that Holly and other evangelical Christians are intolerant and closed minded when they believe that only Christians will be saved. I don't know whether I believe in a heaven or hell, but to think that only Christians will go to heaven, if there is one, seems judgmental and intolerant.

Holly reported that she felt most anxious and depressed when she thought she couldn't stand the thought of her child not being saved, so that belief was the initial focus of the therapy after introducing the client to the ABC model and the B-C connection. Two approaches seemed to decrease her depression and especially her anxiety.

1. Exploration of what the doctrine of salvation meant to her. I, as the therapist, asked whether Holly believed that someone is saved by God or by the mere profession of belief in Jesus as Lord and Savior. She said that only God can save someone, but it was important to expose a person to the truth about salvation and have the chance, or even multiple chances to profess faith that Jesus was Lord and Savior through which the grace of God becomes real or actual.
2. Questioning Holly whether any of her friends at church had children who did not profess belief in Jesus as Lord and Savior, and if so, how were they handling it.

In discussions on #1, Holly came to some sort of resolution that God was sovereign and would extend grace to her child so that even if the child was not in the most religiously optimal setting, the child would still have ample opportunities to learn the

truth about salvation and profess faith in Jesus. She said that her job as a Christian mother was to give the child the opportunity to hear the truth explained in multiple ways during her childhood. For her there was only the truth; the rest was in God's hands. That line of discussion in therapy helped to reduce her frustration intolerance about her child's salvation and created more hopefulness that Samuel would cooperate with her about the child's religious education.

Addressing #2 in therapy involved requesting Holly would be willing to discuss the topic of the salvation of one's child with her friends from church whose children didn't accept Jesus as Lord and savior. She found that some of them were very unhappy about the fact, but others had come to believe that they did what they could and decided that through praying for their child they had the hope that eventually their child might come to a saving belief. This seemed to help Holly's depression and her hopefulness increased over the next few sessions.

The final phase therapy involved bringing Samuel into a couple of sessions where Holly explained where she was in thinking about the issue. Moderating their demandingness helped them discuss practicalities how they would expose their child to both faiths and ultimately honor their child's choice even if they didn't agree with the child. They even came up with some creative arrangements about how they would handle religious holidays. For example, Holly became willing to celebrate Hanukkah as well as Christmas. She said that in her mind she would think that one of the candles on the menorah would represent the light of Jesus to the world. This helped Samuel accept that Holly was not being rude and dismissive about the faith religious practices of his parents.

Follow up with the clients after termination and the birth of the child revealed that they experienced far less conflict about the religious issue, Holly's depression and anxiety had lifted, and they were much more hopeful about the future religious life of their child. Samuel attended church with Holly and the baby and had met and befriended another Jewish man at church who was also married to a Christian woman. Holly and Samuel also planned to begin a group at the Reformed temple near them that held classes for religiously mixed couples.

What I Have Learned About Using REBT with Religious People

Accommodating Individual Differences

Considerable research has been done on religious beliefs and practices of religious individuals with respect to gender, culture, ethnicity, socioeconomic status, and intelligence; however, it is difficult to identify literature on what psychotherapy interventions work with religious clients or what modifications need to be made to the therapy to accommodate gender, culture, ethnicity, socioeconomic status, and intelligence.

Despite the lack of research in these areas, I have some observations made over nearly thirty years of treating religious individuals. Attendance at places of worship is greater among women, whether the place of worship is religiously liberal or conservative. I have also found that women bring to therapy a wide array of mental and emotional issues, often about problems in interpersonal relations, such as marital affairs as the children grew older, grief over loss of family and friends, and children who do not share their religious values and behaviors. Within the church nearly one-third of the men who presented for therapy were dealing with pornography, romantic attachments to women in the place of employment, and marital problems. REBT therapy with both the men and the women didn't appreciably differ except that the men often presented when the problem was more habitual and they were caught by a partner as they were engaged in the problem, for example, caught looking at pornography. Often the men were less motivated to change, and if motivated, wanted the rate of change to be fast. Therefore, often with the men, one of the early issues to address was resistance to therapy.

With respect to religious individuals with relatively higher levels of education and higher socioeconomic class there was less reluctance for both males and females to seek therapy. This may be due in part to the fact that more liberal individuals were more willing to seek therapy and religious individuals with higher levels of education and higher socioeconomic status attend liberal places of worship. REBT with these individuals didn't appreciably differ with respect to level of education or socioeconomic class, except that these individuals wanted more reassurance that the therapy would be confidential because they feared that if others discovered their presenting problem, it could negatively impact social status or employment.

Ethnicity is very much related to a religious individual seeking therapy and the form of therapy sought. Among all ethnic groups, African American women have the highest church attendance and they tend to present for therapy to pastors before seeking help from psychotherapists. Albert Ellis recognized this trend; therefore, in the 1990s was interested in reaching out the pastors in these churches to educate them on the ABC model and how it could be integrated with faith.

Do's and Don'ts

Religious individuals are a special population that, while diverse, also share commonalities. Best practices when using REBT with the population include recognizing the commonalities and diversity. The following is a list of do's and don'ts that is designed to help develop best practices with this population.

Do's

1. Do assume that a religious client may be interested in the particular religious beliefs of the therapist before she/he feels comfortable with the therapist.
2. Do check with the client to make sure the client understands the meaning of the word 'belief' within REBT. Typically, religious individuals use the word 'belief' as an inference, for example, "I believe that Muhammad is the last and final prophet and messenger of Allah."
3. Do check for the presence of unconditional self acceptance, unconditional other acceptance, and unconditional acceptance of life.
4. Do check for client resistance to acknowledge dysfunctional beliefs, emotions, and behaviors. Some religious individuals, for example, conservative Christians, may be reluctant to ascribe dysfunctional beliefs, emotions, and behaviors because doing so would be to fail to acknowledge that God is calling them away from such.
5. Do check for culturally-based attitudes toward counseling. For example, in some cultures counseling is synonymous with advice-giving. In some cultures there is more emphasis on the community than does most Western cultures. In such cultures the client may be the family or the community as much as the individual. Some Middle Eastern cultures view depression as evidence of depth of character and thereby be more reluctant to be treated for the depression. Still other cultures stigmatize mental and emotional illness and prefer to conceptualize the "problem" to be biologically based.

Don'ts

1. Do not assume all religious individuals, even within a religious subgroup or denomination, subscribe to the same doctrines or potentially share the same irrational beliefs with respect to those beliefs. For example, one Baptist may believe that everyone must accept Jesus as their Lord and Savior whereas another Baptist believes that it would be in the best interests of individuals if they accepted Jesus as Lord and Savior, but people have free will and so there is no demand that they accept Jesus.
2. Do not assume that all religious individuals would respond best to using verses from a religious text as the most effective form of cognitive debate. More liberal religious individuals may prefer stories from a religious text, or even prefer traditional secular cognitive debates.
3. Do not assume that religious values are necessarily viewed as the most important values within a hierarchy of values.
4. Do not rush to pathologize some religious practices/dogma. For example, it is common in some Christian denominations to believe that God speaks to the individual, that the Holy Spirit heals individuals; or value glossolalia (speaking in tongues); however, these may not necessarily be evidence of pathology.

Which Aspects of REBT Deliver the Most Benefit for Change and Which Don't

There are several aspects of REBT that can potentially benefit religious individuals in very significant ways; however, there are some aspects of the model that can be modified to lessen client resistance and not be experienced by the client as an attack upon their religious inferences and values. The following list are some suggestions along these lines.

Aspects of REBT that Deliver the Most Benefit for Change

1. **Challenging beliefs, not values:** The fact that REBT challenges irrational beliefs without challenging most goals and values of the client, and often doesn't challenge the client's religious inferences lowers resistance because the client does not experience the therapist as attacking their cherished religious values and goals.
2. **Distinguishing self and roles of the self**: The therapist can distinguish the self from what the self does within given roles of the self. This distinction permits the therapist to help the client to hold to the doctrine that the individual is created in the image of God and that reality is beyond judging, whereas the actions of that self within given roles can be judged. This can help the client grasp unconditional acceptance of the self and others and yet embrace the idea of spiritual progress by working to improve behaviors.
3. **Guilt, being guilty, and remorse**: Unfortunately, many Christians who believe in the Fall, that is, that humans are born as sinners, or guilty of sin, also confuse being guilty and the necessity of feeling guilt. REBT can help religious individuals accept that while they may be guilty, feeling guilt will not help them move beyond that state of being because guilt is grounded in self-downing. However, the theory distinguishes guilt and remorse where remorse acknowledges that one may be guilty of something but refrains from self-downing and thereby helps the individual experience hope for a change.
4. **Types of demands**: REBT is helpful for many religious clients because it distinguishes among types of demands, for example, metaphysical demands, moral demands, legal demands, and pragmatic demands. While it is often quite challenging to help religious clients grasp the difference between metaphysical demands and moral demands, it is important to try. For example, a religious client would most likely view worshiping God as a moral demand and REBT wouldn't challenge that demand. However, to believe that someone absolutely must be moral and worship God and has no freedom to do otherwise, is a violation of the doctrine of human freedom (an ontological/metaphysical state). If the client makes the distinction, he/she can see how it is the metaphysical demand that is causing the client's dysfunctional emotion rather than the moral demand.

Aspects of REBT that if Modified Deliver Benefit for Change

1. **Religiously-based cognitive debates**: I have found that for some clients, particularly, conservative religious clients, using religiously-based cognitive debates are more effective than using secular debates.
2. **Include more behavioral interventions**: There is a tendency for some Christians, particularly evangelical Christians to emphasize cognition over behavior. They may, therefore, feel more comfortable with cognitive interventions but minimize the importance of behavioral interventions. Appealing to the Bible on this point is often helpful. For example, there is a story in the Bible about a man by a pool who had suffered some form of infirmity for thirty-eight years. The man claimed that he couldn't be healed because he couldn't get down to the water. Jesus is said to have responded to the man to get up, pick up his mat, and walk. This could be viewed as a behavioral intervention in the hope of changing the man's self-downing of himself as nothing more than an invalid.
3. **Helping clients broaden their view of their own scriptures**: Working with numerous religious clients, I have learned that at times some of them overemphasize some verses without balancing the content of those verses with verses that amplify the doctrine or point out divergent views. For example, within Christianity there are some biblical verses that seem to indicate that humans have a fallen nature that renders them depraved intellectually, emotionally, and behaviorally. The therapist can present these verses alongside verses that seem to point to the view that humans are created in the image of God, or within Judaism there is the doctrine of the sovereignty of God and yet humans are to cooperate with God to redeem the world, the doctrine of "Tikkun olam", or biblical verses that seem to point to the free will of humans and yet other verses that seem to support a soft determinism about the activating event.
4. **Forms of theology**: Many religious individuals believe that God reveals truths in special revelation, i.e., revealed theology within sacred texts, but also believe that God reveals truths through natural theology, i.e., empirical truths about the world are from God but revealed through science and reason. For example, Roman Catholic Christians believe that revealed theology teaches that God is a Trinity, whereas this truth is not revealed through nature. However, natural theology and reason can "prove" the existence of a God. This distinction may help some religious clients realize that scientific truths of psychology about the nature of humans can be added to the body of truths revealed about humans in sacred texts. For example, a client mind believe by reading the New Testament that it is good to cast one's anxiety on God, but also believe that psychology can reveal specifically how one can do this.
5. **Spend more time on inferences**: I have learned that there are complex philosophical/logical connections between inferences and beliefs and that often inferences contain "emotionally loaded" words that tend to have an invariant association with evaluative cognitions that are overly dichotomous and exhibit the black-white fallacy. I have found that putting the inferences on a continuum of how

much the client believes the inference or the shades of truthfulness of the inference can help dislodge the dichotomous belief more than debating the dysfunctional belief. This is especially with some individuals who have a personality disorder and mistake a debate of a belief as an attack upon the self.

I have often had clients move down a ladder of abstraction or potential evaluation to move a client away from an absolutistic dysfunctional belief. For example, rather than debating the belief "I absolutely couldn't stand associating with a Muslim." I might have a client consider changing the belief to an inference, "It could prove to be a challenge to be around a Muslim when she/he states a theological belief with which I disagree." Or one could have the client practice moving to a description of a state of affairs, "I have noticed that in about 70% of our conversations this Muslim states a theological belief with which I disagree." Since beliefs more than inferences or descriptions have more disturbance-producing potential, this strategy would tend to move the client away from the dysfunctional emotion while the therapist works on debating the dysfunctional belief.

Conclusion

REBT has the potential to help religious clients overcome dysfunctional emotions and behaviors through its cognitive, emotive, and behavioral interventions. However, much more work needs to be done to determine effective ways to integrate religious beliefs and practices within an REBT framework. REBT practitioners have developed integrated interventions, but these have yet to be adequately tested for effectiveness.

References

Dryden, W. (1987). *Counselling individuals: The rational-emotive approach*. London, England: Whurr Publishers.

Ellis, A. (2000). Can rational emotive behavior therapy (REBT) be effectively used with people who have devout beliefs in God and religion? *Professional Psychology: Research and Practice, 31,* 29–33. https://doi.org/10.1037//0735-7028.31.1.29.

Ellis, A., & Bernard, M. E. (1985). *Clinical applications of rational-emotive therapy*. New York, NY: Plenum.

Emmons, R. A. (1999). *The psychology of ultimate concern: Motivation & spirituality in personality*. New York: The Guilford Press.

Gartner, J. (1996). Religious commitment, mental health, and prosocial behavior: A review of the empirical literature. In E. P. Shafranske (Ed.), *Religion and the clinical practice of psychology* (pp. 187–214). Washington, DC: American Psychological Association.

Harris, R. (2009). *ACT made simple*. Oakland, CA: New Harbinger Publications.

Hook, J. (2013). Is Christian counseling effective? What the Research Shows. Retrieved from https://www.aacc.net/2013/12/12/is-christian-counseling-effective-what-the-research-shows/.

Johnson, S. (2006). The congruence of the philosophy of rational emotive behavior therapy within the philosophy of mainstream Christianity. *Journal of Cognitive and Behavioral Psychotherapies, 6,* 45–55.

Johnson, S. (2013). Using REBT in Jewish, Christian, and Muslim couples counseling in the United States. *Journal of Rational-Emotive & Cognitive-Behavior Therapy, 31,* 84–92. https://doi.org/10.1007/s10942-013-0161-4.

Naeem, F., Gobbi, M., Ayub, M., & Kingdon, D. (2009). University students' views about compatibility of cognitive behavior therapy (CBT) with their personal, social and religious values (a study from Pakistan). *Mental Health, Religion & Culture, 12,* 847–855. https://doi.org/10.1080/13674670903115226.

Nielsen, S. L., Johnson, W. B., & Ellis, A. (2001). *Counseling and psychotherapy with religious persons: A rational emotive behavior therapy approach*. Mahwah, NJ: Lawrence Ehrlbaum Associates.

Nielsen, S., Johnson, B., & Ridley, C. (2000). Religiously sensitive rational emotive behavior therapy, theory, techniques, and brief excerpts from a case. *Professional Psychology: Research and Practice, 31,* 21–28. https://doi.org/10.1037//0735-7028.31.1.21.

Pies, R. (2011). Research article: The Judaic foundations of rational-emotive behavioural therapy. *Mental Health, Religion & Culture, 14,* 459–472. https://doi.org/10.1080/13674671003802754.

Probst, R., Ostrom, R., Watkins, P., Dean, T., & Mashburn, D. (1992). Comparative efficacy of religious and nonreligious cognitive-behavioral therapy for the treatment of clinical depression in religious individuals. *Journal of Consulting and Clinical Psychology, 60,* 94–103.

Schaap-Jonker, H., Eurelings-Bontekoe, E., Verhagen, P., & Zocks, H. (2002). Image of God and personality pathology: An exploratory study among psychiatric patients. *Mental Health, Religion & Culture, 5,* 55–71. https://doi.org/10.1080/1367470110112712.

Taylor, S. (2006). Commentary: The interface between cognitive behavior therapy and religion: Comment on Andersson and Asmundson. *Cognitive Behaviour Therapy, 35,* 125–127. https://doi.org/10.1080/16506070600786766.

Vieten, C., Scammell, S., Pilato, R., Ammondson, I., Pargament, K., & Lukoff, D. (2013). Spiritual and religious competencies for psychologists. *Psychology of Religion and Spirituality, 5,* 129–144. https://doi.org/10.1037/a0032699.

Weinrach, S., Dryden, W., DiMattia, D., Doyle, D., MacLaren, C., O'Kelley, M., et al. (2004). Post-September 11th perspectives on religion, spirituality, and philosophy in the personal and professional lives of selected REBT Cognoscenti. *Journal of Counseling & Development, 82,* 426–438.

REBT with Ageing Populations

Ruth Malkinson and Liora Bar-Tur

Introduction

> As the numbers of senior citizens in nearly all countries keep growing tremendously and perhaps 25% or more of them have fairly severe emotional problems, their psychological treatment becomes increasingly important. (Ellis, 1995, p. 5)

Ellis (1995) did not realize that the world will soon face a demographic revolution. Between **2015 and 2030** the number of people in the world aged 60 years or over is projected to grow by **56%**, from **901 million to 1.4 billion**, and by 2050, the global population of older persons is projected to more than double its size in 2015, reaching nearly **2.1 billion**.

The number of people aged 80 years or over, is growing even faster.

Projections indicate that in 2050 the oldest-old will number **434 million**, having more than tripled in number since 2015, when there were 125 million people over age 80. Over the next 15 years, the number of older persons is expected to grow fastest and by 2030, older persons will outnumber children aged 0–9 years (1.4 billion versus 1.3 billion);

By 2050, there will be more people aged 60 years or over than adolescents and youth aged 10–24 years (2.1 billion versus 2.0 billion). (United Nation: World Population Ageing, 2015).

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The Challenge of Ageing

Growing old in the twenty-first century is a great challenge as well as a high risk. Longevity is increasing, and the quality of life for the majority of older adults is improving, with better health due to advances in medicine and a more widespread knowledge of healthy living. How to live a good and fulfilling long life is both a natural concern and a challenge for older adults.

Ageing is a stage in life in which numerous changes associated with loss can be expected to occur in major life domains. Deterioration of health, retirement, relocation, occupational and financial loss, loss of social roles, identity, status, support, and the loss of spouse and significant others (siblings, friends) pose an ongoing threat to daily function, forcing the individual to adapt. How to achieve optimal ageing is the focus of much concern and challenge. The increases in longevity and in the quality of life of older adults challenge mental health professionals in their aim to help the ageing population not only to live longer and healthier, but better and happier. Despite the challenges old age, according to Ellis (1999), has also its advantages. Many older people either have a steady relationship or are not interested in having one. They have already raised their children and are not anxious about them. They are retired from their career and are not frantically trying to achieve prominence. They may be comfortable financially, perhaps not as wealthy as they would like to be, and they may even be socially secure, especially if they live in a senior citizen community or retirement home. Research is demonstrating that many older adults are relatively healthy, active, and independent. Nowadays, they have many more resources for aging successfully and maintaining high levels of well-being (Hill, 2011).

A growing number of older adults are being socially active and creatively involved with their communities (Sougleris & Ranzijn, 2011; Williamson & Christie, 2009). Furthermore, studies demonstrate that older adults can optimize their ageing experience (Ryff, 2014). They can maintain and implement preventive health behaviours, act on resources available to them to cope with age-related decline, and increase their well-being. Thus, a major shift in psychological research and in the approach to interventions for the older population are necessary. The focus should be on wellness not illness for the majority of the younger population of older adults, whereas coping with losses and deterioration in functioning should be the focus of counselling those that have physical or/and emotional mental disadvantages and difficulties in adjustment, especially the oldest-old and their family caregivers (Bar-Tur & Malkinson, 2014; Ryff, 2014).

The Concept of Positive Ageing

Positive ageing can be viewed as a scientific multidimensional concept that combines various terms describing ageing well: optimal, successful, productive, and healthy ageing.

Positive ageing consists of five independent factors: health, cognition, activity, affect, and physical fitness. It is described in practice by a broad set of biopsychosocial factors and is assessed through both objective and subjective indicators (Fernnadez-Ballesteros, 2011).

Positive ageing interventions aim to help the individual to act on resources available to her or him to optimize the ageing experience, with the assumption that it is possible to modify one's own ageing experience (Hill, 2005). Positive ageing focuses on positive rather than on the negative aspects of growing old: Cultivating a sense of well-being by focusing selectively on the meaningful aspects of old age (Ryff, 2014). Moreover, the aim is to combat the negative images of ageing.

Promoting and protecting individual physical, mental, and psychosocial strengths can be achieved by using key elements of the ABC (Activating events-adversities, Beliefs-Consequences) model of optimal ageing such as unconditional self-acceptance and frustration tolerance, which focus on one's ability to accept ageing-related aggravations (Ellis & Velten, 1998). In addition, optimizing the ageing experience can be achieved by positive functioning (Ryff, 2014), strategies of successful ageing (Baltes & Baltes, 1990) and positive ageing (Bar-Tur & Malkinson, 2014).

Key REBT Theoretical Concepts in Working with Ageing Populations

Cognitive Behavior Therapy (CBT) has been reported as an effective time-limited intervention that focuses on changing the negative thoughts and related emotions and behaviors as a way of minimizing the distress related to inflexible negative thinking (Laidlaw & Thompson, 2014). The focus of positive ageing intervention is on proactive coping and well-being (Bar-Tur & Malkinson, 2014; Ellis & Velten, 1998; Ryff, 2014). In the ABCDE of REBT, ageing is viewed as a developmental stage in life characterized by physical and cognitive deterioration and social losses that can be approached philosophically, cognitively in a more adaptive way to increases life satisfaction and wellness (Ellis, 1999, Bar-Tur & Malkinson, 2014). In the words of Ellis (1999): "REBT and other cognitive behaviour therapies take the position that the irrational and dysfunctional beliefs of older people are learned and constructed and therefore can be changed "(p. 14). Within the REBT framework, we will elaborate on three key concepts of REBT which are pertinent to all ages but especially when working with aging populations.

The ABC Model of Coping with Aging: When A Is Ageing

> …People constructively create their early and later disturbances and they largely do so by their beliefs about the adversities in their lives. (Ellis, 1999, p. 7)

The centrality of cognitions and the Belief-Consequence connection as is emphasized in REBT is most relevant and applicable to interventions when working with individuals confronting adversities related to aging. REBT psychoeducational reading material, teaching coping skills and coping statements, combined with Positive Psychology strategies aimed at increasing Frustration Tolerance (FT), and building resilience are available in the toolbox for therapists and counsellors working with aging population.

Learning the ABC (Activating Event-Adversities, Belief-Consequence) for Optimal Ageing

Emotional well-being according to Ellis is related to one's ability to accept oneself with weaknesses and with the decline in physical and cognitive resources, especially as one grows older. The idea is to learn how to replace irrational beliefs and attitudes regarding old age and to change them with rational realistic attitudes. How to replace "I must have work" or "I must be healthy" with "I want to be productive" "I wish I have more money or better health". To accept the "older" self and not to put oneself down. To tolerate deteriorating abilities and challenging stressful events that occur in ageing. Thus, the aim is to assist older adults to unconditionally accept themselves and increase their frustration tolerance when facing age-related changes and losses (Ellis & Velten, 1998). An extension of the ABC model of REBT to help older adults cope with aging losses and promote their well-being is suggested within the framework of positive ageing interventions.

The Concept of Acceptance or Unconditional Acceptance (UA)

The concept acceptance of self, others and life, a term coined by Ellis …"refers to acknowledgement of one's fallibility and flaws, without rating worth either positively or negatively…USA does not mean that one approves of, likes, or ignores one's flaws and weaknesses" (DiGiuseppe, Doyle, Dryden, & Backx, 2014, p. 52). In facing accumulated age-related changes and losses, the concept of acceptance of self, others, and the acceptance of the changing reality of getting old are significant and most pertinent. Physical, mental and social changes are part of the aging process. Thus, accepting and tolerating the fact that aging is a developmental stage in life with changes and losses but also gains rather than focusing on the difficulties and hardship it involves is essential, as well as adopting a flexible and wider attitude to life, focusing on both positive and negative aspects of growing old, taking responsibility and continuing to be active and engaged as long as possible.

The Concepts of Frustration Tolerance and Frustration Intolerance

Frustration Tolerance "refers to the belief in one's strength or ability to sustain effort, survive or to strive in the face of frustration, discomfort or pain" (DiGiuseppe et al., 2014, p. 48). These ageing-related losses require greater frustration tolerance (based on Dr. Marie Joyce's suggestion regarding FI, DiGiuseppe et al., 2014, p. 49). The cumulative losses challenge the individual's autonomy and coping. Moreover, Frustration Intolerance is a cognitive construct with emotional and behavioural consequences that posit a barrier to adaptive coping. A higher level of frustration tolerance has the potential of decreasing emotional disturbance and increasing resilience and well-being among older adults.

Key Best Practice REBT-Based Assessment and Treatment Strategies and Techniques in Working with Ageing Populations

REBT Studies Showing Positive Effects on Problem/Population

As mentioned earlier, with the growing number of people in the world aged 60 years or over estimated that by 2030 they will comprise 13% of total world population with estimated prevalence of 2.7% (across England and Wales) for severe depression. The need to provide prevention and intervention for late-life depression has become critical (Laidlaw, 2013). There are no REBT studies targeted at working with ageing population., however, there are studies reporting a relationship between irrational thinking and distress as well as the efficacy of REBT in Major Depressive Disorder as compared to CT and medication (David, Szentagotai, Lupo, & Cosman, 2008).

REBT Specific Practices

The REBT Depression Manual developed by David, Kangas, Schnur, and Montgomery (2004) is an evidenced-based one, and was used in the above cited RCS (David et al., 2008). It provides detailed strategies and techniques that include teaching the ABCDEF of REBT, cognitive, behavioural and emotive techniques to promote unconditional self-acceptance, to reduce secondary symptoms and to identify and focus on the main irrational belief of demandingness as the central irrational belief involved in depression (David et al., 2004, p. 4).

Self-acceptance and Self Compassion in Ageing

In his chapter entitled Self-Acceptance in Aging, Laidlaw (2013) elaborated about the integration of two concepts-self compassion and self-acceptance. Laidlaw follows Dryden's definition of unconditional self-acceptance "…is a stance that a person adopts towards oneself as a complex and unique yet fallible and flawed individual; however, there is no rating or value judgement made about oneself, indeed there is strong absence of self-judgement. The acceptance of oneself is very simply unconditional". Integrating the two increases the potential of reducing emotional distress and positive psychological growth when working with older adults", (Laidlaw, 2013, p. 264). Similarly, Ellis postulated that "REBT is oriented toward helping older people to achieve unconditional self-acceptance and high frustration tolerance" (Ellis, 1999, p. 13). As a psychoeducational strategy working with older clients on self-acceptance and self-compassion it includes reading material and practicing changing irrational dysfunctional belief into a rational functional one (DiGiuseppe et al., 2014).

Frustration Intolerance (Low Frustration Tolerance)

Ageing-related demandingness with regard to health and physical deterioration are common: "I must be capable and functional the way I was in the past", "I can't tolerate myself for not functioning as I should". Apart from Ellis's paper "REBT and CBT for elderly people" published in 1999, and "optimal aging: Get over getting old" written by Ellis and Velten (1998), there are no specific REBT studies evaluating best practices to working with older population but CBT for older population is reported to be efficacious as an active, directive time-limited and structured aimed at reducing distress exacerbated by ageing processes (Laidlaw, 2013, 2014). Ellis (1999) recommended cognitive (logical, empirical pragmatic disputation, and coping statements) behavioural and emotional techniques including shame-attack exercise and rational emotive imagery as a practice to experience healthy negative emotions rather than depression or anxiety (p. 12). Skill training, relaxation and homework assignments are included. Cognitive and experiential strategies to dispute frustration intolerance are recommended practices (DiGiuseppe et al., 2014). Disputing Common irrational beliefs among older adults include self-downing ("I am no body if I am not healthy and independent"), hostility creating ("other people must treat me kindly and fairly"), and low frustration tolerance ("I can't stand myself as an old person") (Ellis, 1999).

Treatment Guidelines from the Empirically-Supported Therapy Literature that Inform Best Practice in REBT with Ageing Populations

As mentioned, with the demographic changes of the population and the increasing numbers of older adults, there is a growing body of evidence-based psychotherapeutic interventions to assist older adults cope with the challenges of ageing. Among these interventions, CBT is reported as a form of efficacious treatment specifically for older adults diagnosed with depression and anxiety. It aims to empower older adults to learn ways to optimally adapt to late-life changes focusing on their strength rather than on age-related psychological problems). The emphasis in CBT is collaborative relationship wherein the therapist takes the role of a "coach" providing psychoeducation and new ways to approach the problems with between sessions assignments (Bar-Tur & Malkinson, 2014; Laidlaw, & Thompson, 2014). Reported effective cognitive strategies in treatment with the elderly include positive problem solving, acceptance, positive appraisal and coping statements (Ellis, 1999).

REBT Interventions from the Perspective of Positive Ageing

The focus of positive ageing intervention is on proactive coping defined as "an effort to reinforce general resources that facilitate promotion towards challenging goals and personal growth" (Schwarzer, 2000, p. 349). Included are internal resources such as optimism and self-efficacy, and external resources such as time, knowledge, money, planning skills, and social and/or practical support. Support for this approach was reported in a study conducted on community-dwelling Australian adults, indicating the effects of proactive coping, personal growth and purpose in life, with older adults but still marked effect on satisfaction with life. Promoting and protecting individual physical, mental, and psychosocial strengths can be achieved by using key elements from the optimal aging ABC model, such as unconditional self-acceptance and frustration tolerance that focus on one's ability to accept aging-related aggravations (Ellis & Velten, 1998). Furthermore, re-establishing meaning and purpose can be applied by working through the six dimensions of positive functioning as suggested in Ryff's model of psychological well-being (Ryff, 2014). The six dimensions are: Self-acceptance, positive relations with others, autonomy, environmental mastery, personal growth and purpose in life. Ryff's conceptual framework is applied in Well-Being Therapy (WBT), a short-term psychotherapeutic strategy that leads the patient from an impaired level of well-being to an optimal level in the six dimensions of psychological well-being. Self-acceptance, can be practiced by learning how to maintain a positive attitude towards the self and one's past, and how to increase and invest more in positive relations with significant others. Autonomy can be enhanced by increasing independent functioning, expressing personal voices, and strengthening decision making abilities on how to live their lives while resisting social pressure

to think or act in certain ways as expressed by family, friends, and others. Another dimension is aimed at achieving environmental mastery or the capacity to manage everyday life and create a context that matches the individual's personal needs and values. Some older adults may find it very difficult to pursue their own needs actively, especially if they conflict with, or are different from, those of their family members. Finding purpose in life by having a sense of direction, finding meaning in one's present and past, and setting goals to stay active and engaged, are further significant dimensions of increased positive functioning achieved through engagement in gratifying social activities. Volunteering is a recommended engagement that can activate, and simultaneously benefit from, a person's resources. Volunteering encompasses mental, social and emotional engagement and provides meaning in life as well as being a source of self-esteem and personal worth in old age. Older people who volunteer and are involved in social activities reported feeling more cheerful, more peaceful, more satisfied, and more vital.

Working with the clients on all five dimensions, older adults thus preserve a sense of personal growth (the sixth dimension), and its accompanying sense of continued development and openness to new experiences. In addition, practicing the six dimensions for positive functioning can enhance the adaptability to changing reality and the development of optimal potential (Ryff, 2014). A substantial body of research suggests that interventions such as utilizing strengths, writing down three good things or blessings every evening, savouring and gratitude exercises can build positive states and alleviate depressive symptoms caused by deficient well-being, positive emotion, engagement and meaning in life (Seligman, Rashid, & Parks, 2006; Seligman, Steen, Parks, & Peterson, 2005; Rashid & Seligman, 2011).

REBT Assessment and Practice from Positive Ageing Lenses

Assessment of older adults should cover multidimensional aspects of ageing:

Firstly, the older person's physical, cognitive and emotional state needs to be assessed.

Health is one of the most commonly assessed domains in older people as it may affect the physical, cognitive and emotional functioning. A detailed report of the older client's medical history should be therefore addressed.

Secondly, it is important to get acquainted with the older adult's personal, social and historical narrative. Family background, significant milestones in his/her life journey and how it affect the ageing process.

As one ages, the environment in which he/she is aging becomes of significant importance. Having a family and social support, carrying social roles and keeping some activities can contribute to one's well-being. It is important to find out details about where one lives and spends most of the time and as one becomes sick and dependent who takes care of him. Who is the primary caregiver and what is the nature of the relationships with the caretaker.

REBT and Positive Ageing postulate the importance of socio-cultural and religious background therefore special attention must be paid also to these domains.

As resources (social, physical, and cognitive) are increasingly depleted in old age the inner, psychological resources as well as social technological support become of major importance at this stage of life and should therefore be thoroughly assessed, addressed and enhanced (Bar-Tur & Malkinson, 2014).

Treatment Strategies

Working with older clients requires flexibility in applying treatment strategies. The therapist should carefully assess, respect and negotiate, when possible, the preferred and most suitable strategy. As therapy progresses it needs to be reassessed and adopted to the old client's changing conditions.

The following strategies are recommended:

Psychoeducation of the philosophy of REBT and Positive Psychology can be the first phase in the intervention. This phase involves teaching the ABC model of emotional disturbance, focusing on cognition as a mediator between the adverse event and the emotional, behavioural and somatic consequences.

Addressing issues such as self-acceptance, identity, roles, expectations from oneself and from others, bereavement and frustrations can be effectively dealt with using key elements of REBT such as demandingness and irrational expectations, self-downing, awfulizing, low level of tolerance and accepting the need for support and help while keeping one's autonomy and more. The therapist can than introduce the old client with basic models of ageing well (Baltes & Baltes, 1990; Ellis & Velten, 1998; Hill, 2005; Ryff, 2014) as well as teaching coping skills to deal with losses and with caregiving (Boss, 2011; Malkinson & Bar-Tur, 2014).

In addition, practicing Positive Psychology strategies with the client in the sessions and as homework between sessions are recommended to enhance well-being (Lyubomirsky, 2008; Seligman et al., 2006).

Which Guidelines Do We Particularly Use and Why

Key guidelines in working with older adults are flexibility, ongoing assessment and collaboration with family members and caregivers when the older adult cannot function independently.

Flexibility in the process of treatment is required due to the changing reality of the clients, such as health problems which require change in the schedule of planned meetings, communication between sessions if necessary, home visits, contact with family members or other professionals.

Major assessment will often require collaboration and communication with professionals from different disciplines in the community who are involved in the care for the older person.

In psychotherapy, flexible boundaries with the older population such as self-disclosure, answering personal questions when appropriate, accepting small gifts from the older client as a token of appreciation and respect) in order to boost self-acceptance, and positive self-image. Oftentimes, therapy with older adults includes working with the family members, especially when their condition deteriorates.

In addition to applying REBT with older adults and their families, REBT is very effective to working with professional and primary caregiver of the older person.

Psychoeducation specifically teaching the ABC of rational and irrational beliefs is essential as to what are aging losses, understanding the process of bereavement and that to age successfully requires mental, emotional and social resources and the older persons' acceptance of their changing reality.

And lastly, in order to enhance well-being of the ageing population and their caregivers, outreach programs need to be included in any intervention program.

Brief Case Example: A Gift for 90th Birthday

Edit started therapy at the age of 90. This was her 90th birthday gift from her daughter: A few sessions with a psychologist. Something she always wanted to do and have never done. Edit was a widow, a mother of 2 children, a grandmother and a grand-grand-mother. At the age of 90 she was still very busy, socially engaged and active in the family business. She liked being active and felt that her role is important as she needs to supervise and balance her son who was in charge of the family business, but according to Edit, less committed and sometimes careless.

Sessions were conducted once a month along two years. Edit felt that this is the right pace. Not too often and with enough space to accumulate experiences and events that she could discuss with the therapist (LB). After 2 years, Edit became very sick and eventually passed away.

Edit was born in Germany but was growing up in England where she and her parents found refuge from the Nazi regime. She met her husband after the war and they moved to Israel. She studied psychology but did not complete her training. When her children grew up she worked part time in the family business and devoted most of her free time to charity and to cultural activities.

About 10 years prior to starting therapy her husband became ill and later developed Alzheimer disease. Edit as the primary caregiver gradually reduced her social and cultural activities. Two years after his death, Edit became ill and suffered from serious lung disease. Her physical health and her general mood deteriorated. However, she refused to receive help as suggested by her children, fighting to be independent "As long as I can walk I prefer to manage on my own. A caretaker will make me lazy, dependent, passive and more sick".

At the first session Edit introduced herself as an old lady who wants still to enjoy life and struggles to remain active and meaningful "I don't age gracefully" she said with a sad smile talking about her health. I miss my social and philanthropic engagements. I no longer have any social roles and almost no friends. All my close girlfriends passed away or are too sick to get together and when we talk on the phone they only complain about their health". Edit had a close and good relationship with her daughter and grandchildren but in her own words said: "I feel that I become a burden on my children who keep worrying about me". My daughter keeps calling all the time and my poor son has a 91 year old mother who is still alive and refuses to leave him alone in the business". Using humour and trying to belittle her difficulties, Edit was also trying to "help the therapist "tolerate an old lady". "I don't like talking about myself. It is boring to listen to an old woman" s complains. You must be very special if you listen to all the pains and difficulties of old people". Thus, at the beginning of therapy, Edit talked mostly about her positive experiences, an active social life successful family business and her pride of her daughter and grandchildren. She said: "I don't want to discuss my past it brings up all the mistakes I did and it is too late to deal with them now".

It took a few sessions before she could share the darker sides of her life story, her unsatisfying relationships, and her current disappointments and occasional conflicts with her son.

The aims of therapy were:

(i) To help Edit accept her aging self and her health deterioration, as well as her past.
(ii) To develop unconditional self-acceptance to overcome her self-downing. To be more at peace with herself.
(iii) To legitimize and work through her grief and to help her mourn the losses of her old age and some significant losses along her life (losses as a result of the holocaust, loss of childhood, the early death of her father, her husband's sickness, her incomplete education and professional development).
(iv) To let go of her "must" about being independent, to accept the fact that she is too sick to live alone, and to give up the "must" to control and supervise the family business and to trust her son's management.
(v) To help her increase frustration tolerance, and to dispute demandingness, automatic irrational beliefs.

The sessions included—psycho-education in which the therapist discussed with her issues such as the universal processes of ageing, the concepts of positive aging, successful aging, and psychological well-being and the psychological process of bereavement. The therapist gave Edit some papers and books to read at home including the book "Optimal Aging"' by Ellis and Velten (1998). Legitimizing the challenges of getting old, accepting the limitations and the changing reality of old age helped Edit to understand that it is better for her positive functioning to receive more help and she agreed to take a 24-h caretaker. "She is a sweet girl. I really like her,

but you know the phrase: Things too sweet in taste, in digestion sour" she said with a smile when asked later in therapy, about living with the caretaker.

The focal task of the second phase in therapy was working through her positive identity and Unconditional Self-Acceptance. The sessions during this phase included a short life review that Edit was presenting, bringing photos, albums, a book written about the history of the family and a very impressive album made by the family for her 90th birthday. Discussing her identity, she was later asked to write a personal introduction card in the form of several bullet points, by way of response to the above question: "Who am I at this particular phase of my life?" Edit found it very difficult to write about herself at present, her roles and engagements, and her immediate answer was, "I am just a sick old lady".

The bulleted identity points raised important reflective questions such as: "What are my roles and meaningful engagements in life today? Do I present myself in a positive or negative light? Do I emphasize my achievements or my shortcomings? Do I dwell on the past and my losses or emphasize the positive aspects of the present?" By analysing the "identity card", the therapist could help Edit highlight her positive experiences and strengths. To shift from thinking about what she is not and can no longer do, to what she can still do and achieve in the present.

The next phase was teaching Edit the ABC model, focusing on cognition as a mediator between the adverse event and the emotional, behavioural and somatic consequences. This was especially effective when discussing her un realistic expectations and her disappointments from her functioning and her son's attitude and functioning in the role of the family director. Edit received homework assignments at the end of each session and came back with a lot of paper work she has done between sessions. It gave her a sense of accomplishment and feelings that she can still learn new things and develop.

The last phase was devoted to learning strategies of positive psychology and positive aging and setting some short-term goals for the next few months. She booked tickets for the opera and a holiday vacation with her daughter and granddaughter.

She practiced the Gratitude strategy, mindfulness, breathing and making a list of good things that happened during the week. It helped her shift from automatic negative thoughts to a more balanced positive thinking and it helped increase satisfaction with her present life.

At the end of therapy, when her health deteriorated and she could no longer attend therapy, sessions continued at her home. She was very peaceful, and she said "I lived full good life; I am ready to depart from the world. I don't worry about the business anymore. I only feel sad for my daughter who is so attached to me and refuses to accept the fact that I can't live for ever."

What We Have Learned About Using REBT with Ageing Populations

Accommodating Individual Differences: Client Gender, Ethnicity, Socio-Economic Status, Cognitive and Other Factors

As a theory of change, Rational Emotive Behavior Therapy holds that people have the choice to interpret events in a rigid or flexible way: If flexibility of thinking reduces emotional distress, then inflexibility increases it. Ageing is a phase in life that losses are inseparable from the normative process, and many changes are expected to occur in many life domains. Deterioration of health, physical, cognitive and mental functioning, retirement, or social roles, are events with potential for increased mental distress. In older adults, grief following the loss of a spouse, a family member or a friend is unique among younger adults because older adults experience changes in cognitive functioning, physical health and at times, changes in the quality of life (Robin-Welty, Sthal, & Reynolds, 2018). On the other hand, living longer and improved quality of life require a shift of approach in psychological attitudes and interventions for the third-age population, as well as paying attention to differences in longevity and the experience of widowhood in both sexes. Old age can be different for women who outlive men, and are more often widowed earlier (American Association of Retired Persons 2001). This is particularly the case with oldest-old women. The fact that the majority of this age-group are women is represented in the profiles of the old clients who are mainly women who live alone, experience loneliness and cope with losses through death, as well as losses related to body image and femininity. In addition to the losses of a spouse and friends these widows frequently experience as mothers, the loss of a child, and as grandmothers may mourn the loss of a grandchild.

Although aging is an individual process it always occurs ring within a socio-economic, cultural and historical environment. In addition to focusing on physical, social and economic aspects of ageing, accommodating to the changes and losses, accepting individual differences, gender differences, different sexual identities, and the challenges involved in promoting mental health of older adults, are important changes. Interventions which incorporate practice of self-acceptance and control of negative irrational expectations and thoughts increase in positive emotions, positive attitudes, and positive function can help older adults promote their well-being.

As we have stated throughout the chapter, REBT model applied to ageing population has many similarities to that of working with younger populations. However, there are some differences unique to this stage of life: adversities characteristic of older clients such as cognitive, physical, spousal, familial and social changes and deterioration need to be accounted for and assessed.

The Dos and the Don't

The Dos

In the 21st century there is open and easy access to knowledge and education. Young parents can learn a lot about raising children and child development. However, when it comes to their parents and grandparents and especially issues related to old age and the ageing processes, it seems that there is lack of understanding and a lack of interest in learning, and even gerontophobia. Psychoeducation regarding old age and the ageing process is thus necessary, and a central part of counselling older families and older adults.

Psychoeducation

Psychoeducation to the client and to his/her spouse, and children, in particular, to the primary caregiver who frequently experience anticipated loss as in the case of a spouse diagnosed with Alzheimer, in cases of grief following suicide or grief in older LGBTQ adults. Psychoeducation is therefore an important first step in helping the old person or family members cope better and treat themselves or their elderly with more understanding, less fear and anger and with more compassion. It helps an old person to learn about the universal and natural processes of ageing, about the strategies of coping better and about the inevitable mourning process that accompanies many of the elderly. It helps them feel more in control over their anxieties, depressive feelings with self-acceptance and self-compassion. When an old person becomes aggressive, or refuses to get help or develops paranoid thoughts and paranoid delusions, children or caretakers often experience frustration, helplessness and even anger. When the therapist provides them with information relevant to their specific difficulty, this helps them increase their control over uncontrollable situations and thus reduces their anxieties, helplessness and negative attitude towards the old person.

The therapist should then explain clearly and briefly the ABC model of REBT, especially with old age-related activating events, and make sure the older client understands what is excepted from her/him with regard to between-sessions practice.

Providing support and encouragement is an integral part of psychoeducation, that is working on self-acceptance and self-compassion, which maybe more important for some clients than teaching and practicing in the sessions or self-practice.

Therapists should also focus on working through their own personal attitudes to old age, difficulties, frustrations and helplessness in working with the sick and old client.

Between-sessions assignments

Between-sessions assignments when working with older adults need to be carefully tailored to fit the client's needs and in accordance with her/his cognitive and physical capabilities. It is important to plan homework assignments together with the client and assess suitability and likelihood of it being carried out. It is important to make

sure that assignments given are clear and that the old client feels that she/he will be able to cope.

Combine the ABC of REBT with positive ageing

The ABC of REBT views ageing as a phase of life involving losses and physical and cognitive deterioration that can be evaluated rationally (with consequences of healthy negative emotions) or irrationally (with consequences of unhealthy negative emotions). Positive ageing focuses on optimal successful, productive and healthy aspects of life to help older adults optimize their resources as they grow old. Combining the two increases the therapist interventions' repertoire to shift from one to another in accordance with the client's changing health condition. Additionally, the therapist can maintain the ABC paradigm, and instead of the "classical" D use positive feedback to encourage the individual client to optimize her or his resources and teach some positive ageing strategies.

The use of humor with older adults

One of Ellis's innovative REBT techniques is the use of humor and humorous singing in therapy as a way to dispute irrational thinking. In Ellis & Velten's book, "Optimal aging" (1998), Ellis recommended using humor and humorous singing, especially regarding one of the frequent age-related irrational belief of awfulizing "….as to disrupt your routine way of thinking about yourself, others and life conditions. Since it takes physical effort to sing, using the songs practically forces you to put some energy to change your thinking patterns" (there, p. 166). Similarly, using humor as a way of self-acceptance as one ages experiencing a variety of A's (Activating events) of body, physical and cognitive changes over which one has no control but to accept, and doing so humorously is preferable.

In sum, therapists working with older adults and their families have to maintain flexibility, adopt interventions to for individual needs, and be tuned to possible changes and difficulties. Moreover, not as common as with young clients, reaching out to the old clients, and to their family may be in some cases necessary to keep therapeutic continuity.

The Don'ts

Therapists should be careful and refrain from putting too much pressure on the aging client and/or his/her family regarding compliance frequency and duration of sessions.

They should also avoid suggesting too many and too long between-sessions practices.

When motivation and energy of the clients seems low it is recommended to refrain from between-sessions practice and if possible, they should be incorporated within-sessions.

Which aspects of REBT deliver the most benefit for change and which don't? Which do?

REBT holds that although adversities are unavoidable throughout one's life the choice of how to view them remains. This core attitude of REBT emphasizes the positive rather than the negative approach to ageing regardless of age: It is never too late to change irrational beliefs into rational ones and to learn how to moderate emotional, dysfunctional consequences. Throughout the ageing process people are exposed to many adversities and often unexpected and sudden losses. Adjustment to losses and coping with challenges and adversities require emotional integrity, cognitive and mental resources. The distinction between rational (RB's) and irrational beliefs (irBs) and healthy negative emotions (HNE) and unhealthy negative emotions (UNE) provide an efficient framework to empathize with this life-phase accept what cannot be changed due to ageing.

Which don't

Applying "pure" REBT with older adults do not always deliver the expected changes as it requires cognitive, emotional and physical resources that are not available to the old or sick client. For some older adults REBT active and directive interventions are straining and they may need more supportive a "psychodynamic stance". Some older adults prefer at this stage to review their life story (very common among people who experienced a trauma earlier in their life and have never shared it with others e.g. Holocaust survivors). Combining additional strategies and flexibility that fit the individual needs will deliver better expected change.

Concluding Remarks

The vast increase in the older population's longevity, health, and quality of life, together with substantial technological, social, political, and life-style changes, have led to the understanding that there is a need to expand the knowledge, and training in working with the older population, and a re-evaluation and refinement of existing models of interventions. Whereas there are individuals who age successfully, experiencing rewarding time and maintaining their competence, independence, interests, and good mental and physical health, others experience decline early and live out their final years in poor health, often without social supports. The aim of professionals working with the older population is to suggest effective strategies for moderating the hassles and stressors of old age, and help their old clients enhance their positive functioning and well-being. REBT strategies combined with strategies of positive aging are efficacious and recommended. However, professionals need to keep in mind that the diversity in the ageing process makes it difficult to adopt one strategy or one model of ageing well and coping with the challenges of old age. Therefore, we recommend to tailor for each older client suitable mode of intervention, keeping in mind what George Bernard Shaw said:

> The only man I know who behaves sensibly is my tailor; he takes my measurements anew each time he sees me. The rest go on with their old measurements and expect me to fit them.
>
> George Bernard Shaw, "Man and Superman".

References

Baltes, P. B., & Baltes, M. M. (1990). Psychological perspectives on successful aging: The model of selective optimization with compensation. In P. B. Baltes & M. M. Baltes (Eds.), *Successful aging: Perspectives from the behavioral sciences* (pp. 1–34). London: Cambridge University Press.

Bar-Tur, L., & Malkinson, R. (2014). Positive aging: From negative to positive models on aging. In N. A. Pachana & D. K. Laidlaw (Eds.), *The Oxford handbook of clinical geropsychology* (pp. 927–948). London: Oxford Press.

Boss, P. (2011). *Loving someone who has dementia: How to find hope while coping with stress and grief*. San Francisco: Jossey-Bass.

David, D., Kangas, M., Schnur, J. B., & Montgomery, G. H. (2004). *REBT depression manual: Managing depression using rational emotive behavior therapy*. Romania: Babes-Bolyai University (BBU).

David, D., Szentagotai, A., Lupo, V., & Cosman, D. (2008). Rational emotive behaviour therapy, cognitive therapy and medication in the treatment of major depressive disorder: A randomized control study post treatment outcomes and six months follow up. *Journal of Clinical Psychology, 64*(6), 728–746.

DiGiuseppe, R. A., Doyle, K., Dryden, W., & Backx, W. (2014). *A practitioner's guide to rational emotive behavior therapy* (3rd ed.). Oxford: Oxford University Press.

Ellis, A. (1995). Rational emotive behaviour therapy and cognitive therapy for elderly people. *Journal of Rational Emotive Therapy, 17,* 5–18.

Ellis, A. (1999). Rational emotive behavior therapy and cognitive therapy for the elderly. *Journal of Rational Emotive and Cognitive Therapy*, *17*(1), 5–18.

Ellis, A., & Velten, E. (1998). *Optimal aging: Get over getting older*. New York: Open Court.

Fernnadez-Ballesteros, R. (2011). Positive aging: Objective, subjective and combined outcomes. *Electornic Journal of Applied Psychology*, *7*(1), 22–30.

Hill, R. D. (2005). *Positive Aging: A guide for mental health professionals and consumers*. New York: W.W. Norton.

Hill, R. D. (2011). A positive aging framework for guiding geropsychology intervention. *Behavior Therapy*, *42*, 66–77.

Laidlaw, K. (2013). Self acceptance and aging: Self acceptance as a mediator of change in CBT with older people. In M. E. Bernard (Ed.), *The strength of self-acceptance: Theory, research and practice* (pp. 263–280). New York, NY: Springer.

Laidlaw, K., & Thompson, L. W. (2014). Cognitive behaviour therapy with older people. In N. A. Pahchana & K. Laidlaw (Eds.), *The Oxford handbook of clinical geropsychology* (pp. 603–621). London: Oxford Press.

Lyubomirsky, S. (2008). *The how of happiness: A scientific approach to getting the life you want*. New York: Penguin Press.

Malkinson, R., & Bar-Tur, L. (2014). Cognitive grief therapy: Coping with the inevitability of loss and grief in later life. In N. A. Pachina & D. K. Laidlow (Eds.), *The Oxford handook of clinical geropsychology* (pp. 837–855). London: Oxford Press.

Rashid, T., & Seligman, M. E. P. (2011). An overview of fourteen sessions of PPT. In M. E. P. Seligman (Ed.), *Flourish: A visionary new understanding of happiness and well-being* (pp. 41–43). New York: Free Press.

Robin-Welty, G. A., Sthal, S. T., & Reynolds III, C. F. (2018). Grief reaction in the elderly. In E. Bui (Ed.), *Clinical handbook of B and bereavement and grief reactions* (pp. 103–138). Humana Press, Springer. https://doi.org/10.1007/978-3-319-65241-2.

Ryff, C. D. (2014). Psychological well-being revised. *Journal of Psychotherapy and Psychosomatics, 83,* 10–28. https://doi.org/10.1159/000353263.

Schwarzer, R. (2000). Manage stress at work through preventive and proactive coping. In E. A. Locke (Ed.), *The Blackwell handbook of principles of organizational behavior* (pp. 342–355). Oxford, UK: Blackwell.

Seligman, M. E. P., Rachid, T., & Parks, A. C. (2006). Positive psychotherapy. *American Psychologist, 61,* 774–788.

Seligman, M. E. P., Steen, T. A., Park, N., & Peterson, C. (2005). Positive psychology progress: Empirical validation of interventions. *American Psychologist, 60,* 410–421.

Shaw, Bernard. "Man and Superman: Act I." Bartleby.com.

Sougleris, C., & Ranjin, R. (2011). Proactive coping in community dwelling older Australians. *International Journal of Aging and Human Development*, *72*(2), 155–168.

United Nation. (2015). *World Ageing Population 2015 Highlights*. www.un.org/en/development/desa/population/…/ageing/WPA2015_Highlights.pdf.

Williamson, G. M., & Christie, J. (2009). Aging well in the 21st century: Challenges and opportunities. In C. R. Snyder & S. J. Lopez (Eds.), *Oxford handbook of positive psychology* (pp. 65–170). N.Y.: Oxford University Press.

REBT with LGBTQ Clients

Raymond L. Moody

Introduction

Lesbian, gay, bisexual and transgender (LGBT) communities have witnessed significant progress in recent years in terms of increased visibility, acceptance, protections, and rights. However, in many developed countries, the progress for sexual minorities has outpaced that of transgender communities. Many clinicians will work with LGBT clients, as these clients experience disproportionate rates of physical and mental health problems compared to the general population (IOM, 2011; King et al., 2008) and some evidence suggests that lesbian, gay, and bisexual clients are more likely to seek psychological services compared to heterosexual clients (Cochran, Sullivan, & Mays, 2003). However, transgender clients are likely to desire psychological services but face increased barriers to accessing and remaining engaged in treatment (Shipherd, Green, & Abramovitz, 2010). Despite the significant need for LGBT sensitive psychological services, a substantial number of service providers report insufficient knowledge of the context, unique needs, and best practices for working with this population (Graham, Carney, & Kluck, 2012).

LGBT people continue to experience greater risk of psychological and physical health problems compared to the general population (IOM, 2011; Meyer, 2003). This includes elevated risk for mood and anxiety disorders, substance use disorders, post-traumatic stress disorder, suicidal ideation and suicide attempts (Cochran et al., 2003; IOM, 2011; King et al., 2008). Further, LGBT people experience greater risk for physical problems associated with elevated psychological distress, including risk for cardiovascular disease and some cancers (Lick, Durso, & Johnson, 2013). Globally, heterosexual people are significantly affected by HIV but in developed countries gay and bisexual men as well as transgender women account for a majority of new infections each year (CDC, 2015). Research has identified several psychological risk

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factors that compound the risk of HIV transmission among these populations, including experienced trauma, depression, sexual compulsivity, and substance use (Parsons et al., 2017; Stall et al., 2003). Health disparities observed among LGBT populations is often attributed to the presence of stigma-based stress associated with having a sexual or gender minority status (Meyer, 2003) as well as the impact these stressors have on psychological processes necessary for well-functioning (Hatzenbuehler, 2009).

LGBT clients face unique and chronic stressors associated with having a stigmatized sexual orientation (e.g., non-heterosexual identity) and/or gender identity (e.g., transgender identity; gendered behavior inconsistent with assigned birth sex; Hatzenbuehler, 2009; Meyer, 2003). The term minority stress has been used to describe these unique stressors and includes distal experiences of victimization, harassment, and discrimination based on having a perceived sexual minority status or gender minority status. The term also includes more proximal stressors of expectations of rejection, concealment of non-heterosexual sexual orientation or transgender identity, and internalized heterosexism (i.e., internalization of negative societal attitudes regarding non-heterosexuality or gendered behavior inconsistent with assigned birth sex). According to the minority stress framework, these unique stressors are experienced in addition to general stressors and the elevated cumulative stress is associated with elevated risk in experiencing psychological and physical health problems (Meyer, 2003). Minority stress impacts psychological processes that contribute to risk for psychological disturbances, including coping and emotion regulation strategies, social and interpersonal functioning, as well as cognitive processes such as the development and activation of belief systems (Hatzenbuehler, 2009).

Key REBT Theoretical Concepts in Working with LGBTQ Clients

B-C Connection

One of the key theoretical concepts of REBT in working with LGBT clients is the B-C connection. Like most clients who are new to therapy, LGBT clients may attribute most of their psychological distress to their environment. For example, clients may report that if only their parents were more accepting of their relationship they would not be depressed. Many LGBT clients come to therapy after spending a significant amount of time trying to change their environment. Some may have even found some success in relieving some of their distress by changing environments, such as moving away from home to a place that is more accepting of their sexual orientation or gender identity. Research shows that many LGBT people move to large urban cities with a visible LGBT community (e.g., gayborhoods) but some LGBT clients may not have the same access to these communities (Pachankis, Eldahan, & Golub, 2016). Successful attempts in changing environments and the associated alleviation of psychological distress may reinforce the idea of an A-C connection

and the belief that the oppressive social climate or discriminatory treatment by others is what needs to change in order for the client to find relief. Research suggests that there is some truth to this belief and that as social policy and public attitudes shift to more favorable treatment of LGBT people the mental and physical health of these individuals improves (Hatzenbuehler, Keyes, & Hasin, 2009). However, changes in social policy and public attitude often happen slowly and are often beyond significant influence of the individual client. In the B-C connection of REBT, therapists and clients have a target of treatment that can be significantly influenced by the client through treatment.

When teaching the B-C connection, it is important to validate the influence that stigma has had on the development and reinforcement of maladaptive beliefs. Acknowledgement of the current environment and the unique and chronic stressors sexual and gender minorities experience can convey empathy and understanding of how the client developed the beliefs that are contributing to their current levels of psychological distress. In teaching the B-C connection, clients can be taught that they are not responsible for their discriminatory environment. Therapists may elicit examples from the client where they have changed their environment but failed to decrease unhealthy negative emotions or the change produced undesirable behavioral consequences. Therapists can validate that the client may have an easier time if they did not have to deal with sexual minority and gender related stressors but that in reality they are likely to encounter mistreatment because of their sexual orientation and/or gender identity. It is important to work with LGBT clients to develop an understanding that acknowledging and accepting the world for what it is (e.g., the client's parents will not come to their wedding because of who they are marrying) does not mean that the client is approving of the world.

Difference Between Healthy and Unhealthy Negative Emotions

A second theoretical REBT concept important when providing treatment to LGBT clients is the difference between healthy and unhealthy negative emotions. As mentioned above, LGBT clients experience greater rates of depression, anxiety, substance use, and suicide compared to the general population. In REBT, an important distinction between healthy and unhealthy emotional and behavioral consequences is the functionality of those consequences. Teaching clients to examine the functionality of an emotion or behavior is important throughout the course of treatment. Some clients, however, may only attend to some aspects of functionality and therapists may need to work with the client to elicit the full range of functions an emotion or behavior serves. For example, a lesbian woman may think anxiety about disclosing her sexual orientation is functional because it prevents her from being rejected by others. A therapist may draw her attention to the fact that anxiety prevents her from being as socially engaged as she would like and perhaps limits the meaning that comes from social interactions or that her anxiety prevents her from receiving social support.

One challenging emotion for many clinicians and clients is distinguishing between healthy and unhealthy anger. Several clients of mine have reported that anger is helpful as it is a powerful motivator of political activism and these clients often believe that people need to be angry to be heard and make changes. For these clients, it may be helpful for the client to recognize that anger may serve a good function when engaging in activism but not when they are at home engaging in activities where anger is not desired (e.g., washing the dishes). Focusing on situations when the anger is not helpful and irrational beliefs that are driving anger in situations where anger is not wanted is beneficial to helping the client regulate their emotions to have a more desirable healthy emotion across a range of situations.

Educating Clients Concerning the Difference Between Rational and Irrational Beliefs

Similar to the distinction between healthy and unhealthy emotions, many LGBT clients new to REBT will need education surrounding the difference between rational and irrational beliefs. When I first trained in REBT, I remember how many clinicians were surprised at how quickly they were expected to identify and modify the irrational beliefs that were contributing to the client's presenting problem. Many clinicians in this training wanted to spend time assessing the client's history in an effort to develop a broad understanding of the client's belief system and the origins of these beliefs. As described below, there may be some advantages to a slower paced introduction and history taking with LGBT clients. The benefits of this are mostly in terms of building rapport and a strong therapeutic alliance with clients who may have a healthy level of skepticism with health care professionals and understanding the influence of minority stress on the development of irrational beliefs. However, according to the theory of REBT, clients will see the most improvement in their presenting levels of distress once they start modifying irrational beliefs into rational alternatives. Environmental influences are likely to shape the schemas of LGBT clients thereby influencing the beliefs that are activated within a given situation (Hatzenbuehler, 2009). For example, continued rejection from family members and other members of the community shape beliefs around self-worth and expectations of rejection. From an REBT perspective, the appraisal of these beliefs is what contributes to the significant levels of psychological distress among these clients.

Despite increased risk of psychological and physical health problems observed among individuals in LGBT communities compared to the general population, a majority of LGBT individuals will exhibit high levels of resiliency and psychological health. Like most clients, LGBT clients presenting for treatment will experience distress stemming from one or more of the four primary forms of irrational beliefs. Not all LGBT clients will present with irrational beliefs related to their sexual orientation or gender identity. These individuals may have developed healthy rational beliefs surrounding their sexual orientation or gender identity throughout their life

as they reconciled their identity. Factors that are likely to influence the development of healthy rational beliefs compared to unhealthy irrational beliefs include the presence of role models and social support, inclusive policies and education surrounding non-heterosexuality and variations in expression of gender identity, as well as the reactions and consequences of disclosure (Hatzenbuehler, 2009).

For clients presenting with irrational beliefs related to sexual orientation or gender identity, demanding beliefs about how the client's environment must treat oneself and other members of the LGBT community are often at the forefront of psychological distress. The distinction between a demand and a strong preference is important in shifting this rigid irrational belief to a more flexible rational alternative. This may be a difficult distinction for any client and even the therapist treating the client. For example, many clients and therapists may subscribe to the belief that a person's parents should love and accept them unconditionally as they are. This preference may be so strong that it is viewed as a demand (e.g., one's parents *must* love their children unconditionally). LGBT clients are aware of the treatment heterosexual and cisgender members of the community receive and often believe that they deserve to be treated similarly. Demanding beliefs that one be treated the way one feels they deserve can be problematic for most clients, including LGBT clients.

Stemming from the demands surrounding equal treatment, LGBT clients often experience and present with beliefs of frustration intolerance. Most LGBT clients will have experienced some form of stigma-based discrimination, harassment, or victimization in their lifetime (Hatzenbuehler, 2009; Meyer, 2003). Exposure to painful experiences of discrimination, harassment, or victimization is likely to contribute to the beliefs that the LGBT individual may not be able to handle future experiences of hostility or rejection. The consequences of this belief often include heightened rates of anxiety and depression symptoms as clients may become hypervigilant to ward off any future negative experiences. The term rejection sensitivity has been used to describe these anxious expectations and avoidance of rejection (Meyer, 2003). LGBT clients may choose to conceal their identity or avoid situations that may risk disclosure in an effort to avoid any adverse events (e.g., rejection) and the associated negative emotions. For these clients, avoidance may serve to reinforce the client's beliefs of frustration intolerance which could contribute to further social isolation and depression.

The internalization of negative societal attitudes toward non-heterosexuality and gender variant identities, also referred to as internalized heterosexism, has been referred to as one of the most destructive minority stress processes (Meyer, 2003). Most LGBT clients are socialized early in their life with values that normalize heterosexuality and gendered behavior that is consistent with a person's assigned birth sex. For example, a parent may encourage a young boy to kiss a young girl on the cheek but discourage a young boy from kissing another young boy on the cheek. Similarly, a young boy is likely to receive toys marketed for boys (e.g., trucks) and a young girl is likely to receive toys marketed for girls (e.g., dolls) and children will be discouraged from playing with toys marketed for a different gender than their own. This socialization often teaches children to value heterosexual attraction and congruent gendered behavior before they are aware of their own sexual orientation

and/or gender identity. As a result, many LGBT individuals go on to develop beliefs that LGBT members of society are devalued because of their sexual orientation or gender identity and these beliefs may be internalized by LGBT individuals as global self-evaluations of worthlessness because of their LGBT status. Research shows that these internalized beliefs are associated with a range of unhealthy negative emotions as well as adverse behavioral consequences (Moody, Starks, Grov, & Parsons, 2017; Newcomb & Mustanski, 2010).

One primary focus in working with LGBT clients is to change irrational global attributions based on internalized stigma to more flexible rational alternatives. This process is aided by focusing on unconditional self-acceptance. There is broad literature supporting the benefits of identity affirming behavior for LGBT clients (Johnson, 2012; Pachankis & Goldfried, 2004; Pachankis, Hatzenbuehler, Rendina, Safren, & Parsons, 2015). From an REBT perspective, self-esteem is based on a dysfunctional process of self-evaluation and low self-esteem is associated with psychological distress. For LGBT clients, low self-esteem is associated with increases in symptoms of anxiety and depression (Meyer, 2003). High self-esteem can also be problematic for clients when they become resistant to helpful feedback (Chamberlain & Haaga, 2001). The challenge of working on self-esteem is that there is no objective way of rating self-esteem and a client's self-rating is subjective based on their current environment. Ellis argued that when clients work on unconditional self-acceptance, "the individual fully and unconditionally accepts himself whether or not he behaves intelligently, correctly, or competently and whether or not other people approve, respect, or love him (Ellis, 1977, p. 101). For any client, particularly LGBT clients, this is a lofty goal but working towards beliefs that can help these clients have unconditional self-acceptance across situations regardless of the experience they have with others is a powerful tool in managing stigma filled environments.

Key Best-Practice REBT-Based Assessment and Treatment Strategies and Techniques in Working with LGBTQ Clients

Research on best REBT-based practices in working with LGBT clients is virtually non-existent. A literature of LGBT affirmative therapies more broadly has emerged in recent years which incorporate strategies and techniques from psychodynamic and cognitive behavioral therapies (Alessi, 2014; Goldblum, Pflum, Skinta, & Balsam, 2016; Johnson, 2012; Pachankis & Goldfried, 2004). This approach to treatment is largely based on research demonstrating direct associations between experiences of sexual minority stress, transgender specific stressors, and increased vulnerability for mental health problems (Meyer, 2003), as well as the literature demonstrating the negative impact sexual minority stress and transgender specific stressors have on psychological processes important in maintaining good mental health in adverse situations (Hatzenbuehler, 2009). Guidelines on LGBT affirmative assessment and

treatment strategies have been put forth and can be used to inform use of REBT with LGBT clients.

Establishing a Strong Therapeutic Alliance

As discussed, many LGBT clients will have experienced stigma-based mistreatment and sometimes this mistreatment may be in the context of situations where the LGBT client is seeking psychotherapy or other healthcare related service. It is therefore important for therapists to create a strong affirmative therapeutic alliance with their LGBT clients as these clients may enter into therapy with some skepticism about the kind of care they are to receive (Fassinger, 2000). Often a client's first interaction with a therapist involves completion of intake paperwork and an initial clinical interview which provides important information necessary for identifying a client's presenting problem and developing an initial case conceptualization. When treating LGBT clients, it is important for intake paperwork and assessments to be inclusive of the diverse experiences and identities of all clients. For example, questions assessing gender should include options for transgender and other variations in gender identity. Additionally, a client's preferred name and pronouns (e.g., masculine, feminine, gender neutral) should be also assessed and used rather than the name and pronouns on official documentation (e.g., government identification, insurance cards, medical records). The use of inclusive language is vital in the development of a strong therapeutic alliance. In addition to inclusive paperwork, therapists should strive to use inclusive language, avoiding heterosexist assumptions, during clinical interviews and throughout the course of treatment. For example, when asking a client about their experiences in romantic relationships a therapist should ask questions in a way that avoids assuming the client is interested in a heterosexual relationship.

Therapists should demonstrate that they possess sufficient knowledge regarding the unique stressors that members of the LGBT community experience while also understanding that the presence of sexual orientation and gender related issues varies from client to client. Research demonstrates substantial variability across clients in terms of the salience of sexual orientation and gender identity as well as evidence to suggest that some clients will experience fluidity in their sexual orientation and gender identity across the lifespan (Diamond & Butterworth, 2008). It is important for therapists to assess how a client self-identifies both in terms of sexual orientation and gender identity as well as the salience of sexual orientation and gender identity to their overall self-concept. As such, clients are treated as the experts of their own personal experience with sexual orientation and gender identity issues but are not required to serve as educators of challenges faced by the LGBT community more broadly.

Assessing the Presence of Minority Stress and Reducing Minority Stress with Treatment

One of the primary targets in affirmative therapy for LGBT clients is the reduction of minority stress (Goldblum et al., 2016). As described earlier, the processes of minority stress include external stigma-based stressors, such as harassment and discrimination for being LGBT. These distal stressors are heavily influenced by the client's environment and a client may find relief through changing their environment. However, distal minority stressors are often difficult to change in the course of psychotherapy. There are also minority stressors that are more proximal to the client such as expectations of rejection, concealment of sexual orientation and/or gender identity, and internalized heterosexism. These proximal stressors have stronger associations with psychological distress but are also more amenable to change in psychotherapy(Hatzenbuehler, 2009). In line with the principles of REBT, affirmative therapy suggests clients are likely to benefit more from work that focuses on managing internalized stressors (e.g., negative global evaluations about oneself) than work focused on changing the aversive environment.

To adequately address the impacts of minority stress, therapists must first assess the presence of minority stress and the association between minority stress and the presenting problem. Alessi (2014) suggests a two-part assessment of sexual minority stress that can be broadened to include assessment of transgender related stressors as well. In the first part of the assessment, the different processes of minority stress are examined: exposure to prejudicial events, anticipated stigma, concealment of sexual orientation or gender identity, and internalized heterosexism. In the second part of the assessment, the effect of minority stress on psychological processes that are hypothesized to mediate the relationship between minority stress and psychological distress are examined: coping and self-regulatory strategies, social networks and interpersonal networks, and cognitions (e.g., schemas/unhealthy beliefs).

To identify areas of minority stress to explore in a clinical interview, there are a range of assessment tools that can be included in intake paperwork and examined to identify areas where a client may experience elevated minority stress. Many of these measures have been developed for the purposes of research with some designed to assess all of the minority stress processes (e.g., Daily Heterosexist Experiences Questionnaire; Balsam, Bednell, & Molina, 2012) or specific minority stressors (e.g., Internalized Stigma Scale, Amadio, 2006; e.g., Everyday Experiences of Discrimination; Burgess, Lee, Tran, & van Ryn, 2008; e.g., Rejection Sensitivity Scale; Pachankis, Goldfried, & Ramrattan, 2008). The Minority Stress Scale is a 12-item scale that can be administered to clients and raw scores can be compared to those on a T-score chart to identify specific areas for further examination. This measure was recently incorporated into an assessment and treatment planning internet based platform, Innerlife.com (Innerlife.com, 2014).

In a clinical interview, therapists can ask about experienced prejudicial events related to a client's sexual orientation or gender identity. These experiences could be acute or chronic and have likely influenced the belief system of an LGBT client.

Reducing the amount of prejudice the client is exposed to can be difficult in the course of therapy but REBT therapists can work with the client to challenge the irrational beliefs associated with these experiences. Assessment for proximal minority stressors can be accomplished by asking the client to discuss their comfort with their sexual orientation or gender identity. For example, a therapist may assess a client's comfort with disclosing their sexual orientation to others by asking a female lesbian client, "who knows about your attraction to women?" and "how supportive have people been when you told them you are lesbian?" Expectations of acceptance or rejection from others is also important and can be assessed with questions similar to, "how comfortable do you feel being open with people in your community?" and "what are you most concerned about if people found out about your sexual orientation or gender identity?" Finally, therapists should assess how the client feels about themselves and their sexual orientation or gender identity, listening for self-stigmatizing beliefs that can be specific to sexual orientation or gender or more global.

A thorough assessment of minority stress may help the therapist avoid downplaying or overemphasizing the role sexual orientation or gender related stressors play in the development and maintenance of psychological problems. In treating issues where the role of sexual orientation and gender identity are ambiguous, it is important for therapists to periodically check in with the client to see how they think their sexual orientation or gender identity fits into their conceptualizations of their presenting problems. Some clients may reject the idea that their problem has anything to do with their sexual orientation or gender identity and suggest other influences. The client may also share meaningful insight into beliefs they have about their presenting problem and how it may relate to their sexual orientation or gender identity. For example, a therapist may ask a client who is seeking help with procrastination about their beliefs that everything they do needs to be perfect. Asking about how this perfectionism may be related to their sexual orientation could produce a connection with perfectionism as a method to prevent any form of sexual orientation-based rejection.

In some cases, LGBT clients may see a clear connection between beliefs surrounding their sexual orientation or gender identity and the presenting problem. For example, a client who is anxious about being outed at work may have strong beliefs that he is going to be rejected by his peers because of his sexual orientation and not be successful in his job. In other instances, a client may present with a problem but not be aware of any potential beliefs about sexual orientation or gender identity that may be driving the presenting problem. The therapist may need to hypothesize with the client what potential distressing beliefs the client may have. In these situations, assessment of minority stress experiences may be helpful.

Examining the Impact of Minority Stress on Social and Psychological Resources

After a therapist has developed an understanding of the client's experience with minority stress, it is recommended that the therapist examine the availability and effectiveness of psychological resources (Alessi, 2014). Coping and emotion strategies are likely to be impacted by minority stress. For example, a client may avoid conversations about relationships or engage in substance use to avoid or manage negative affect. Minority stress (e.g., rejection/discrimination) and avoidance behaviors are likely to influence the availability of social networks and interpersonal relationships necessary for social support. Fears surrounding disclosure of sexual orientation or gender identity may also serve as barriers to the closeness of interpersonal relationships, restricting support provide by available networks. As discussed, cognitions are important to the development and maintenance of psychological distress. A thorough assessment of the impact minority stress has had on the development of belief systems contributing to psychological distress is necessary with LGBT clients.

Treatment strategies with LGBT clients should target the reduction of psychological distress through reappraisal of irrational beliefs, development of adaptive coping strategies, increasing social support, and improving the quality of interpersonal relationships. Irrational beliefs are at the core of the most proximal minority stress processes (Hatzenbuehler, 2009). For example, internalized stigma is most distressing to an LGBT client when it is viewed as a global negative trait. Similarly, rejection sensitivity is most distressing when the LGBT client views they are unable to manage the discomfort of experiencing rejection. A therapist may draw upon a number of the commonly used REBT disputes when challenging irrational beliefs that contribute to psychological distress with LGBT clients.

Reappraisal of irrational beliefs is a factor in effective coping when encountering activating events contributing to psychological distress. Other coping strategies for reducing psychological distress included seeking support from others which can involve the disclosure of sexual identity or gender identity. Disclosing sexual identity or gender identity is associated with improvements for LGBT clients but perceived threats may serve as barriers to the disclosure process. Treatment may focus on identifying cognitive and emotional barriers to disclosing sexual identity or gender identity. For example, awfulizing beliefs about being rejected may obscure the potential benefit of disclosure and receiving social support from a colleague. Treatment may also focus on identifying sources of social support for the client to engage with between therapy sessions. For most clients, identification of inclusive and accepting social networks is extremely important for clients to receive needed support during the course of treatment.

Treatment Guidelines from the Empirically-Supported Therapy Literature that Inform Best Practice in REBT with LGBTQ Clients

Treatment guidelines for psychological practice with lesbian, gay, and bisexual clients were developed and recently updated by the American Psychological Association (2012). Treatment guidelines for psychological practice with transgender and gender non-conforming clients have also been recently developed by the American Psychological Association (2015). REBT therapists are encouraged to be familiar with these guidelines and to shape their treatment of LGBT clients around the current recommendations. The guidelines emphasize the importance in therapists possessing foundational knowledge and awareness of the diversity of sexual orientation and gender identity and expression in clinical populations. This includes knowledge of terminology used by LGBT clients, awareness that sexual orientation and gender identity operate on a continuum, and that sexual orientation and gender identity are distinct characteristics of an individual client. The guidelines also highlight the need for therapists to understand the influence of stigma on the development of psychological distress and the challenges that stigma presents in clients obtaining supportive services. The role of sexual orientation and gender based stigma in the development of irrational beliefs among LGBT clients has been discussed throughout this chapter.

Assessing Personal Biases Surrounding Sexuality and Gender Expression

When treating LGBT clients, therapist should do an honest self-assessment of their own personal attitudes and beliefs surrounding sexual behaviors among lesbian, gay, and bisexual clients, as well as their attitudes and beliefs surrounding transgender and gender non-conforming identities and behaviors. Negative personal biases held by the therapist can adversely affect assessment and treatment of LGBT clients. For example, beliefs that pathologize same-sex attraction or gender non-conforming behavior may overemphasize the influence of an LGBT client's sexual orientation or gender identity on the client's presenting problem. In a similar vein, therapists who are uncomfortable discussing issues of sexual orientation and gender identity may underexplore the influence these characteristics may have on the development of irrational beliefs among LGBT clients. There are several checklists that therapists can use as well as behavioral exercises to identify these biases. Therapists are encouraged to seek additional training and use referrals when they believe their attitudes and beliefs may adversely impact their LGBT clients. Understanding these biases will help in building and maintaining rapport with clients.

For the REBT therapist, assessment of personal biases around sexual orientation and gender identity and expression can allow the therapist to minimize countertransference and use oneself as a measuring device in treatment. Concern over

countertransference—a therapist's personal attitudes and emotional response toward a client—originated in psychodynamic psychotherapy. However, REBT therapy is more susceptible to countertransference than other less directive forms of therapy where personal beliefs and emotional reactions could interfere with providing effective therapy (DiGiuseppe, Doyle, Dryden, & Backx, 2013). As such, therapists may also benefit from their own therapy and consultation with other therapists to help identify irrational beliefs and associated reactions in an effort to keep them from interfering in the provision of therapy to LGBT clients.

Structuring REBT Around the Tenets of Affirmative Therapy

Generally, guidelines for providing treatment to LGBT clients have emphasized treatment that is affirming of having a sexual minority or gender minority status. The goal of many affirming cognitive-behavioral approaches to treatment for LGBT clients is to reduce minority stress processes (Pachankis, 2014). Pachankis and Goldfried (2004) summarized some of the proposed tenets of affirming therapy. First, therapy should be encouraging of LGBT clients to identify and seek social support from LGBT peers. REBT therapists may help identify venues where social support networks are available as well as address irrational beliefs that lead to emotional barriers in accessing that support. Second, therapists should work with clients to help clients see the influence stigma and oppression has had on their wellbeing. REBT therapists can assist in identifying experiences of oppression and how these experiences have influenced the sets of irrational beliefs the client applies to activating events. Third, shame and guilt surrounding same-sex attraction, identity, and behavior, and/or gender identity and expression should be examined. REBT is well suited to target unhealthy negative emotions like shame and guilt. Finally, affirmative therapy recognizes that anger is an expected emotion among clients who are oppressed and this anger should be validated with LGBT clients. REBT therapists can work with clients to have healthy anger and support clients in taking action driven by this functional emotion (i.e., activism).

Working Towards Unconditional Self-acceptance

Until 1973, homosexuality was considered a mental disorder by the American Psychiatric Association. Affirming therapy is in stark contrast to the pathologization of same-sex sexual behavior. Gender dysphoria remains a diagnosable mental disorder for transgender individuals and there is controversy over this diagnosis because of the potentially pathologizing effects it can have on transgender individuals (Bouman et al., 2017). Today, there appears to be a growing consensus among mental health practitioners that conversion therapies—treatments aimed at controlling or eliminating same-sex attraction or gender non-conforming behavior—are ineffective and

harmful to LGBT clients. Attempts to change sexual orientation and/or gender identity in therapy may further influence irrational beliefs and drive elevations in depression and suicidal behavior.

In line with affirming therapy, REBT conceptualizations of presenting problems highlight the need to focus on irrational beliefs associated with an activating event rather than the activating event itself. Some clients may have been referred to therapy or sought therapy on their own in hopes of changing aspects of their sexual orientation or gender identity. In this case, sexual orientation and gender identity are viewed by the client as significant aspects of the activating event and clients likely believe their emotional reactions are directly linked to the activating event itself. The irrational beliefs tied to sexual orientation or gender identity may also prevent the client from exploring their sexual orientation and gender identity in a healthy way that allows them to reconcile their identity.

For example, a client struggled with his sexual identity and wavered back and forth on identifying as heterosexual or bisexual. He held a belief that if he explored his interest in men that he would never be able to truthfully identify as heterosexual again. He believed he would have difficulty dating women in the future, if he desired, because of the stigma associated with bisexuality. His belief is not fully irrational as bisexual people often experience stigma both in heterosexual and homosexual communities but his beliefs were catastrophic in nature when he would endorse "never" being able to date a woman again. Further, his unexplored curiosity in men also served as a significant barrier to meaningful relationships with the women he dated. In situations similar to these, it is recommended that REBT therapists target irrational beliefs pathologizing non-heterosexuality and gender variant expression to clear the way for personal exploration. In these situations, therapists may model unconditional acceptance of the client in an effort to help them develop unconditional self-acceptance. Finally, for many clients, the journey to establishing a sexual or gender identity involves a significant amount of uncertainty (e.g., rejection versus acceptance) and increasing the tolerance of this uncertainty is a key component of REBT practice.

A Need for Research Remains to Better Inform REBT Practice with LGBT Clients

More research is needed to examine the best practices for cognitive-behavioral therapies among LGBT clients. Recently, several handbooks have been produced to guide practitioners delivering cognitive-behavioral therapies to LGBT clients (*Handbook of Sexual Orientation and Gender Diversity in Counseling and Psychotherapy*, 2017). However, there are limited empirical studies examining the impact of various cognitive-behavioral treatments on psychological distress and risk behaviors despite the evidence to suggest a significant need for effective treatments (King, Semlyen,

Killaspy, Nazareth, & Osborn, 2007). This is especially true for REBT focused research where the number of published empirical studies is virtually non-existent.

Brief Case Example

Jason is a 24-year-old gay white male. He recently graduated from college and was working in academia while he applied to graduate school. He was referred to REBT by a member of his family after he discussed feeling depression and anxiety following a recent breakup. Prior to the onset of his depression and anxiety symptoms and attending treatment, the client decided to end a long-term relationship with his boyfriend. His goal for coming to therapy was that he wanted to cope with the breakup in a healthy way. He reported that he had a lot of stress in his life preparing his applications for graduate school and working full-time that he did not want his breakup to interfere with his vocational goals or his goals of finding happiness in a new relationship.

Jason reported that he was open about his sexual orientation but that he felt some anxiety about discussing his emotions with his family and friends surrounding his recent breakup. Jason and his boyfriend had an open relationship (i.e., non-monogamous) towards the end of their relationship and Jason had anxiety about his parents or friends disapproving. In session, we discussed the influence of heteronormative social values, the idea that most people grow up in a society where heterosexuality is considered normal and deviations from heterosexuality are devalued. Along these lines, monogamy is part of the heterosexual narrative and deviations from that (i.e., an open-relationship) are also viewed as abnormal. In session, we examined why he would feel anxious about potential future stigma. Jason revealed that he had a strong demand for approval from others. This was further evident when Jason reported that he would agree to continue dating men he was not interested in dating because he did not want to appear to be a "bad guy."

Jason contemplated taking a break from dating because he was uncertain if his decision to breakup with his ex-boyfriend was a good decision. He also had anxiety about being rejected by someone he liked and did not want to feel guilt for rejecting someone he did not like. Treatment focused on identifying specific irrational beliefs that were causing him to feel depression, anxiety, or guilt. For example, Jason felt depressed when he was rejected because he believed he may never find someone who makes him as happy as his ex-boyfriend once did (awfulizing). Jason felt guilty when he rejected someone else because he hurt someone's feelings and he does not like to be hurt so he believed he was a bad person (global attributions). Functional disputes helped Jason recognize that his emotions were causing him to isolate socially and this was inconsistent with his goal of being happy and meeting someone. Jason had several people in his life that he had high levels of compassion for and could identify reasons why someone might not be all bad or all good (friend dispute). Finally, Jason needed additional opportunities to reinforce rational beliefs about him when he would typically feel anxious or guilty. Collaboratively, we developed a behavioral

exercise where he would agree to go on a series of dates with anyone who asked regardless of his interest. At the end of the date he would inform anyone he was not interested in dating further that he was not interested in seeing them again. Jason terminated treatment reporting improvement in his psychological distress.

What I Have Learned About Using REBT with LGBTQ Clients

Accommodating Individual Differences: Client Gender, Ethnicity, Socio-Economic Status, Intelligence, and Other Factors

In writing this chapter, I have drawn on some of the most popular theories of LGBT development and health, as well as research that focused more broadly on psychodynamic and cognitive behavioral therapy with LGBT clients. In research, it is common for investigators to distill the LGBT community down into manageable categories, often losing valuable information describing the large amount of diversity present within these communities. LGBT clients vary in terms of sexual attraction, sexual behavior, and sexual identity, as well as in terms of gender expression and gender identity. Along these lines, LGBT clients also vary significantly in terms of socioeconomic status, immigration status, racial/ethnic backgrounds, education level, religious upbringing and practice, and political affiliations. These various identities often intersect and can influence the diverse sets of rational and irrational beliefs presented in therapy. For example, one client may report experiences of rejection from his family and awfulizing beliefs may be challenged by his connection to other members of the gay community, but another client may report experiences of rejection from his family as well as racism within the gay community creating a need for a different validating approach to challenging awfulizing beliefs.

The literature on intersectionality discusses identifying the salience and valence of each identity among clients who have multiple minority identities (Stirratt, Meyer, Ouellette, & Gara, 2008). Assessment of the salience of each minority identity will provide information on how much each identity influences the client's self-concept and feelings of self-worth. Assessment of the valence of each identity will provide information on whether the identity influences the client's self-concept and feelings of self-worth in a positive or negative direction. Minority stress is not isolated to sexual orientation and gender identity and similar stressors can be observed for other minority identities (e.g., racism, classism). Intersectionality research suggests that the impact of minority stress be considered in the context of other salient identities. A client's difficulties with sexual minority stress could be compounded if they are also experiencing hardship related to an identity that is very important to their self-concept. Affirmative REBT practices described throughout this chapter are likely to

be more effective when the complexity of the client's identity is considered, improving the valence of multiple identities and balancing the salience across identities.

The Do's and Don'ts of Therapy with LGBT Clients

Do take sufficient time to develop and demonstrate an understanding of the client's experience with sexual orientation and gender. Don't spend too much time taking history that the client does not experience any relief from the presenting problem. It is important to understand the client from what the client shares and to begin with a broad assessment of the client, listening for clues as to what aspects of the client's identity are most salient. The therapeutic relationship with an LGBT client will be strengthened if the therapist is aware of the client's sexual attraction, identity, the types of sexual behavior the client engages in or desires, the client's gender identity, as well as other important and potentially more salient aspects of the client's identity, from the client's own viewpoint, before the therapist suggests meaningful associations. Similar to other clients, most irrational beliefs from LGBT clients can be reduced down to one or more of the four main irrational believes in REBT. However, many of these clients may not be able to identify the specific irrational belief that is causing the unhealthy negative emotion. In these situations, a therapist might work with the client to hypothesize beliefs that are consistent with the client's personal experience and salient for the client. This work is likely to increase rapport and has a greater likelihood of producing a healthy emotion.

Throughout this chapter there has been considerable emphasis on understanding the unique experiences of LGBT clients and how these experiences contribute to the presenting problem. Many clients may have interesting stories to tell and some may even find relief from just sharing these stories to an interested therapist. However, REBT therapists should be mindful to strike a balance between this history taking and rapport building and the basic tenets of REBT. A client who has attended therapy for a few sessions and does not begin to develop skills for managing their distress outside of the therapy room may not be motivated to return. Once a therapist has an initial conceptualization of the presenting problem and an initial understanding of how sexual orientation and gender identity may fit into that conceptual problem, the therapist may want to begin identifying specific irrational beliefs and disputing those beliefs in conjunction with any additional history taking that is needed.

Do monitor for signs of transference from the client and work with the client to identify and challenge generalizations the client may bring from the outside world into therapy. Don't become argumentative or confrontational with clients. Clients who have experienced high levels of discrimination, harassment, and rejection may enter treatment guarded and untrusting of their therapist. Due to the hypervigilance associated with rejection sensitivity, LGBT clients may be looking for signs of judgement and disapproval as a warning sign of potential rejection from their therapist. Some clients may test the therapist, sometimes resulting in a self-fulfilling prophecy, putting out ideas or acting in ways to elicit judgment from the therapist. For these

clients, a slow introduction to REBT may be necessary allowing for sufficient building of rapport before introducing the idea that the client may be responsible for the emotional reaction they are having and before challenging some of the client's irrational beliefs. LGBT clients who perceive a weak or negative alliance with the therapist are more likely to terminate treatment early (Israel, Gorcheva, Walther, Sulzner, & Cohen, 2008). In an effort to build good rapport and prior to working with LGBT clients, a thorough self-assessment of implicit and explicit biases toward sexual orientation and gender identity and expression is recommended. As mentioned earlier, unconditional self-acceptance is an important principle in REBT with LGBT clients. Assessing and challenging personal biases towards members of the LGBT community can help demonstrate unconditional acceptance of the client regardless of what the client brings to therapy.

The same research that demonstrated a strong therapeutic relationship is one of the most important aspects of helpful therapy with LGBT client also suggests that therapy that is perceived as argumentative or confrontational was perceived by clients and therapists as unhelpful (Israel et al., 2008). REBT therapists should demonstrate an understanding of the client's challenges but avoid lecturing the client. It is recommended that therapists instead rely more on Socratic questioning than on didactic dialogue.

Do work collaboratively with the client to develop exposure exercises that allow for client's to activate an emotional response and practice newly developed rational beliefs. Don't force your client to confront situations that may be so uncomfortable or potentially dangerous that it could reinforce irrational beliefs or result in the client being harmed. LGBT clients often come to therapy with a range of anxiety and shame inducing irrational beliefs. For example, many clients report fear of rejection as a barrier to approaching a potential romantic interest. Below, the potential utility and benefits of shame attacks and other behavioral activating events are described. However, heterosexist cultures create potentially dangerous environments for LGBT clients and the generation of between session behavioral exercises should be done collaboratively with the client and considerate of potential risks to the client. After explaining Ellis's efforts to have his requests for a date be rejected by 100 women, a client of mine was both intrigued and nervous about engaging in a similar exercise. Working collaboratively with the client we both were concerned about potential physical violence if he were to approach a heterosexual man who had anti-gay attitudes. He wanted to engage in a similar exercise so we identified potential venues where he might request a date from a stranger but that would minimize potential retaliation (we chose walking around busy coffee shops in New York and asking the first male barista behind the counter on a date). Therapists should validate the clients concerns and avoid potential exercises that may expose the client to violence or other traumatic events.

Disclosure of LGBT identity is often difficult for many clients and is best conceptualized as a lifetime process. When dealing with disclosure concerns, it may be helpful to treat disclosure like an exposure hierarchy. In these cases, starting with imaginary exposure exercises where the client visualizes the disclosure and negative response may be helpful. The client then identifies a smaller network (e.g., a close

friend) and then works his way up to larger and more important networks. The age of the client should be considered when discussing disclosure with the client. Research suggests that disclosure is beneficial for adults but may place youth at increased risk for suicide if the youth experiences hostility (Meyer, 2003).

Which Aspects of REBT Deliver the Most Benefit for Change and Which Dont?

Which Aspects of REBT Deliver the Most Benefit for Change?

A key takeaway from research on psychological treatment with LGBT clients is that these clients often present for treatment with similar problems compared to clients from other populations. For example, many LGBT clients will want to work on difficulties in dating or managing stressors at work. At the same time, the minority stress processes discussed throughout this chapter are likely to impact the presenting problem of the client. There is tremendous diversity within LGBT communities and it would be difficult to identify a specific set of strategies that work for all LGBT clients. There are some approaches, however, that may be more effective than others when challenging the irrational beliefs stemming from stigma-based stress and developing and reinforcing alternative rational beliefs.

Keeping the client focused on irrational beliefs they are holding. Demands about how the world should treat LGBT people may seem justified to many LGBT clients. For most clients, it is often difficult to accept treatment less than what the client feels is deserved and this presents as even more difficult when it is an unchangeable characteristic of the client that contributes to the undeserved treatment. As described earlier, treatments aimed at modifying a client's sexual orientation or gender identity are seen as invalidating and can have negative results for the client. Some clients, however, may want to focus treatment on how to change activating events (e.g., finding a new job; selecting a chosen family). Efforts on behalf of the client to modify their environment may be beneficial to the client if done from a place of healthy concern. However, many clients will want to make this decision from a place of anger, anxiety, or depression. REBT therapists should encourage the client to address their unhealthy negative emotions first. Otherwise, the client may be engaging in avoidance which has the potential to reinforce irrational demands about the world and beliefs of low frustration tolerance.

Demonstrating the differences between unhealthy and healthy emotional and behavioral consequences. REBT emphasizes the importance of having some level of agreement from the client that irrational beliefs by the client are significantly contributing to the presenting problem. It is often important to first help the client distinguish between healthy and unhealthy types of negative emotions and their associated behavioral consequences. Many LGBT clients who are new to REBT may have difficulty distinguishing between unhealthy and healthy negative emotions and

it may be helpful to draw upon examples from others. For example, several REBT texts have discussed Dr. Martin Luther King, Jr.'s response to discrimination and mistreatment of African Americans to distinguish between anger that is functional (e.g., anger that leads to advocacy and action) versus anger that is dysfunctional (e.g., anger that leads to thoughts of hopelessness). Examples such as these are extremely useful in helping the client distinguish a healthy emotion that is moving a client closer to their overall goal and an unhealthy emotion that makes it difficult for a client to focus on the goal at hand. Having the client understand the differences between healthy and unhealthy emotional and behavioral consequences is essential for the client to be able to observe the progress being made in treatment.

Working towards unconditional self-acceptance. While I have not identified a hierarchy for disputing irrational beliefs with LGBT clients, one factor that is important to consider when working with LGBT clients is the presence of internalized stigma. As mentioned, LGBT clients may internalize the stigma associated with their sexual orientation and/or gender identity and are prone to making global attributions based on these characteristics. Further, some may even attempt to compensate for their internalized stigma by placing high value and self-worth on characteristics of themselves that they believe are in their control (e.g., physical appearance; success at work). For clients with internalized stigma, unconditional self-acceptance is helpful but can be difficult for some clients. In these situations, it is helpful to have a client practice unconditional acceptance with others. In this regard, friend disputes can be extremely helpful in disputing personal self-globalizing irrational beliefs. Functional dispute may also work for some LGBT clients but some clients may push back arguing that one function of their belief is that it prevents them from experiencing any major emotional or physical pain.

"Coming-out" is associated with increased psychological well-being for most LGBT individuals. The decision to disclose sexual orientation or gender identity is one that LGBT clients continually make as they move through life. For many, expectations of rejection and awfulizing beliefs about that rejection often serve as significant barriers to coming out and it is likely that the client will experience some rejection, perhaps even from family members or long-time friends, that will be very painful. However, the concealment of sexual orientation and associated anxiety and depression often outweigh the impact of the rejection(Hatzenbuehler, 2009). REBT therapists may help in the coming-out process by challenging the unhelpful awfulizing beliefs, increasing frustration intolerance, and reinforcing the client's belief that they can handle difficult situations.

Incorporating behavioral exercises into treatment. For rejection sensitivity, behavioral exercises in rejection are often most beneficial for adult LGBTQ clients. Many of the clients developed this rejection sensitivity at a young age when rejection consequences were more severe (e.g., being kicked out of a social group in high school or kicked out of home). Rejection exercises help the client experience the discomfort of rejection but also their ability to cope with the rejection in a way they may not have perceived was possible. For rejection work, building a hierarchy is important because it outlines a clear plan of progress for the client and an opportunity to acknowledge achievements. Clients may find it helpful to start with smaller non-sexual orientation

related rejection exercises (e.g., asking for change) and build up to larger ones (e.g., asking someone on a date in a bar).

Which Aspects of REBT Don't Deliver the Most Benefit for Change?

Focusing on changing the activating event in treatment. REBT literature discusses the importance of identifying the activating event of a presenting problem to elicit the irrational beliefs that create distress for the client. I have mentioned throughout this chapter that some client's may be set on trying to change the activating event and may even find relief from some changes in their environment. However, the LGBT client is much more likely to find relief from developing the skills to identify and dispute irrational beliefs when they arise and develop rational beliefs as healthy alternatives. This is consistent with the REBT literature more broadly. Another dilemma therapists may face is promoting acceptance of the activating event. As with many forms of psychotherapy, emphasizing acceptance is a key part of REBT treatment. A concern here is that if a client accepts the activating event as their reality and does not recognize that the beliefs tied to that activating event can be modified, then the client is likely to experience increased distress.

Disputing irrational beliefs with didactic lecturing. Each client is likely to respond differently to the various types of dispute techniques used in REBT. Different disputes may need to be used for different clients and for different problems with the same client. As discussed earlier, many clients may benefit from friend disputes because it allows the client to see the problem from a distance where the emotional intensity may be dampened. Most LGBT clients will respond well to the other forms of dispute as well. Use of didactic disputes runs the risk of being perceived as the therapist lecturing the client or confronting the client, potentially rupturing the therapeutic alliance. Rather, developing hypotheses based on an understanding of the client's presenting problem and leading the client to a potential solution through Socratic questioning is likely to result in more benefits for the client.

Along similar lines, use of behavioral dispute techniques may not produce many benefits if the client does not feel safe in the exercise or the exercise is too intense to where the client engages in avoidance behaviors.

Conclusions

Much of what has been proposed in this chapter is drawn from the literature on minority stress and experience in working with LGBT clients using the principles of REBT. Research is desperately needed comparing the effectiveness of REBT to other treatment modalities. The current literature supports associations between minority stress

and psychological distress among LGBT clients and the role that irrational beliefs play in the development and maintenance of distress (Meyer, 2003; Hatzenbuehler, 2009). Additionally, although progress is being made toward increased visibility and acceptance of LGBT communities, this progress is slow and not always linear. REBT is likely to benefit LGBT clients by identifying irrational beliefs associated with minority stress, disputing those beliefs, and developing rational alternatives from an identity affirming prospective.

References

Alessi, E. J. (2014). A framework for incorporating minority stress theory into treatment with sexual minority clients. *Journal of Gay & Lesbian Mental Health, 18*(1), 47–66. https://doi.org/10.1080/19359705.2013.789811.

Amadio, D. M. (2006). Internalized heterosexism, alcohol use, and alcohol-related problems among lesbians and gay men. *Addictive Behaviors, 31*(7), 1153–1162. https://doi.org/10.1016/j.addbeh.2005.08.013.

American Psychological Association. (2012). Guidelines for psychological practice with lesbian, gay, and bisexual clients. *American Psychologist, 67*(1), 10–42. https://doi.org/10.1037/a0024659.

American Psychological Association. (2015). Guidelines for psychological practice with transgender and gender nonconforming people. *American Psychologist, 70*(9), 832–864. https://doi.org/10.1037/a0039906.

Balsam, K. F., Bednell, B., & Molina, Y. (2012). The daily heterosexist experiences questionnaire: Measuring minority stress among lesbian, gay, bisexual, and transgender adults. *Measurement and Evaluation in Counseling and Development, 46*(1), 3–25. https://doi.org/10.1177/0748175612449743.

Bouman, W. P., Schwend, A. S., Motmans, J., Smiley, A., Safer, J. D., Deutsch, M. B., et al. (2017). Language and trans health. *International Journal of Transgenderism, 18*(1), 1–6. https://doi.org/10.1080/15532739.2016.1262127.

Burgess, D., Lee, R., Tran, A., & van Ryn, M. (2008). Effects of perceived discrimination on mental health and mental health services utilization among gay, lesbian, bisexual and transgender persons. *Journal of LGBT Health Research, 3*(4), 1–14. https://doi.org/10.1080/15574090802226626.

CDC. (2015). Trends in U.S. HIV Diagnoses, 2005–2014. *CDC Fact Sheet*. http://www.cdc.gov/nchhstp/newsroom/docs/factsheets/hiv-data-trends-fact-sheet-508.pdf.

Chamberlain, J. M., & Haaga, D. A. F. (2001). Unconditional self-acceptance and psychological health. *Journal of Rational-Emotive and Cognitive-Behavior Therapy, 19*(3), 163–176. https://doi.org/10.1023/a:1011189416600.

Cochran, S. D., Sullivan, J. G., & Mays, V. M. (2003). Prevalence of mental disorders, psychological distress, and mental health services use among lesbian, gay, and bisexual adults in the United States. *Journal of Consulting and Clinical Psychology, 71*(1), 53.

Diamond, L. M., & Butterworth, M. (2008). Questioning gender and sexual identity: Dynamic links over time. *Sex Roles, 59*(5), 365–376. https://doi.org/10.1007/s11199-008-9425-3.

DiGiuseppe, R. A., Doyle, K. A., Dryden, W., & Backx, W. (2013). *A practitioner's guide to rational-emotive behavior therapy*. Oxford: Oxford University Press.

Ellis, A. (1977). The basic clinical theory of rational-emotive therapy. In A. Ellis & R. Grieger (Eds.),*Handbook of rational-emotive therapy*. New York: Springer.

Fassinger, R. E. (2000). *Applying counseling theories to lesbian, gay, and bisexual clients: Pitfalls and possibilities Handbook of counseling and psychotherapy with lesbian, gay, and bisexual clients* (pp. 107–131). Washington, DC, US: American Psychological Association.

Goldblum, P., Pflum, S., Skinta, M., & Balsam, K. (2016). *Psychotherapy with lesbian, gay, and bisexual clients: Theory and practice* (p. 330). Comprehensive Textbook of Psychotherapy: Theory and Practice.

Graham, S. R., Carney, J. S., & Kluck, A. S. (2012). Perceived competency in working with LGB clients: Where are we now? *Counselor Education and Supervision, 51*(1), 2–16. https://doi.org/10.1002/j.1556-6978.2012.00001.x.

Handbook of sexual orientation and gender diversity in counseling and psychotherapy. (2017). Washington, D.C.: American Psychological Association.

Hatzenbuehler, M. L. (2009). How does sexual minority stigma "get under the skin"? A psychological mediation framework. *Psychological Bulletin, 135*(19702379), 707–730.

Hatzenbuehler, M. L., Keyes, K. M., & Hasin, D. S. (2009). State-level policies and psychiatric morbidity in lesbian, gay, and bisexual populations. *American Journal of Public Health, 99*(12), 2275–2281. https://doi.org/10.2105/AJPH.2008.153510.

Iom, I. O. M. (2011). *The health of lesbian, gay, bisexual, and transgender people: Building a foundation for better understanding*. Washington, DC: National Academies Press.

Israel, T., Gorcheva, R., Walther, W. A., Sulzner, J. M., & Cohen, J. (2008). Therapists' helpful and unhelpful situations with LGBT clients: An exploratory study. *Professional Psychology: Research and Practice, 39*(3), 361–368. https://doi.org/10.1037/0735-7028.39.3.361.

Johnson, S. D. (2012). Gay affirmative psychotherapy with lesbian, gay, and bisexual individuals: Implications for contemporary psychotherapy research. *American Journal of Orthopsychiatry, 82*(4), 516–522. https://doi.org/10.1111/j.1939-0025.2012.01180.x.

King, M., Semlyen, J., Killaspy, H., Nazareth, I., & Osborn, D. (2007). A systematic review of research on counselling and psychotherapy for lesbian, gay, bisexual and transgender people.

King, M., Semlyen, J., Tai, S. S., Killaspy, H., Osborn, D., Popelyuk, D., et al. (2008). A systematic review of mental disorder, suicide, and deliberate self harm in lesbian, gay and bisexual people. *BMC Psychiatry, 8*(18706118), 70.

Lick, D. J., Durso, L. E., & Johnson, K. L. (2013). Minority stress and physical health among sexual minorities. *Perspectives on Psychological Science, 8*(5), 521–548. https://doi.org/10.1177/1745691613497965.

Meyer, I. H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. *Psychological Bulletin, 129*(5), 674–697.

Moody, R. L., Starks, T. J., Grov, C., & Parsons, J. T. (2017). Internalized homophobia and substance use among gay and bisexual men: Examining depression, sexual anxiety, and gay community attachment as mediating factors. *Archives of Sexual Behavior*.

Newcomb, M. E., & Mustanski, B. (2010). Internalized homophobia and internalizing mental health problems: A meta-analytic review. *Clinical Psychology Review, 30*(20708315), 1019–1029.

Pachankis, J. E. (2014). Uncovering clinical principles and techniques to address minority stress, mental health, and related health risks among gay and bisexual men. *Clinical psychology : A publication of the Division of Clinical Psychology of the American Psychological Association, 21*(4), 313–330. https://doi.org/10.1111/cpsp.12078.

Pachankis, J. E., Eldahan, A. I., & Golub, S. A. (2016). New to New York: Ecological and psychological predictors of health among recently arrived young adult gay and bisexual urban migrants. *Annals of Behavioral Medicine, 50*(5), 692–703. https://doi.org/10.1007/s12160-016-9794-8.

Pachankis, J. E., & Goldfried, M. R. (2004). Clinical issues in working with lesbian, gay, and bisexual clients. *Psychotherapy: Theory, Research, Practice, Training, 41*(3), 227–246. https://doi.org/10.1037/0033-3204.41.3.227.

Pachankis, J. E., Goldfried, M. R., & Ramrattan, M. E. (2008). Extension of the rejection sensitivity construct to the interpersonal functioning of gay men. *Journal of Consulting and Clinical Psychology, 76*(18377126), 306–317.

Pachankis, J. E., Hatzenbuehler, M. L., Rendina, H. J., Safren, S. A., & Parsons, J. T. (2015). LGB-affirmative cognitive-behavioral therapy for young adult gay and bisexual men: A randomized controlled trial of a transdiagnostic minority stress approach. *Journal of Consulting and Clinical Psychology, 83*(5), 875–889. https://doi.org/10.1037/ccp0000037.

Parsons, J. T., Millar, B. M., Moody, R. L., Starks, T. J., Rendina, H. J., & Grov, C. (2017). Syndemic conditions and HIV transmission risk behavior among HIV-negative gay and bisexual men in a U.S. national sample. *Health Psychology, 36*(7), 695–703.

Shipherd, J. C., Green, K. E., & Abramovitz, S. (2010). Transgender clients: identifying and minimizing barriers to mental health treatment. *Journal of Gay & Lesbian Mental Health, 14*(2), 94–108. https://doi.org/10.1080/19359701003622875.

Stall, R., Mills, T. C., Williamson, J., Hart, T., Greenwood, G., Paul, J., et al. (2003). Association of co-occurring psychosocial health problems and increased vulnerability to HIV/AIDS among urban men who have sex with men. *American Journal of Public Health, 93*(6), 939–942.

Stirratt, M. J., Meyer, I. H., Ouellette, S. C., & Gara, M. A. (2008). Measuring identity multiplicity and intersectionality: Hierarchical Classes Analysis (HICLAS) of sexual, racial, and gender identities. *Self and Identity, 7*(1), 89–111. https://doi.org/10.1080/15298860701252203.

REBT with Clients with Disabilities

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The World Health Organization (2011) estimates that more than a billion people world-wide live with some form of disability, i.e., 15% of the world's population (WHO, 2011, p. 7). In the United States, over 60 million people have one or more disabilities (www.cdc.gov/disabilities, 2017). The rate of disability increases with increasing age. In the United States, nearly 34% of those over 75 years of age are disabled (Kraus, 2016).

One of the broadest definitions of disability appears in the guidance that accompanied Section 504 of the Rehabilitation Act of 1973. It states that a disability is "any physiological disorder or condition, cosmetic disfigurement or anatomical loss affecting one of more of the following body systems: neurological; musculoskeletal; special sense organs; cardiovascular; reproductive; digestive; genitourinary; hemic and lymphatic; skin and endocrine; or 2) any mental or psychological disorder such as mental retardation, organic brain syndrome, emotional or mental illness and specific learning disabilities (29 C.F.R. at Sec. 1613 (b))".

In the United States there is also a legal definition of disability which appeared in the Americans with Disabilities Act (1990) as well as the earlier Section 504. This is "a disability is a physical or mental impairment that substantially limits one or more major life activities; b) a record of such an impairment c) being regarded as having such as impairment (42 U.S.C. at 12102 sec. 2 (A-C))". Major life activities include functions such as "caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning and working (29 C.F.R. at sec 1613.702 (e))". These regulations are important to those in the United States because they define whether, even with a physical or mental disability, the individual is a "qualified" person with a disability under the law and thereby the individual's rights are protected. In 2008, the revised law stated that "an impairment that substantially limits one major life activity, need not limit other major life activities in order to be considered a disability (ADAAA, 2008)."

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Disability is a complex concept, incorporating many important factors. Disabilities differ according to diagnosis; age of onset; area that is affected (e.g. SCI, paralysis, blindness) whether it is progressive (MS, arthritis) or stable (partial paralysis), whether the disability is caused by a medical condition (cancer, heart disease, stroke) or a catastrophic event (auto accident or sports accident). whether it is an invisible disability (learning disability, closed head injury or intellectual disability such as mental retardation), whether the person with the disability requires assistance or is independent; Disability status, in a way, is an equal opportunity employer. It can occur at any age to people of any race, religion, national origin, cultural identity, gender identity or identification.

People with disabilities (PWDs) are often economically and educationally disadvantaged due to disability discrimination. PWDs have been feared and treated badly and differently than the majority Society throughout history from being seen as tainted in biblical times to being inhabited by demons (Norden, 1994) in the Middle Ages. In Modern Society, we also praise physical prowess and beauty, and when individuals cannot meet these standards, they are denigrated, excluded and shunned.

Three models have been proposed to explain disability discrimination. The Moral model examines disability in terms of sin and moral lapses attributed to the person who has the disability, or if an infant, to the baby's parents (Olkin, 2002). The Medical model views the problem of disability as a disease process within the patient which needs to be cured so that s/he can be like the others who function in Society (Balter, 2012, p. 131; Olkin, 2002). The Social model is a newer model which originated in the 1970s and hypothesizes that most PWDs problems are due to a Society that does not allow them equal access to its resources or power which PWDs now, as consumers, demand (Artman & Daniel, 2010).

Key REBT Theoretical Concepts in Working with Clients with Disabilities

The following are the key REBT concepts which are most helpful to address when clients with disabilities come to therapy for disability-related problems or when a day-to-day problem somehow involves the person's disability.

Unconditional Self-acceptance

Unconditional self-acceptance (USA) is the most important REBT concept for PWDs since members of this large, very heterogeneous group are told sometimes subtly, and sometimes directly that they are somehow less worthy of respect, awards, appointments and love than those who are non-disabled. Ellis (1997; Ellis & Abrams, 1994) claims that humans often confuse self-worth with self-esteem, the latter of which

is characterized by achievements, wealth and respect. According to Ellis (Ellis & Abrams, 1994, p. 151) USA means that individuals "fully and completely accept themselves without qualifying conditions," … such as being of service to others or excelling in the individual's field of choice. Ellis believed that one's worth and acceptance is based on the individual's uniqueness (the person's thoughts and feelings). Ellis stated that as people who were born into the world, we exist and as such, "we have the right to continue to exist and to be as safe sound and happy as possible (p. 152)." This is not an easy concept to teach people who have been raised to globally rate themselves based on their accomplishments. Because of this difficulty Ellis presents both inelegant and elegant ways of reaching this goal. An inelegant method would be to use self-statements such as "I will accept myself as worthwhile because I am human and I exist whether or not I am approved of or perform well, just because I choose to accept myself (Ellis & Abrams, 1994, p. 154)". He also offers a more elegant approach, which is "I am a person who does good or bad deeds but I am neither good nor bad as a total person (Ellis & Abrames, 1994, p. 156)". Ellis (1997) teaches PWDs that even though they may have deficits due to their disabilities, that may be bad or unfortunate, "these deficits are never shameful, disgraceful or contemptible" (Ellis & Abrams, 1994, p. 20).

Unconditional Life-Acceptance

Ellis (1997) discusses Unconditional Life Acceptance (ULA) a concept that is very important for PWDs, since this population often has difficulties performing activities of daily living (ADLs), and faces barriers in dealing with many public places and processes. It is difficult to get a wheelchair into a bank if there is no automatic door even if there is a ramp inside the building. It is impossible to access some hearings if the building has no ramped entrance. Sometimes even using a library with stairs and no space for access or shopping in a crowded supermarket can become an exercise in frustration for someone with mobility limitations, rather than a convenient stop. The physical and communication barriers that exist may lead to frustration and anger for the PWD and rejection by those who are non-disabled.

High Frustration Tolerance

Another key REBT concept that Ellis (1997) applies to himself and covers in depth is the need for PWDs to develop high frustration tolerance rather than low frustration tolerance. Ellis used himself as a role model with patients and would tell them how he handled the annoying and time consuming tasks that were necessary to keep him alive including frequently testing his blood sugar and having to eat numerous small meals throughout his day which would take away from his productive time. There are not

many psychologists who can be role models since only two percent of psychologists acknowledge having a disability (Artman & Daniel, 2010).

Ellis (1997) emphasized that PWDs often combine low frustration tolerance with self-downing based on their limitations and the difficulties they encounter in performing even simple tasks. He acknowledged that many PWDs are "frequently criticized, ridiculed and put down" by non-disabled individuals, but that "they never have to agree with bigotry and prejudice (Ellis, 1997, p. 19)."

The Multimodal Nature of REBT

Another key REBT concept that is important in working with PWDs is the multimodal nature of this approach. Often, PWDs lack the requisite skills, not only to deal with the intricacies of their disabilities, but also, depending on factors such as age of onset, may never have encountered groups of peers and never had social skills training nor learned interactive and performance skills others learn at school. PWDs may also need to learn management skills to deal with employees who assist them, as well as assertiveness skills since people with whom they interact will often speak with their employee rather than the PWD based on another irrational belief, an assumption that PWDs, because they have a physical or communications disability, also must "be mentally retarded." The "assumption of retardation," is very frustrating for PWDs because it is isolating and difficult to dispute when others rigidly refuse to acknowledge the individual with a disability.

Therapists also need to remember that PWDs seek therapy to deal with the same problems that other clients seek therapy for, and often these problems are not disability-related. Therefore, therapists need to realize that having a disability is not a psychological issue.

There are certain steps that are helpful for REBT therapists to take before seeing clients with disabilities. Many therapists are not trained to see these clients even though PWDs are a minority culture. Artman and Daniel (2010) and Olkin (2002) point out that no matter what the problems presented, PWDs are often seen as within the purview of Rehabilitation Psychology which means that the disability dominates and the underlying message is that having a disability defines all the individual's other capabilities. Therefore, REBT therapists who are scheduled to see a client with a disability, need to check their own beliefs regarding disability before the first meeting with the client. PWDs have experienced undeserved discrimination and will leave therapy if they sense that the therapist is uncomfortable or threatened by their disability. If the therapist has this type of feeling or fear, it is best to refer the client to someone else (Zaborowski, 1997). Also, when working with a client with a disability, the therapist needs to begin by acknowledging the patient's reality, no matter how foreign this reality may sound to the therapist. If this is not done, it will be difficult to form a therapeutic relationship with the client or openly communicate with that client.

Key Best-Practice REBT-Based Assessment and Treatment Strategies and Techniques

In the late 1990s, a number of years after the passage of the Americans with Disabilities Act (1990), REBT practitioners (Alvarez, 1997; Balter & Unger, 1997; Calabro, 1997, 1990; Ellis, 1997; Zaborowski, 1997), wrote about techniques they successfully used with the disability populations with whom they worked. Alvarez and Calabro worked in rehabilitation facilities, Alvarez with post-stroke patients and Calabro with spinal cord injury patients, two very different populations; however, Alvarez (1997) was able to adapt Calabro's (1990) therapeutic framework to his population.

Calabro proposed a three phase approach to adjusting to disability. In the first stage, Pre-encounter, the patient is still in shock and denial and not ready to confront the life adjustments that s/he needs to make. Most of the approach (Alvarez, 1997) during this phase includes both individual and group support and education. During the second phase, Post-encounter, the patient expresses emotions such as anger, anxiety and depression and is not yet ready to acknowledge or work on his/her irrational beliefs (Alvarez, 1997). It is not until the Rational Re-encounter phase that the patient is ready to make connections between his/her irrational beliefs and dysfunctional feelings and behaviors and to work on changing both. This model helps the practitioner understand when the patient can tolerate active disputing and when support is still needed. Alvarez noted that with post-stroke patients, group treatment worked better than individual treatment because patients could listen to other patients and learn from their problems and solutions. They felt less alone and knew others were in similar situations to them.

Calabro (1997), integrated REBT approaches with Maslow's hierarchy of needs which he used as an organizing concept. Calabro, relabeled "needs" as psychological priorities, to dispense with the mandated nature of the process (p. 197). Calabro noted that at the beginning of the rehabilitation process, patients were in denial and had not yet processed the impact of their spinal cord injuries. As they proceeded through rehabilitation, patient anxiety increased. Calabro (1997) found that a number of distorted thought patterns were related to anxiety including survival beliefs, anxiety related to lack of choices, anxiety related to discomfort and pain and anxiety related to having a disability. Calabro introduced patients to Ellis' concept of self worth, which he defined as "positive self regard independent of attributes or performance (Calabro, 1997, p. 207)". "One major problem that Calabro encountered was that patients who were finally ready to begin changing their beliefs to ones that would help them adapt to their spinal cord injuries, were usually ready to be discharged from the rehabilitation facility and might not be able to access further REBT counseling.

Balter and Unger (1997) utilized REBT as the treatment of choice while working with Chronic Fatigue Syndrome clients. Chronic Fatigue Syndrome (CFS) resembles as both a chronic illness and a physical disability. It usually presents as a viral infection marked by muscle pain, a sore throat and swollen glands, but it never seems to go away. It is characterized by periods of exhaustion and weakness, and sometimes

memory loss. It usually occurs in previously healthy and active people who are overachievers. CFS is known to be stress sensitive and "emotional stress is inherent to the disease because of its unpredictability (Balter & Unger, 1997, p. 225)."

The authors ran an REBT stress management group using Ellis' (Ellis 1992) group therapy structure, with the limiting factor being that the problems raised were to be related to chronic fatigue syndrome. The clients were screened using previous criteria in CFS research, a medical diagnosis, demographics data, individuals with other psychiatric diagnoses were excluded, and clients had to have at least six of the usual 11 symptoms and a 50% reduction in activity. The sessions were short (one hour and a quarter) so as not to fatigue the participants. The group was titled "stress management" to destigmatize it. Members of the group volunteered CFS related problems involving irrational beliefs. Each group involved a review of everyone's week, one or two member problems, skills instruction or an. educational component and ended with various relaxation exercises. The problems presented often involved low frustration tolerance and catastrophizing. Group members were taught to dispute their irrational beliefs. Before the initial group meeting, members filled out stress and depression inventories. The group began with 15 members and ended with eight, because some members had been too fatigued to attend all sessions. Stress and depression measures were again filled out. Although no statistical analyses were performed because of the small numbers, results noted that participants had lower stress and depression scores than before the group began and also stated that they had learned coping and relaxation skills as well as to dispute their irrational beliefs.

Ellis (1997) used himself as a "disabilities" role model because he refused to whine about his adversities and he continued to work hard despite them. He stated that he was "allergic to procrastination (p. 18)." He listed numerous medical conditions and disabilities with which he had to contend such as using hearing aids because of his hearing loss, diabetes, poor vision, and other concomitant conditions. He called his hearing aids a "pain in the ass," and disliked the severe dietary restrictions and constant blood monitoring due to his diabetes, but since he valued his work and his life he decided to use REBT to overcome his tendency toward low frustration tolerance and thereby "accept what I cannot change (Ellis, 1997, p. 19)". Ellis stated that PWDs experience LFT and self-denigration and both of these factors are the bases of human neurosis, He acknowledged that PWDs were often reviled, and criticized as being not as good as other people (p. 19).

Ellis (1997) pointed out the importance of adding HFT (high frustration tolerance) to USA to increase therapeutic efficacy. He again used himself as a role model and at the same time as a role model for disability advocacy. He stated that "deficiencies are unfortunate, bad or even noxious, but never shameful, disgraceful or contemptible (Ellis, 1997, p. 20)." He added that PWDs never have to agree with other people's bigotry, prejudice or denigration. He thought it important to show clients with disabilities how to make philosophic changes to minimize anxiety, depression rage and self pity (p. 21). Ellis also emphasized the importance of having a vital interest and a long range purpose.

Zaborowski (1997) was an REBT practitioner and a strong advocate for those who are blind or visually impaired. She posited that the real barrier to adjustment to vision

loss is in the individual's thinking patterns. One of her concerns was that sighted mental health professionals who did not know fully functioning blind individuals, "assumed that blindness always means tragedy (p. 215)." Zaborowski (1997) defined blindness as "vision loss which severely interferes with daily functioning and usually requires the use of alternative methods to accomplish routine as well as related tasks (pp. 215–216)." Since the definition of blindness includes vision which encompasses less than 20% of the visual field, those with some residual sight will often believe that by limiting their lives (less reading, etc.), they don't have to admit that they are no longer independent. Zaborowski believed that the REBT therapist's job is to know blindness and to be able to present alternative beliefs to the client. Some of the disputes are pragmatic involving learning alternative methods of addressing activities of daily living such as reading and travel; whereas others involve low frustration tolerance and self-worth (p. 217).

Since the goal of treatment is to assist the client to give up misconceptions about blindness and adopt more realistic views which involve learning new skills, the therapist might suggest that the client become involved in organizations for the blind as well as getting involved in a rehabilitation program which will teach needed skills. She also recommended that the newly visually impaired person work with an REBT therapist who could dispute irrational beliefs concerning blindness as well as help the client to change low frustration tolerance to high frustration tolerance (p. 218).

Balter (2006, 2012) agreed with Ellis regarding the importance of USA and ULA but not UOA (unconditional other acceptance). Because of the general meaning of the word "acceptance," PWDs when told that they have to accept other people's evaluations and insults as well as prejudicial pronouncements, may leave treatment, or worse than that, may believe that the therapist does not care for them or respect them, thus leading to another rejection or depression. If the practitioner wants to use a similar paradigm, one can substitute unconditional other acknowledgement (UOa). Acknowledgement just means that the client heard what another person said or acknowledges an attitude that the client witnessed, but refuses to apply it or let it impact her/his life. As Ellis (1997) stated, a client never has to accept prejudice or denigration.

It would be best for the REBT practitioner to use a "sociotherapeutic approach (Balter 2006, 2012)". In this approach the therapist listens carefully and respectfully to the client, and where appropriate validates the clients' beliefs regarding the majority culture "without making the client look like a victim (Balter, 2012, p. 132)."

When working with clients with disabilities (or any clients) it is often best practice, to "listen carefully to the client's description of his/her world and collect extensive data before trying to assess irrational beliefs (Balter, 2012, p. 132)." Using open-ended questions and empathy is helpful in collecting the needed data. "When looking at societ al factors, it is helpful to use patient narratives, role plays and event and thought diaries to collect data (p. 132)." If the practitioner has a physical disability, it may be helpful to sometimes be a role model, or at least answer client questions, without making your answer seem like the only answer. The sociotherapeutic approach also may result in client and therapist needing to renegotiate roles when the client

realizes that the culture will not change to satisfy them but that they never need to agree with the cultures' beliefs.

The practices used by the authors cited, whether they be in-patient rehabilitation-based, or individual include many of those encouraged by Ellis. These practices include using group approaches with patients during rehabilitation, disputing irrational beliefs, incorporating patient support into early treatment. Helping clients develop USA and ULA, supporting clients in not incorporating beliefs that prejudicial or denigrating, supporting clients in understanding that they can be self-actualizing and achieve happiness.

We do know that certain distinctive features of REBT make this approach both appropriate and preferable to use with PWDs. One such feature is that flexibility is at the core of psychological health (Dryden & David, 2008, p. 197). PWDs, who adapt to both their disabilities and to life situations, have learned that flexibility is the key to successfully coping with both positive and negative challenges. Part of the definition of having a disability is having to cope with performing activities of daily living differently than others. It also helps those with disabilities approach problems, knowing that flexibility will allow them to meet their goals. Its multimodal approach also make REBT appropriate for this population including the broad range of techniques incorporated, its emphasis on psychoeducation and skills building (Dryden & David, 2008, pp. 199–200).

The most important aspects of REBT are its emphasis on Unconditional Self Acceptance (USA) and making acceptance a cornerstone of REBT. REBT therapists help clients to strive for USA and ULA. Acceptance is a core issue for most PWDs when dealing with disability issues. It is also an important issue for PWDs when dealing with non-disability issues since REBT therapists are able to accept the client and deal with the issue at hand.

In terms of therapeutic techniques for PWDs, pragmatism is the key. The therapist needs to use techniques which are usable, respectful and work. Some clients are more comfortable with the usual talking and disputing; whereas, other PWDs are more comfortable with psychoeducation and pragmatic exercises including mood and thought diaries. The only key is use what works for the specific client.

These approaches work with clients even though they are not empirically supported.

Treatment Guidelines from Empirically-Supported Therapy Literature that Inform Best Practice in REBT with People with Disabilities

Arthritis is one of the most disabling conditions in the world today. It impacts over 50 million people in the United States and over 100 million people within the European Union (http://www.worldarthritisday.org/factsrmd. Retrieved 12/9/2017). Arthritis is an example of an illness that causes not only physical disability but also

many of the concomitant problems one sees with PWDs such as economic and work problems, accessibility problems, physical pain, fatigue, and social problems. Since a number of CBT studies and studies involving other treatment approaches have been performed with both Osteoarthritis and Rheumatoid Arthritis patients, this diagnosis is a good vehicle for comparing different approaches.

Both McCracken et al. (2008) and Sciacchitano et al. (2009) using REBT theory as a basis for their studies examined the relationship between ego and discomfort anxiety based beliefs and the coping styles of approval, achievement and comfort in arthritis patients in Australia. They hypothesized that those who used approval styles functioned in the here and now and used avoidance so that they did not have examine long term consequences of their arthritis. They also use approval seeking behaviors to gain approval from significant others (Sciacchitano et al., 2009, p. 43). Comfort related beliefs were found to be related to personal control and an attempt to reduce and avoid anxiety by creating harmony, The third approach, considered to be the most realistic which was considered to be the most successful and realistic was the achievement approach which sought out both social support and informational support and in which its proponents took personal responsibility to deal with their illness. These schema were thought to predict successful adaptation to arthritis, however, no follow up studies are evident. The concept is interesting, however, it is not evident that it could be successfully used to assist patients to adapt to their arthritis.

Evers et al. (2002) study was typical of CBT studies performed with arthritis patients. The study was conducted in the Netherlands and involved early stage (eight years since diagnosis) high risk subjects (having high scores on measures of depression, anxiety and negative moods) to measure the effects of a CBT intervention on mood and pain. The study involved 112 high risk subjects 64 of whom were randomly placed in the experimental group and the rest were put in a no treatment control group. The experimental group participated in ten bi-weekly CBT sessions which included modules which they could choose among including coping, illness cognitions and stress. A booster session occurred four weeks later. The experimental, when re-tested showed decreases in depression, negative moods, fatigue and helplessness. These gains were maintained. No changes were noted in the control group. This study is important because it adds to the literature which demonstrates CBT efficacy with arthritis patients.

Lee et al. (2017) explored the efficacy of mindfulness as a moderator of knee pain in osteoarthritis patients. The investigators defined mindfulness as "the ability or practice of maintaining a non-judgmental state of heightened awareness of ones thoughts, emotions, or experiences on a moment to moment basis (Lee et al., 2017, p. 824)". The investigators hypothesized that the practice of mindfulness, which included observing, describing, non-judging and non-reacting would be associated with decreased pain, decreased depression, decreased stress and an increased quality of life for arthritis patients. The study was conducted in Boston and involved 80 subjects. Subjects had to meet the medical criteria for knee osteoarthritis. The study cover was a comparison of standard physical therapy versus Tai Chi (which lasted 52 weeks). The factors involved in the study (depression, quality of life, stress and

mindfulness Pre and post testing was performed. The results indicated that mindfulness (Tai Chi) appeared to moderate the influence of pain on stress. The most important factors were describing, acting with awareness and non-judging, This study demonstrates the acceptance and impact of mindfulness factors on moderating pain and began to introduce mindfulness as a treatment modality for arthritis patients.

Nyklicek et al. (2015) explored psychological distress in rheumatoid arthritis over a 12 month period The investigators explored the ways in which mindfulness was associated with psychological distress The study also examined the influence of an optimistic attitude and hypothesized that optimism would be related to fewer symptoms and reduced psychological distress. The research was conducted in the Netherlands. Each of the predicted factors was measured and results indicated that only those subjects high in mindfulness showed a decrease in psychological distress. This study like the previous mindfulness study, demonstrated some impact of mindfulness when the patient could use the modality.

Davis et al. (2015) compared CBT-Pain, mindful awareness and arthritis education as treatments for arthritis pain. The study, conducted in Arizona involved 144 subjects, (who all had to have a physicians diagnosis of rheumatoid arthritis) who were randomly assigned to one of three experimental groups.

Davis et al. (2015) is typical of studies that compare more than one modality to arthritis related pain. This study compared CBT, mindful awareness and arthritis education in connection with arthritis pain.. The CBT-Pain group included cognitive reappraisal skills, faulty pain cognitions and relaxation training. The Acceptance based Mindfulness group's goal was to instruct subjects to be both aware and non-judgmental regarding present experience including pain. Both the CBT and mindfulness groups included experiential exercises. The arthritis education group instructed subjects about arthritis and various treatments and exercises. It was non-experiential. Each group had a two hour weekly meeting. Subjects also filled out daily diaries for 30 days during the treatment phase which assessed stress, pain, morning level of disability and pain related cognitions. Subjects also completed 30 days of daily diaries after the completion of the group meetings.

The results of the study indicated that the mindfulness approach was more successful than the CBT approach in reducing pain and stress reactivity but that the CBT approach was more successful than mindfulness in limiting pain contingent thoughts, but none of the approaches was successful at limiting the magnitude of pain that the subjects experienced. Both mindfulness and CBT were found to be effective in improving subjects' levels of perceived control, but that mindfulness had broader effects in managing daily pain and stress. No impact was found on pain in the education group.

The results of the Davis et al. (2015) are important because they prove that more than one psychological intervention may be used to treat pain and distress in arthritis patients and that it is possible for psychologists to use these approaches simultaneously with patients.

Martz and Livneh (2016) examined psychosocial adaptation to disability within the context of positive psychology. Their study was meta analytic and examined study results that focused on the six positive psychology constructs; hope, opti-

mism, resilience, benefit–finding, meaning-making and post-traumatic growth in the context of adaptation to disability. Positive psychology emphasizes an individual's strengths and positive elements in people's experiences after experiencing trauma or stress (Martz & Livneh, 2016, p. 4). Rather than looking at individual trauma, this study explored chronic illness and disability. The authors pointed that rehabilitation psychologists encourage patients to focus on their strengths and abilities to produce a pathway to one's goals Hope is defined as the belief one has in his/her abilities to do this and in the literature, hope was found to be negatively correlated with depressive symptoms in spinal cord injury patients, traumatic brain injury patients and MS patients. Optimism, defined in this study as the tendency to focus on a positive future was correlated with adaptive coping strategies and better psychosocial adaptation. Resilience (Matz & Livneh, 2016) was defined as the "ability to maintain stable equilibrium following adversity (p. 6)" and was associated with hardiness an internal locus of control and acceptance of disability.

Seligman et al. (2006) found that actively and deliberately building positive qualities such as resilience and hope would counter negative symptoms and serve as a buffer against future occurrences of depression. Seligman and his associates also found that clients needed detailed instruction and encouragement to use positive attitudes and engage in positive activities (Olaoye, 2012). Among the positive exercises that Seligman recommended were savoring, which involves taking time to enjoy an activity that one usually rushes through (Olaoye, 2012, p. 144) and using a good things diary (writing down three good things that happened during the day; indicating why these occurrences are good, and expressing gratitude for them (Olaoye, 2012, p. 144).

The Benefits of Adding Mindfulness and Positive Psychology Approaches to REBT with Clients with Disabilities

Mindfulness has been shown experimentally to decrease stress (Lee et al., 2017) and to increase quality of life (Lee et al., 2017) and self-efficacy (Davis et al., 2015) in patient populations. PWDs face frequent stressful situations in their everyday lives, and may encounter stressors in the most mundane everyday interactions. Many PWDs, based on a history of experienced discrimination, or dealing with barriers in every day settings (e.g. accessing a school, or library) accept this stress as normal. Learning to be non-judgmental and non-reactive can only benefit those who may need this training. Not all PWDs will need to learn mindfulness skills; but it is helpful to be able to have this tool available in one's toolbox. Ellis (2006) in reviewing mindfulness found that mindfulness approaches were not necessary but also were not compatible with REBT practice if patients wanted to meditate. Ellis pointed out that some people like himself (Ellis, 2006) found meditation boring but that it could be helpful to allow people to examine their thoughts objectively.

Brief Case Example

This case study describes a client recently diagnosed with Multiple Sclerosis. This disease strikes 400,000 people in the United States and 2.5 million people worldwide. It is seen more often in females than males. The most frequent age of onset is between ages 20 and 40. The most frequent form of the disease is the relapsing remitting form in which symptoms may appear and then either completely or partially disappear. The other two forms of the disease Primary Progressive and Secondary Progressive usually leave permanent disabilities as they progress.

Case Study

Joanne is a well-dressed, well-spoken 35 year old female who was referred for treatment by a social worker in her neurologist's office. She was referred because of her high level of anxiety and elevated depression secondary to a diagnosis of Multiple Sclerosis. She states that she is married and has two young children who were born before she was diagnosed. Her daughter is five years old and her son is three and a half years old. She came into my office carrying a cane but did not seem to be dependent on it. She did appear to be tired and sad.

Joanne reports that she had started experiencing numbness in her feet and blurred vision. When asked if these were her only symptoms, she admitted to feeling some weakness, having some coordination problems and feeling very tired. She states that the worst of the symptoms became less severe after a few weeks, but she reports, "still feeling funny." Her diagnosis was made based on the results of an MRI and spinal tap, performed 18 months ago. Her "official diagnosis," as she calls it is MS-Relapsing Remitting Type. When asked what her goals are, she responded, "to prove my neurologist wrong and to show that I really have Lyme disease." Before her diagnosis she had been hiking in Vermont with her husband, a college Biology professor. Everyone knows that there are deer in Vermont and deer have ticks. Lyme disease, at least may be curable. The worst things about MS, according to Joanne are the fatigue, sleep problems and fearing what is coming next. She stated that she has always believed in a fair world policy in which if you worked hard enough and did what was right in your life, then your life would go well. She stated that she had always led a tightly controlled life which left no room for error. She was now despairing and looking for a reason to blame herself, because this "problem" must have occurred because she had done something wrong. The anxiety she was experiencing appeared to be related to her not being able to identify "what she had done wrong to deserve this". When asked to prioritize which problem she wished to tackle first, she opted for her need "that she not have another exacerbation of symptoms, no matter what her neurologist had told her about RRMS." She was more than frustrated when asked to describe her feelings, She said that she was very angry and did not deserve this. She said that her life focused on planning and controlling all aspects of her childrens' education and activities, taking care of her household and husband and working part time. She stated that her life is controlled by structure and certainty. Since her neurologist told her that MS and certainty were unrelated, she

was sure that it must be an incorrect diagnosis. When asked to contemplate whether the diagnosis could be possibly be correct, she refused to accept that possibility. She stated that all she wants from therapy is her "old normal self, back". At the end of the first session, she informed me that she might not come back if I could not guarantee that her wish would be granted. We made an appointment anyway and she accepted the assignment of reading about the causes and symptoms of Lyme disease as well as acquainting herself with her type of MS. I suggested that she check both national and local websites for further information.

Joanne returned to therapy three weeks later because she had had another "incident." She had done her homework and had printed out information both on Lyme disease and on Relapsing Remitting MS. She also brought in her mood and thought diaries. She stated that she had printed out the information because her blurry vision made on-screen reading difficult. She reported that she had become very depressed when she realized that her symptoms fit the RRMS profile, but really did not match Lyme disease. She said that she had also done a life review to try to understand what she had done to deserve this (RRMS). She had not been able to find any bad acts except her inability to fulfill her obligations during an exacerbation of symptoms. She thought that this might be a sign of moral weakness. We then discussed figures in history who had a disability and functioned despite it. We began with figures like Helen Keller who was blind deaf yet lead a movement for educating those like her. We included FDRs lower limb paralysis due to Polio and yet he was able to lead an economic recovery and a war effort. Christopher Reeve who was quadriplegic and yet able to promote SCI research was included as was Itzhak Perlman, a master violinist who performs with the great orchestras of the world despite his post-polio paralysis. I asked her to show me how these figures were morally weak and she could not do so. I asked her, if for homework, she would like to do further research on historical figures who had had a physical disability. She was fascinated by the assignment and agreed to do it. We scheduled the next appointment for two weeks following.

By her third appointment, Joanne who was a researcher by profession, had not only investigated historical figures with disabilities but was able to see that their disabilities were not caused by moral flaws. She had also done more research on RRMS and had found that the cause of the disease was not controllable or preventable. She therefore was ready to stop blaming herself for what had happened to her. She said that she was ready and eager to return to work but in order to do so on a regular basis, she had to figure out her own identity and possibly invent a cover story for when she had another symptom flareup. She also had to work on some coping statements to use on herself when dealing with others became overwhelming. She stated that she knew that this was necessary but that she was not quite ready to go there. We again scheduled an appointment at a two week interval. When she returned for session 4, Joanne was ready to discuss the concept of disability and what it meant to be a person with a disability. I pointed out that the whole person is not disabled but the individual may have functional problems with one or more body parts. That is why person first language is preferred. First person language means, a "person with a disability." This indicates that the disability is one characteristic that the person has and by no means defines the individual. She was still hesitant to take on a disability identification but

was more interested when we discussed invisible vs visible disabilities. She said that she was not distressed at having an invisible disability because then others would not need to know that she had one. It was pointed out however, that she would need to know. She decided to think about it. We discussed the advantages of mindfulness training and how it might relieve some of distress and depression. She again resorted to her need to research it and would let me know. She decided to schedule a regular appointment every two weeks to discuss ongoing problems using an REBT approach.

This case covers the following issues. The therapist, in order to work with this client, had to acknowledge the client's reality (it could be Lyme disease) and utilize techniques and homework assignments that would address the client's beliefs where she was at, at each point in treatment. Challenging the client probably would have driven her away. The client was given homework that would interest her and engage her without being directly threatening. Being "with the client" was very important to Joanne, probably more important than actively disputing her beliefs. Control was a very important issue in Joanne's life and her control needed to be respected. The client was allowed to move at her own pace and create her own accommodations which were important to her controlling her own environment.

The issue of disability was introduced slowly and in a palatable manner. Joanne's mood diaries indicated a coping style which bordered between comfort and achievement (McCracken et al., 2008). No information was introduced that would contradict either style. Finally, the possibility of adding to Joanne's skills set was introduced with the suggestion of mindfulness training, which would help her observe, not react and be non-judgmental. Again she was encouraged to use her research coping skill before discussing it.

What I Have Learned About Using REBT with Clients with Disabilities

Accommodating Individual Differences: Client Gender, Ethnicity, Socio-Economic Status, Intelligence and Other Factors

> All people have ability status, age, sexual orientation and identity, geography, immigration status, religion, ethnicity, race, and socioeconomic status. (Banks, 2012, p. 37)

People with Disabilities are among the most stigmatized groups in history. Their needs are rarely accommodated and they are marginalized. The other groups that are similarly marginalized are members of ethnic or racial minorities and those with LGBTQ status (Banks, 2012). When clients with disabilities and other minority statuses, are in any type of psychotherapy, the problems of stigmatization and power may also be in the room, either in the identity of the client or the practitioner. One way of accommodating for the various identities that need to be dealt with, is establishing

the client as the expert on himself/herself. The client can then freely state her/his preferences concerning identity and priority of affiliations and problems.

1. When gender is at issue, the REBT practitioner needs to establish client beliefs and priorities and rather than enforce the practitioner's beliefs, If the practitioner has beliefs that conflict with those of the client, the practitioner needs to come to terms with the issue and discuss it with the client to see if they can continue to work together. If the therapist has gender dominated beliefs about the client, the client may need to be transferred to a different practitioner. Gender is important in disability. Males with disabilities are more respected and valued, earn more money and are less denigrated than women with disabilities are. Women with disabilities often have to deal with paternalistic attitudes from employers and health care professionals, are seen as not having full mental capacity or as weak, which are all stereotypic beliefs.
2. Race/Ethnicity and Disability—Select racial groups and ethnic groups are also stigmatized. The amount of stigma may either increase or decrease depending on the political atmosphere in a locality. Sometimes one minority status outweighs another. Many individuals from racial and ethnic minority groups have physical disabilities. Some minority groups are classified as underserved populations meaning that they do not have the same access to mental health and health care as other minority groups. The REBT practitioner needs to be very careful when working with clients with disabilities with multi-minority statuses. Unless the client tells you which belief system s/he espouses (racial, ethnic, disability) the clinician will have a hard time helping the client to establish priorities. Again, the best possible case scenario would be for the practitioner to be from the same ethnic group or racial group as the client for the comfort of both, but that is impossible because few ethnic and racial minority students go into the mental health professions since these professions pay too little. Again, the best way to establish rapport is to have the client as expert on his/her group memberships and priorities and how these identities interact with the disability identity.
3. Socioeconomic Status—People from all socioeconomic statuses are impacted by physical disability; however, because of the different constraints on benefits and employment, and the amount of income one needs for self-support, often clients with disabilities will be from a low socioeconomic status or will maintain a low income in order not to lose benefits. This may be a sensitive client topic especially if the client is ambivalent about work situations (PWDs, even after the passage of the ADA, 1990 and the ADAAA, 2008 have high unemployment rates) and the therapist is trying to push the client into an employment situation and not able to see the down-sides of the situation.
4. Intelligence—People with disabilities cover the full spectrum as far as intelligence unless the individual has a cognitive or intellectual disability. If the client is of normal intelligence or above, s/he is the person that the therapist interacts with most. If the individual has an intellectual disability, the practitioner may also have to interact with a caregiver. However, the practitioner needs to remember

that the client is the prime contact and needs to be involved in decision making situations and needs to be respected.
5. Age—Ageism is rampant. The rates of disability also increase with increasing age. Older clients also are sensitive to how they are seen and addressed, and competence may becomes an issue in how the client perceives his/her own competence and practitioner competence.

The Do's and Don'ts

In this section, I will discuss the do's and don'ts of practicing REBT with people with disabilities.

The do's

1. Before even meeting your client with a disability, it is necessary for the therapist to examine his/her own beliefs regarding disability. PWDs have experienced undeserved discrimination throughout history and it is still prevalent today. If you feel threatened by the person with a disability, by the disability itself, or with disability in general, it is in everyone's best interest if you refer the client to someone who is able to deal with disability (Zabarowski, 1997). It is sometimes difficult for PWDs to begin therapy and you do not want to bring irrational beliefs about disability into the treatment room with you. Remember that you and the client will be working together to meet the client's goals and this will not be possible if you cannot respect the client or his/her condition.
2. If you do not have the training or experience to work with clients with disabilities, acknowledge this and seek supervision and training before doing so. Being in a therapy setting is often stressful for clients with disabilities because of past experiences and they go to treatment for treatment, not to train a novice.
3. There is a great deal of variance within disability. Even if you study disability and read all of the current literature, you might not understand what the client is experiencing. The client is, by necessity, the expert on her/his disability and the limits it imposes on the client's life. The therapist is not there to tell the client how s/he should think, feel or act but to try to understand what the client is experiencing by using the client's own verbalizations and imagery.
4. The therapist needs to listen carefully to the client's description of the world in which s/he resides and if necessary ask respectful questions about that world. Collect extensive data before assessing client irrational beliefs. The beliefs you are labeling as irrational may be irrational in the therapist's world but rational in the client's world (Balter, 2012).
5. It may be valuable to use a socio-therapeutic approach with PWDs (Balter, 2012, 2006). This approach validates client beliefs about the dominant culture without making the client appear to be a victim. In this context it is often valuable to remind the client that s/he can only change herself/himself and is not able to change others, as much as they might like to do so.

6. Not all PWDs come to therapy to discuss disability. They may come into deal with life problems concerning work, parenting, relationships, that bring non-disabled clients to therapy. Find out what the presenting issue is….don't guess. If the presenting issue has nothing to do with disability, treat the problem as you would with someone who is not yet disabled.
7. Respect is a necessary component in all therapy and with all clients, but especially with PWDs, who often are not respected by the larger Society.

The don'ts

1. If you are scheduled to see a client with a disability, do not make assumptions about the person, the disability, the presenting problem or any aspect of treatment before meeting with the client. "Assuming is not valuable in any therapeutic setting".
2. Do not challenge the client's narrative until the therapist and client have a truly trusting relationship and then do so carefully. The PWD has probably heard phrases like "it didn't happen that way," or "you are making it up" or "people don't act that way or say those things." In many instances, this type of response has caused PWDs to leave therapy because the client's experience although real, is not being believed. This type of therapist response is a form of disenfranchisement and makes the therapist into "another inhumane expert." It stops the therapeutic process and eliminates trust.
3. Having a therapist with a disability may or may not be an advantage for the PWD client. It may be a disadvantage if the client believes that s/he is supposed to cope in the same manner that the therapist copes.
4. If you are a practitioner about to see a new client, do not research the diagnosis and set yourself up as an expert about the disability who knows more than the client could ever know. You may know something about the diagnosis, but you do not know how it impacts the particular client.

Which Aspects of REBT Deliver the Most Benefit for Change and Which Do not

Not all aspects of REBT work well with all clients. As such, in this section, I will discuss those aspects of REBT that deliver the most benefit for change with people with disabilities and which don't.

Aspects of REBT that deliver the most benefit for change

1. Teaching the client about USA and ULA and that the client has value independent of deeds and behaviors, and that s/he never has to accept prejudicial behavior.
2. Teaching clients with disabilities high frustration tolerance, how not to catastrophize, and how to dispute irrational beliefs.
3. Using a multi-modal approach to teach skills, relaxation and self-actualization.

Aspects of REBT that do not deliver the benefits for PWDs

1. It is not helpful when therapists refuse to discuss microaggressions that the client has perceived as coming from the therapist. A lack of clear communication patterns between PWD and practitioner sometimes caused by a power differential, may disrupt building a therapeutic alliance.
2. When clients are expected to meet goals that the therapist sets regarding external life events which ignore the role of the disability.

References

Alvarez, M. (1997). Using REBT and supportive psychotherapy with post-stroke patients. *Journal of Rational-Emotive and Cognitive-Behavioral Therapy, 15*(3), 231–245.

The Americans with Disabilities Act of 1990 42, U.S.C. 12101 et seq.

The Americans with Disabilities Act amendments Act of 2008 [incorporated into the Americans with Disability Act of 1990].

Artman, L., & Daniels, J. (2010). Disability and psychotherapy practice: Cultural competence and practical tips. *Professional Psychology, Research and Practice, 41*(5), 442–448.

Balter, R. (2012). Using cognitive-behavioral therapy with clients who identify with more than one minority group: Can one size fit all? In R. Nettles & R. Balter (Eds.), *Multiple minority identities: Applications for practice, research and training* (pp. 117–140). Springer Publishing Company: New York, NY.

Balter, R. (2006). Psychotherapy with clients with physical disabilities. *NY State Psychologist, 5*(4), 29–33.

Balter, R., & Unger, P. (1997). REBT stress management with patients with chronic fatigue syndrome. *Journal of Rational-Emotive and Cognitive-Behavior Therapy, 15*(3), 223–230.

Banks, M. (2012). Multiple minority identities and mental health: Social and research implications of diversity within and between groups. In R. Nettles and R. Balter (Eds.), *Multiple minority identities: Applications for practice, research and training* (pp. 35–58). New York, NY: Springer Publishing.

Calabro, L. (1997). "First things first": Maslows hierarchy as a framework for REBT in promoting disability adjustment during rehabilitation. *Journal of Rational—Emotive and Cognitive Behavior Therapy, 15*(3), 193–213.

Calabro, L. (1990). Adjustment to disability: A cognitive behavioral model for analysis and clinical management. *Journal of Rational-Emotive & Cognitive-Behavior Therapy, 8*(2), 79–102.

Davis, M., Zautra, J., Wolf, L., Tennen, H., & Yeung, E. (2015). Mindfulness and cognitive-behavioral interventions for chronic pain: differential effects on daily pain reactivity and stress reactivity. *Journal of Consulting and Clinical Psychology, 83*(1), 24–35.

Dryden, W., & Daniel, D. (2008). Rational emotive behavior therapy: Current status. *Journal of Cognitive Psychotherapy: An International Quarterly, 22*(3), 195–2009.

Ellis, A. (2006). Rational-emotive behavior therapy and the mindfulness based stress reduction training of Jon Kabat-Zinn. *Journal of Rational-Emotive Behavior Therapy, 24*(1), 63–77.

Ellis, A. (1997). Using rational emotive behavior therapy techniques to cope with disability. *Professional Psychology: Research and Practice, 28*(1), 17–22.

Ellis, A. (1992). Group rational-emotive and behavior therapy. *International Journal of Group Psychotherapy, 42,* 63–80.

Ellis, A., & Abrams, M. (1994). *How to cope with a fatal illness: The rational management of death and dying*. New York: Barricade Books.

Evers, A., Kraaimaat, F., van Riel, P., & de Jong, A. (2002). Tailored cognitive behavior therapy in early rheumatoid arthritis patients at risk: A randomized control trial. *Pain, 100*(1), 141–153.

Kraus, L. (2016). *2016 Disability Statistics Annual Report*. Institute on Disability/UECD. New Hampshire.

Lee, A., Harvey, W., Price, L., Morgan, L., Morgan, N., & Wang, C. (2017). Mindfulness is associated with psychological health and moderates pain in knee osteoarthritis. *Osteoarthritis and Cartilage, 25,* 824–831.

McCracken, J., Lindner, H., & Sciacchitano, L. (2008). The mediating role of secondary beliefs: Enhancing the understanding of emotional responses and illness perceptions in arthritis. *Journal of Allied Health, 37*(1), 30–37.

Martz, E., & Livneh, H. (2016). Psychosocial adaptation to disability within the context of positive psychology: Findings from the literature. *Journal of Occupational Rehabilitation, 26*(4), 4–12.

Norden, M. (1994). *The cinema of isolation: A history of physical disability in the movies*. Rutgers Univ. Press: New Jersey.

Nylicek, I., Hoogwegt, M., & Westgeest, A. (2015). Psychological distress across twelve months in patients with rheumatoid arthritis: The role of disease, activity, disability and mindfulness. *Journal of Psychosomatic Research, 78*(2), 162–167.

Olaoye, E. (2012). Increasing resilience in multiple minority clients using positive psychology. In R. Nettles & R. Balter (Eds.), *Multiple minority identities: Applications for practice, research and training* (pp. 141–162). Springer Publishing: New York, NY.

Olkin, R. (2002). Could you hold the door for me? Including disability in diversity. *Cultural Diversity and Ethnic Minority Psychology, 8*(2), 130–137.

Sciacchitano, L., Lindner, H., & McCracken, J. (2009). Secondary beliefs: A mediator between illness representations and coping behavior in arthritis sufferers. *Journal of Rational-Emotive & Cognitive-Behavior Therapy, 27*(1), 23–50.

Seligman, M., Rashid, T., & Parks, A. (2006). Positive psychotherapy. *American Psychologist, 61,* 774–788.

World Health Organization. (2011). World report on disability.

Zaborowski, B. (1997). Adjustment to vision loss and blindness: A process of reframing and retraining. *Journal of Rational-Emotive & Cognitive-Behavior Therapy, 15*(3), 215–221.

REBT with Forensic Populations

Jason Jones, Richard Barker and Clare Churchman

Introduction

For the purpose of this chapter, we are defining a forensic population as comprising individuals who are being managed or restricted by the criminal justice system. Usually, this means that they are people who have committed offences and are being treated within prison or, in some cases, secure hospitals. The broader definition of forensic as pertaining to the court or relating to scientific methodology to solve crime is not adopted here. As we are focussing on the application of a psychological therapy we are not concerning ourselves with investigative psychology or forensic science in the broader realm.

All three authors currently work in the National Health Service in the United Kingdom, providing psychological assessment and treatment to individuals categorised as mentally disordered offenders. In others words, we have chosen to work with people detained in a health setting (albeit secure) after the commission of a crime. However, we have all also had experience of working within prison settings and providing treatment to people who have been incarcerated. To us, the key issue is being able to develop a psychological model of the problems experienced by the individual that are associated with, and at times causative of, their offending and corollary behaviours. The issue of diagnosing specific disorder (unless this identifies a specific treatment pathway) is less of a concern in our work and this chapter.

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In terms of understanding and working with offending behaviour, REBT is an immensely useful model. It relates to all humans, and therefore is a model that can be applied transdiagnostically and does not require the presence of diagnosed psychiatric disorders. Offenders may well experience mental health problems, but these are often undiagnosed or understood in terms of personality disorders, even so this does not disrupt the use of REBT.

The role of emotions in determining behaviour helps us to understand the motivations people might have in the commission of crime, particularly those where the motive was not simply instrumental gain (though even here the sense of being deprived, even imagined, of the desired object can be understood using REBT). This means that REBT has something to offer most offenders and can be particularly useful in enabling people to reduce their future risk. For example, in cases of repeated violence, where the individual has engaged in violence out of anger (usually associated with shame and anxiety also) the risk of violence in the future can be mediated by helping the person to address the unhealthy anger and work towards healthy anger.

Key REBT Theoretical Concepts in Working with Forensic Populations

The Importance of the C in REBT

The ABC of REBT makes a number of unique insights into human nature and psychological therapy. Quite rightly, most of the emphasis in the theoretical works on REBT is associated with the Belief (B) system, notably the primacy of the demand. While we support the notion that the demand and quite equally the preference are simultaneously Ellis's greatest and most overlooked insights, we have found that the structure of the ABC and in particular helping people in a forensic population with the C is not only the focus of much of the initial work but also a core motivational enhancement for therapy in general. Aside from original works by Ellis, we have found that Wessler and Wessler (1980), Walen, DiGiuseppe and Dryden (1992) and Dryden (2002) develop the means of understanding C within REBT substantially.

The identification of specific healthy and unhealthy negative emotions can offer an understanding of why offences occur and clearly establish a treatment orientation. Many offenders can feel categorised by existing approaches in ways that do not lead directly towards treatment. For example, offenders are often identified in terms of their (usually low frequency) behaviour and typological aspects of the crime, notable in stalking (Mullen, Pathé, & Purcell, 2008), arson (Canter & Frtizon, 1998), rape (Knight & Prentky, 1990) and child sexual abuse (Camilleri & Qunisey, 2008). Whilst the typological category might suggest a dominant emotional response, the typologies are generalised depictions, not individual formulations and as such offer little at the individual level other than a means of comparing the individual's presentation to that of others who have committed similar offences. Thus, description is optimised over

explanation. Such reductionism can be helpful when constructing an understanding of the types of individuals who perpetrate certain crimes. However, behaviours do not occur in a vacuum, or without relation to the individual's experience of their own inner world and how this interacts with the adversities encountered and often created (by our inner worlds) in life.

The REBT insight of the relationship between feelings, actions (including action tendencies) and cognitions occurring at C is enabling when working with offenders. The first key insight is the relationship between emotions and behaviours. All offenders will have been convicted (or charged) with having perpetrated an act that has broken the law. Thus, helping people to understand how their emotions relate to their actions, and indeed their urges to act (action tendencies) is invaluable in terms of determining goals for treatment. Too often we see programmes developed that overlook this key distinction and seem aimed at helping a person to alter their behaviour without understanding how this related to an emotional experience. As REBT does not pathologise the emotion, no diagnosis needs to be offered, the individual can be helped to understand how this might be an unhealthy response to adversity given their goals in life.

One of us (JJ) assessed an individual who had been accused of murder and a psychological opinion had been sought by the defence lawyer. The client was able to express remorse and with support enabled to make sense of how they had gotten themselves angry enough to attack their victim. Because the crime was regretted (not just because of the negative consequences for the perpetrator), all anger was viewed as morally wrong, bad and unforgiveable by the individual. This suggested that specific work was required on the future experience of anger and that this work would be most beneficial if the individual could be assisted to develop a model of healthy anger. Prison based programmes, although informed by REBT at some level, still prioritise the reduction of emotions (especially anger) rather than helping the client to experience a different emotional response to adversity. In this client's case, no matter how little anger they experienced, their moral view was that this was a bad experience (suggesting their own worth as a person was bad if they experienced that which they ought not feel) to be avoided, potentially leading to suppression and consequent behavioural, criminal and health issues at some point in the future.

Unlike any other model that we are aware of, REBT explicitly holds that the goal of addressing unhealthy negative emotions (UNEs) is to enable the person to respond with a healthy negative emotion (HNE). Emotion is best viewed as a metaphorical capsule that includes the situation and inferences at A, the beliefs at B and the feelings, behaviours and cognitions at C. As such we can see that unhealthy negative emotions, resulting from irrational belief systems, are directly associated with self-defeating or self-destructive behaviours (unlike the self-enhancing or self-preserving behaviours associated with HNEs). Often, in our work, we help people to identify that their aggression (violence or sexualised violence) is an example of avoidance or escape rather than a healthy means of addressing their problem. Take the example of an individual who perpetrates an assault on another. The assault may occur as a consequence of unhealthy anger (subsequent to hurt, jealousy or envy, by example), which in turn is brought about by a perception of disrespect coupled

with a demand (and a very strong preference) not to be disrespected. The individual, in assaulting the victim, may derive momentary relief from the discomfort of the social put down, a sense of asserting their power, that carries a short term hedonistic restorative, but ultimately, their resilience to the behaviour of others (the slings and arrows of life) remains unchanged and they remain fragile and essentially exposed. The REBT model helps us to recognise the courage to face our discomfort (associated with healthy anger) and this offers an attractive goal for the offender and for society.

We have found that assisting people to accept and work towards goals of developing HNEs helps them to achieve a focus in psychological treatment programmes. In practice, this can be very useful early on in the therapeutic journey, as individuals can work towards experiencing a process of change (using the model) on a problem that is not necessarily the greatest challenge that they face. This gives them confidence to tackle more difficult issues, and we believe this stems from the model's clarity on the role of C.

Active-Directive Therapeutic Style

In classical REBT, the therapeutic style is one in which the client and therapist actively seek an understanding of the problems experienced by the individual and establish goals and tasks in relation to the goals to help overcome the problems. This can involve more directive components of the treatment, notably directing the client to focus on their ABC, to determine their demands and identify a means of change. We believe this style, if applied well, communicates to the client that the therapist has a desire to help and knows how to help.

Offenders become offenders when they break the law, are judged to have done so and are sentenced as a consequence of their behaviour. Despite more liberal efforts on longer-term crime prevention (such as rehabilitation) there is an inescapable rhetoric of the punishment fitting the crime. Systems are imbued with this view, regardless of their apparent veil of goodwill. As such, best intentions to one side, the majority of relationships an offender will develop will be with others who might seek to disempower, punish, or be focussed on retribution. REBT's therapeutic style readily communicates a desire to help and so this can act as an initial glue within the therapeutic relationship.

The skilled REBT therapist permits an ebb and flow of the degree of activity and direction throughout the therapeutic process. Trower, Jones and Dryden (2016) highlight the importance of varying the style by individual and also by the stage of the therapeutic work. Some individuals may resist what they perceive as intrusion and may be particularly sensitive to the other person actively offering hypotheses (however tentative) and questions. The therapist benefits from listening to and observing for this in terms of the individual's response. Some others may be overly talkative and determined to avoid real work through intellectualisation. Here, the therapist benefits from being more involved, assisting with direction, and not succumbing to passivity. As the therapist becomes more familiar with the client and their needs, the

style can be sensitively modified. The application of the REBT model is not amended by a variation in the style of its application and this strength means that the model can have a wide application in offender populations.

The Theoretical Clarity of ABC Chains

The forensic literature is replete with cohort approaches, including classification systems, risk analysis, and treatment programmes. Group work is often prioritised over individual treatment in penal establishments. Penal systems, across the world, are over-crowded and struggle with the burden of containment let alone rehabilitation and prevention. A similar paradigm exists in health care systems, where the disease model means that resources are primarily expended on treating the sequelae of poor health rather than enabling well-being. Readers will be familiar with these political dilemmas and the pressure to apply a reductionist philosophy to psychological treatments as a typical reaction to such dilemmas. This can lead to falsehoods in understanding and treatment. For example, there is good evidence perpetrators of domestic violence experience problems with anger and jealousy (Maiuro et al., 1988). Treating the anger, as this is assumed to be associated with the violence, seems logical but can ignore the jealousy and the associated anxiety of rejection and loss. Here we might assume anger has a defensive, albeit unhealthy, function. Removing this, without replacing this, can leave an individual vulnerable to continued emotional disturbance.

The REBT approach of enabling multiple ABC formulations of connected or related emotions facilitates a genuinely enabling approach to helping understand offences and treat offenders. Commonly in REBT, ABCs are considered independently or in sequence (as in the meta-emotional problem). As such, we can readily depict an individual who feels anxious about the experience of feeling anxiety. The REBT model allows for more complex relationships of ABCs and we find this particularly helpful in aiding people to understand and intervene with emotional problems associated with offending behaviours.

The first of these is the more familiar complex chain sequence, where one emotion and associated action becomes the adversity conditions of the next and so on. A common one in violent offenders, where their use of violence is associated with emotional distress, is hurt-anger-guilt. Here, the individual experiences the behaviour of another as hurtful and initially condemns themselves (based on the internalised view of the other, for example, for that person to treat me like this must mean I am unlovable). The state of being unhealthily hurt (of being unloved) then triggers the adversity associated with disrespect, which when paired with a demand about being treated with respect leads to a condemnation of the other, and so to unhealthy anger and violence. The perpetration of the violence (against, for example, a significant other) then leads to the adversity of having hurt another (as restitution for the original hurt), which then leads to condemnation of the self as bad. Of course the complex chain does not always end there. However, quite quickly, using a complex sequential

chain of REBT ABCs we are able to promote understanding of events beyond the usual classification or reductionist approach and develop effective interventions that help the individual. We have depicted this graphically in Fig. 1 below.

Similarly, we have found that other means of understanding the relationships between ABCs can assist in developing emotional insight and responsibility in offenders. We have noted that in some individuals ABCs are experienced in parallel, all connected to a single adversity. The immediacy of the experience of three or more emotions can often mask the problems being experienced by the individual. In turn, this can lead to a problem being worked on that is not the most clinically salient, nor understood in relation to other problems. An example of this was found in an offender who had been convicted of possessing indecent images of children. The discovery of the offence had led to the loss of a relationship, a job, and treatment by others that was considered to be unfair and humiliating, and therefore a number of problems could be identified as goals to address in therapy. However, a key one was to consider the range of emotions related to the commission of the offence and in discussing this it was consistently difficult to identify an ABC with the emotion and behavioural tendencies being vague or incoherent. Only when the therapist hypothesised a formulation of ABCs in parallel was the individual able to gain a sense of emotional responsibility. It became evident that the individual had responded to the adversity of reflecting on a perceived absence in his life by drawing out inferences that triggered a range of demands and so led to a variety of emotions, that together fed the desire to offend as he had. The resultant ABCs in parallel enabled the therapist and client to clarify their tasks in therapy and this is depicted in Fig. 2.

Of course, there are many other means of presenting complex information by understanding the relationship between ABCs. We have demonstrated the two types we find ourselves using in individual and group work with offenders.

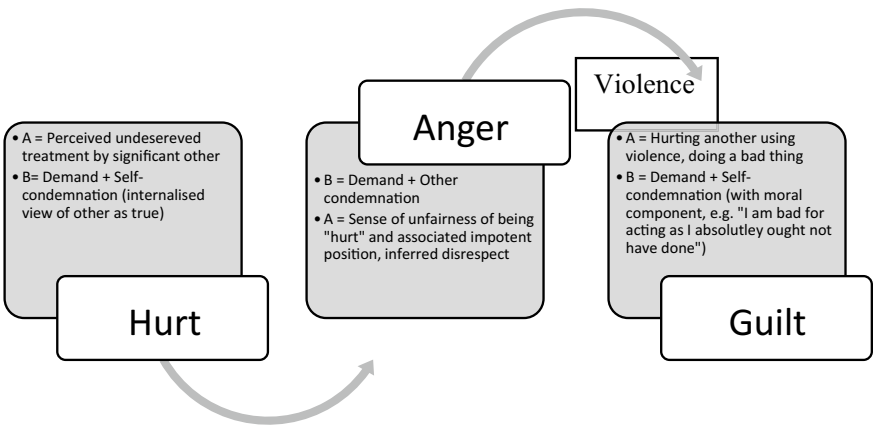

Fig. 1 An example of a complex sequential chain of ABCs

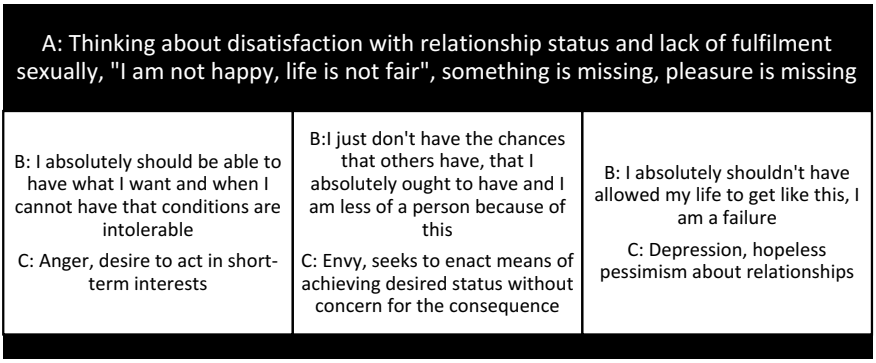

Fig. 2 ABCs in parallel

Key Best-Practice REBT-Based Assessment and Treatment Strategies and Techniques in Working with Forensic Populations

The Importance of Developing Emotional Responsibility

As we have already noted, offending behaviour does not occur in a vacuum. People who commit offences usually have had a combination of adverse life experiences that they have failed to deal with healthily and ultimately act in ways that require legal sanction. The pessimistic outlook for helping offenders to change was captured in the original "What works?" question posed by Martinson (1974). Significant research and treatment programme developments followed that sought to reduce the likelihood of offenders re-offending. Nonetheless, even in the last 10 years the evidence remains mixed at best for a number of approved programmes (Ministry of Justice, 2013, 2016). The focus, perhaps rightly, has been on the methodological issues in proving that the intervention delivered yields the outcome of reduced risk. However, we believe that this has detracted attention from some of the core aspects of treatment models seeking to support people to effect real change. It is clear that punishment (whether by incarceration or supervision) is not effective in itself for stopping people from reoffending. It is also a part of human nature not to change our ways because we are told off, as much as we might want to change. We would argue that this is because we change when we want to change, not because we *have to*. Furthermore, in practice, helping people to realise that they want to change is an inherent component of the REBT model.

Even within the initial teachings of REBT (such as Primary Practicums) there is a focus on establishing the principle of emotional responsibility. It is a concept embedded in Ellis's theory that we contribute most of the variance to our own misery (Ellis, 1956) and this principle is central to volitional change. This, however, is a notable issue when working with clients who are mandated into treatment, as

nearly all offenders are. O'Leary, Day, Foster, & Chung (2009) found that many individuals required to undertake a programme for perpetrators of domestic violence failed to accept responsibility for their actions, rather they blamed their victims. In working with people with anger disorders, as many violent (and other) offenders have, it is widely accepted that the nature of the problem means that the client will lack emotional responsibility (DiGiuseppe & Tafrate, 2007). The core derivative in interpersonal unhealthy anger is other-downing (Trower, Jones & Dryden, 2016). Therefore, if you condemn another, in their entirety, for their behaviour, there is no need for you to accept any emotional responsibility for your anger.

Early in the therapeutic relationship it is important to help the client understand the importance of emotional responsibility. However, with offenders, who may be more sensitised to blame attribution, the therapist needs to be careful and tentative, yet persistent. Sadly, it becomes evident rather early in most of our cases that we can identify individuals who have trouble with accepting a model of emotional responsibility. In such instances, despite, on occasion, hundreds of sessions to address this, we recognise the importance of the client's resistance. We have tried various mechanisms in such instances; for example, addressing problems of less importance, indirect means (helping another person), bibliotherapy, gentle persuasion, asserted persistence, and so on. The primary conclusion we can reach, aside from therapeutic flexibility and creativity, is that emotional responsibility is key to achieving an elegant solution in REBT but not everyone is going to be able to achieve this. We have developed group programmes aimed at using group process to facilitate people to move towards an acceptance of emotional responsibility, but we still only have mixed success. One apparent fact remains, without an acceptance of emotional responsibility REBT (and we would posit most of the talking therapies) will ultimately lead to limited outcomes.

Other-Acceptance and Forgiveness

In our clinical practice with violent recidivist offenders, we have noted a profound resistance to philosophical change in the derivative other-condemnation belief. Commonly this is typical in interpersonal anger, usually primed by the preference and demand about how others act (that in the specific adversity the other has breached). Despite completing good work with such individuals, we note the ready conclusion that individuals arrive at about the global badness or worth of others. In many trainees, we note a reluctance to be vigorous and thorough in disputation and out of sessions assignments, suggesting they perceive one pass over the belief system is sufficient. Given that most therapy, internationally, is conducted with offenders by people who have limited, often programme specific, training, this is a concerning issue.

Therefore, we have adopted a model, when working with derivatives of other-condemnation, that other-acceptance, as the rational alternative belief, is good but only part way good enough. In addition to the usual repetition of work on specific ABCs in anger (before the individual starts to notice themes and is able to generalise),

we have taken heed of the advice of Kassinove and Tafrate (2002) to work towards forgiveness. In order to forgive another, we must have reached the position of other-acceptance and move beyond simply believing they are too complex to warrant a global unidimensional rating. To forgive, we must also begin to accept that the other has acted badly towards us and we are willing to forgive them for that choice of actions, not explain it away or seek to otherwise minimise it, but to embrace the real meaning of unconditional other acceptance. We forgive them *even when* they act against our wishes or principles. This is not a doctrine of passivity. Rather, we seek to help people really focus on the perceived injury and the nature of the relationship with the other to better insulate them against future harm and harm-doing. We have found that this additional effort, beyond classical REBT, with people with anger problems really helps them to move towards a less blaming default position, which in turn helps them to examine reasons for their own responses in more detail (such as when aggression is avoidance of other issues).

Role of Denial in Working with Offenders

In classical REBT, denial is most commonly formulated as a cognitive and behavioural consequence of guilt. Here, we can understand that denial functions as a defence against the realisation of the action about which one feels guilty and the subsequent anxiety that may yield. We have also noticed that denial can occur as a consequence of shame. In order to preserve standing, the individual defends against overwhelming emotions, by denying or minimising that which they might ordinarily feeling ashamed about (for example, having been observed acting below a personal standard). We find that these are the two main emotional processes that generate denial. However, in the forensic literature the admission and denial (confession or not) is a widely studied and broadly applied construct. Sexual (particularly rapists) and violent offenders confess far less that other offenders (Gudjonsson, 2003). Practically, this may be associated with the quality of other evidence gathered during the investigation of the crime (such as fingerprints in burglaries) and also that sexual and violent offenders are less likely to be apprehended whilst committing the crime. Thus the evidence for violence and sexual offences relies more heavily on witness testimony. Given the forensic emphasis on investigation, confession, and deception (for example, Granhag & Strömwall, 2004) it is perhaps unsurprising that efforts focussed on unpicking denial (using amongst others more confrontational techniques) rather than the emotional processes underpinning denial.

Of course, we are not suggesting that wilful, simple denial is not sometimes used by some offenders. Rather, we are suggesting that REBT offers a framework for understanding the emotional distress that is linked to why some people deny. As a therapist in a forensic setting, it is important to bear both elements in mind and the REBT process enables this.

Promoting Philosophical Change

Philosophic change is the preferred goal in REBT, whether this be specific or general philosophic change (Dryden & Branch, 2008). This means that most REBT therapists will enter the therapeutic relationship with this goal in mind, that the client will be able to shift from a demand-philosophy to a preference-philosophy and be able to direct themselves to identifying what to do when they experience emotional distress. As Dryden and Branch note this is an ideal and something that is unlikely to be achievable with the majority of clients. We generally find that our initial goals are specific philosophical change. Take, for example, a man who perpetrates violence in the context of anger (with or without other mental health or personality disorder diagnoses). Our initial focus is almost invariably on working with the offender to understand the relationship between their emotional experience and their behaviour; the individual believing that they have emotional responsibility; working together to determine the demands associated with and replacing those with preferences. We might not have time and the offender might not have the inclination to broaden the focus of the therapy (even if clinically it might be in their better interests because the time in contact with the therapist might be limited by the legislation detaining the individual).

We have worked alongside therapists who do not use REBT and have noted that they focus far less on specific philosophical change. We have also noted that, in our opinion, they can too readily believe that the work is done when a client understands an intellectual argument about their experience. We believe this places the individual, and ultimately others, at risk, because the work has not persisted to enable specific change across a range of situations. Too often we see offenders both in hospital and in prison who accept the need for change in one set of interpersonal circumstances but are not able to apply that new learning to the next relationship and so on. The explicit emphasis in REBT enables the sustained reflection for both therapist and client on the quality of change arrived at because of the therapy.

Treatment Guidelines from the Empirically-Supported Therapy Literature that Inform Best Practice in REBT with Forensic Populations

There are a number of broadly cognitive-behavioural based offender treatment programmes. None of them use an explicit REBT framework, although REBT ideas and concepts are included within them in a more implicit fashion.

Some such as the Enhanced Thinking Skills (ETS) programme began in the mid 1990s as an attempt to incorporate research in thinking skills deficits into an offender treatment programme to help develop better problem-solving. Originally described as the Reasoning and Rehabilitation programme (Ross, Fabiano, & Ewles, 1988) it became the Enhanced Thinking Skills programme in 2000 (Clark, 2000) and even

more recently refreshed again into the Thinking Skills programme. It consists of 20, two-hour groups sessions run between three to five times a week. It is a fairly intense programme mixing skills-based learning, debate and discussion in which examples are used, but usually not those related specifically to the offenders criminal histories. Amongst the various elements that the group treatment focuses on is critical reasoning, defined within the programme as "the ability to recognise and challenge irrational beliefs." However, the focus on "irrational belief's" bear's little resemblance to the classical Ellis tradition, with thinking skills largely set within a Beckian ABC, wherein the B includes both the initial inference about an adversity and the resulting emotional state, and C focuses only on the consequential behaviour. There is an absence of focus on the differences between demands and preferences or subsequent evaluations, with the focus instead upon replacing faulty thinking styles with less provoking alternatives. Whilst this has the advantage of allowing the course to run in a generic non-individualised fashion (useful for wide roll-out across services with treatment adherence focussed on consistent delivery of contents, rather than genuine change) it misses the particular benefit in using REBT with offenders in helping them develop internal responsibility and personalised alterative rational beliefs that are far more likely to be genuinely held by them and acted upon than a more genric statement learnt in a course.

In a similar fashion, the Prison programmes use of REBT can most overtly be seen within the Anger Management programme or CALM (Winogron, Van Dietent, & Gauzas, 1997). This explicitly CBT-based programme was brought into the UK prison service in the early 2000's and is an adaptation of a programme originally designed for use in Canadian prison and probation services. REBT was a more explicit back-bone for the CALM programme given that one of the Authors (Dr Bill Winogran) is an Associate Fellow of the Albert Ellis Institute and Approved supervisor of REBT. The prison-based programme consists of 24, two-hour group sessions focussing on 5 areas. Those areas, include Self-regulation skills, Rational thinking, Social skills, Problem-solving skills and a Relapse prevention area. Naturally, the most overt aspect of REBT can be seen within the rational thinking skills, in which traditional REBT Adversity and Critical A's are reframed as External triggers and a persons irrational beliefs are reframed as Internal triggers. The rational thinking elements are described as thinking that is subject to elements of distortion (as opposed to irrationality or unhealthy beliefs) and fall into one of nine types of thinking distortions, described below:-

- Blinding—drawing a conclusion without or against evidence;
- Over-stretching—taking one rule and applying it to other situations;
- Magnifying/Shrinking—Exaggerating or minimizing the importance of something;
- Black or white thinking—seeing things in extreme;
- Taking things personally—thinking that something is aimed at you without evidence that it is;
- Can't-stand it-i-tis—thinking that you cannot bear it;
- Awfulising—thinking that something is the worst that it can be;

- "mustations"—thinking that something must be as you want it to be;
- People damning—damning the person rather than the act.

Though their remain clear elements of REBT within this treatment programme, we would question the degree to which diminishing the traditional central aspects of REBT to simple thinking distortions (which of course they are) in the absence of the active process of disputation, leads the authors to wonder to what degree those elements have any meaningful impact on the individual. The traditional REBT approach to Anger is well described (see Kassinove & Tafrate, 2002). Whilst the CALM programme focuses on skills, it appears to not place emphasis on the traditional central component of REBT, the process of disputation. Without learning how to apply a process of identifying irrational inferences and evaluations and then dispute them using logical, emotional and pragmatic methods we would question the degree again to which an individual offender could ever "own" their new-found healthier thinking. It remains unclear why this element of REBT seems absent from the CALM programme, speculatively, it may relate to the general absence of REBT training within UK Forensic Psychology courses and so the lack of focus reflects a general mis-understanding of those REBT elements. Similarly, the shift of language from "musturbations" to "mustations" might also be a symbol of those adoption and adaptation of REBT without the requisite understanding of its origins.

Finally, it may also be the case that focusing on skills rather than emotions, particularly emotional responsibility prompts less resistance within the coercive culture of secure services because it avoids dealing with deeper issue of whether or not the offender really takes responsibility for their crime (and any unhealthy negative emotion that went with it). Pragmatically, using REBT, or elements of REBT skills (e.g. teaching elements of REBT without necessarily connecting them to specific individual experiences) may have been a useful compromise when faced with deploying a programme of intervention without access to trained REBT professionals. It also raises the interesting question of whether or not elements of REBT can be taught and have benefit even in the absence of the development of profound philosophical change that comes with fuller exploration of REBT principles?

More recent shifts in policy within the prison service over the past few years, have been sparked by the controversy associated with poorer outcomes for sexual offenders in group treatment than those who did not attend treatment (Ministry of Justice, 2017). This has provoked a sea-change in the underlying theoretical models for the treatment of individuals who have committed sexual offences and also for the treatment of violence generally. This new series of programs have been heavily influenced by the Good Lives approach of Tony Ward and colleagues (Ward, 2002). The fundamental approach of these new programs, called Kaizen (for high risk offenders) and Horizon (for medium to low risk offenders) is the same as that noted elsewhere in this chapter—that telling people what they should not do, rarely motivates genuine change, particularly in environments that are explicitly or implicitly coercive or punishing. Instead, the Good Lives approach builds on the idea that all individuals are motivated to seek out various "goods" in life, typically related to basic needs for relationships, purpose and connectedness to others, and that it is the way in which

we seek out and attain these goods that can be either pro-social or antisocial. Within these new courses, the actual offending nature itself as seen as of lesser importance than helping the clients gain a better sense of self and the goals, values and needs that they have. Thus the Kaizen programme are not offence specific and take offenders with both sexual and violent offences.

Within the Good Lives model criminogenic behaviors become secondary to the client's approach to dealing with an adversity or challenge and may equate in REBT terms to a set of irrational beliefs and values at B, that lead to unhealthy outcomes at C. The therapeutic focus within the Good Lives model is on the identification and attainment of these goods through more effective (and presumably healthier) mechanisms. This may include skills based work to overcome limitations that the client has, but can also include work on learning to tolerate the discomfort associated with those limitations and emotional regulation.

Thus there are some obvious parallels between REBT's and the Good Lives models. Both have a focus on recognizing that in life we want to achieve certain wishes or "goods", and that it is the mechanism by which we achieve that (or fail to due to self-defeating strategies) that leads to discomfort and distress. The Good Lives approach does offer a useful focus on clearly identifying what it is the individual wishes to achieve in life, or through a particular course of action. This is seen as being a particular strength of the model in the coercive and punitive environment of prison because it recognizes that the individual has inherent needs and that the best route to future desistence from antisocial behavior is in helping them to gain the skills to meet those needs in a socially acceptable fashion. This contrasts with previous "treatment" approaches that emphasized the negation or avoidance of those needs and the negative consequences of trying to meet those needs. The good lives model offers a simple framework to explore this using the principle of "old me/new me/future me"—the identification of goals and values, both historically, and in how they want to be allows the individuals exploration of a new sense of self. It is both intrinsically motivating (because new me models almost always see pro-social behaviors as more effective at gaining goods than anti-social behaviors) and inspires hope.

What the Good Lives model offers REBT is a potential to blend the two within forensic populations. The Good Lives approach is largely one that seeks to emphasize the possibilities of change over blame of past behaviors. Unlike previous offence related courses offered within the criminal justice system, Kaizen and Horizon do not require the offenders attending the courses to admit their guilt. Because the focus is on the future (and the principle that more pro-social goal seeking will lead to greater desistence) there is less of a focus on challenging (from the perspective of the model) the denial of their previous offending. Although somewhat counter-intuitive, this focus means that personal responsibility becomes associated with pro-socially working towards valued-goals, rather than associated with a blaming or punitive approach. This would contrast with an REBT focus that may seek to challenge unhealthy evaluation of the self as barriers to developing personal responsibility in offending behavior. Instead the Good Lives model places the personal responsibility entirely within the development of the new me, albeit a new me that is still recognized as being fallible, and too complex to be judged on a single characteristic (because the

elements of the new-me are supported to be pragmatic, multi-faceted, detailed and individualized). The underlying assumption behind this approach is that placing the development of personal responsibility, (effectively at a healthy C in REBT terms) side-steps the potential rejection of the model because of the coercive influence of the culture of the prison or secure hospital. In effect, the Good Lives model recognizes that people won't change unless they have a good idea of what that change will look like. By placing emphasis on the effective new philosophy and all that could potentially come with it, the Good lives model builds motivation to change in an environment that by its culture reinforces holding on to punitive, retributive and resistive ways of values and beliefs.

Brief Case Example

Philippe

Philippe was a young man in his 30s who was serving his first custodial sentence for grievous bodily harm. Philippe was brought up an only child in a single parent family, his father had left the family when Philippe was a young baby and they had no further contact. Philippe struggled at school and often truanted. With other local teenagers Philippe began to get involved in antisocial behaviours such as drug use, graffiti and shoplifting, and was often in trouble with the police. After school Philippe found work difficult and eventually left all employment. He spent most of his time using substances with peers in people's houses, often having drug binges that would last for days.

During one of these binges Philippe propositioned a female friend for sex and then assaulted her when she refused. He was later convicted of GBH. Philippe came into therapy to help him explore and understand the emotional reactions behind his offending behaviour. Although Philippe had previous convictions, he did not have a history of violent offending and he expressed remorse, regret and surprise at what he had done. Philippe was good at talking about his emotions, even though he did not always understand defined concepts, and he took to REBT quickly and easily.

When asked about the offence Philippe described how he had initially thought his victim had been romantically interested in him, having wanted a romantic partner for some time. Philippe described feeling sure that she would say yes when he asked, and remembered feeling surprised and hurt when she declined him. Philippe concluded "you don't think I'm good enough for you!" and he described feeling "rage", wanting to make her feel as bad as he did in return and becoming physically aggressive towards her as a result. He punished her for expressing her preference and for not having the same preference as him.

Philippe's emotional experience during his index offence was formulated as a sequential chain of unhealthy emotions with the emotional response of hurt triggering

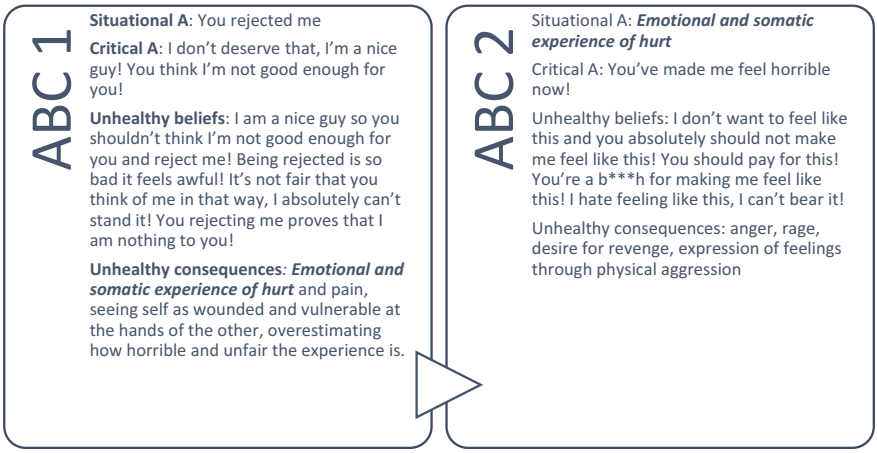

Fig. 3 Philippe's sequential ABC chain for hurt and anger

the meta-emotional response of anger, which included physical aggression at C (see Fig. 3).

With the visualisation of his beliefs and behaviours within the REBT ABC form, Philippe was able to note his sensitivity about rejection by females. He recalled previous feelings of hurt at school when girls declined his invitation to go out on a date or when a relationship ended, however, he was surprised that he had felt hurt enough on this occasion to physically harm someone. Philippe suspected that the use of cocaine at the time of the rejection reduced his ability to cope with the difficult feelings but he was also aware that he had liked his friend for some time and had thought the feelings were reciprocated. Able to identify with the feelings of hurt Philippe was also able to see how his feelings of unhealthy anger were related. He understood that by working on how he handled rejection he could reduce the risk of violent behaviour occurring in the future. For this reason, the focus of the REBT formulation in this instance was on understanding what happened in his index offence rather than ongoing feelings of hurt and anger, which had subsided over the months.

Philippe first began to challenge his critical A, finding other reasons for why his friend may have rejected his advances, for example, "she already has a boyfriend, or maybe she likes me as a friend but just doesn't want a relationship". However, he was encouraged to imagine his initial inference was true and to think instead about other possible responses to the rejection. Philippe was also asked to think about a different goal that he might have had in that situation. He proposed that rather than wanting her to feel as bad as he did, he would have wanted to put the rejection to one side and continue with their friendship.

Initially Philippe suggested alternative behaviours such as shrugging it off and telling himself that it did not matter and that there were plenty of fish in the sea. It took some time to consider whether this was a realistic and likely possibility in the face of rejection by someone that he had liked for a while although eventually

Philippe decided that he would probably feel "a bit upset" rather than not care at all. Philippe went with the REBT term of sorrow to describe a healthy alternative emotion and supposed that he would have probably felt sad about the rejection but have been able to distract himself from it by going out with friends and trying to meet other women instead of focusing on his friend. Importantly he identified that a healthy response would have been to accept his friend's rejection.

Once an alternative emotional experience was identified, Philippe was able to leave his inferential challenges and focus on disputing his irrational hurt provoking beliefs. At first he was surprised to find that there was no reason for why his friend *should not* have rejected him, nice guy or not, but he quickly understood that this was clearly the case in terms of reality. Challenging the demand immediately enabled Philippe to see the situation from his victim's perspective: "Of course she can reject me! If she had to have sex with everyone who asked her that wouldn't be good for her at all!" Following the lead, he was able to utilise empirical, pragmatic and logical disputes on the rest of his beliefs, eventually developing an alternative rational and helpful belief set (see Fig. 4).

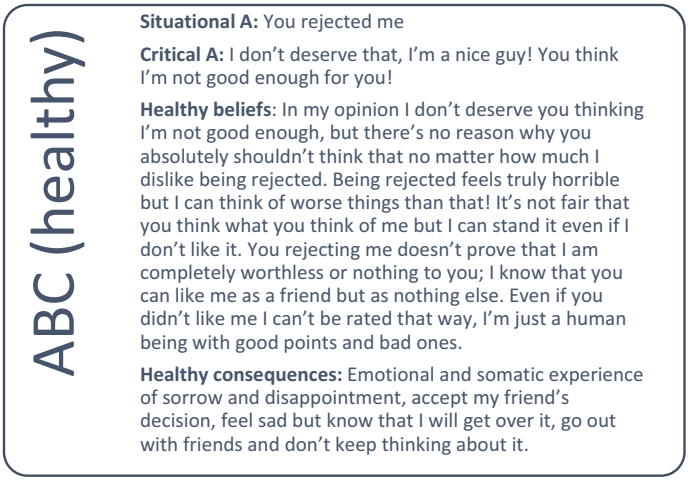

Fig. 4 Philippe's healthy ABC

What We Have Learned About Using REBT with Forensic Populations

Accommodating Individual Differences: Client Gender, Ethnicity, Socio-Economic Status, Intelligence and Other Factors

Forensic populations are heterogeneous, and the work can bring the therapist in contact with individuals with diverse backgrounds. For the most part, however, offenders tend to be from poorer elements of society, typically with adverse backgrounds, poor attachment relationships, predominantly male, have fewer opportunities in life and in England, Wales and the United States people from Black, Asian and Minority Ethnic populations are over-represented in the criminal justice system (Ministry of Justice, 2016; Nellis, 2016).

The gender difference is quite stark, in England and Wales in 2015 women represented only 4.5% of the prison population (Ministry of Justice, 2015a). This means that the forensic population is predominantly male, which is quite different to other populations of individuals who engage in therapy. Of all men in England and Wales in 2015 convicted of an offence, 80% of them had convictions for previous offences (Ministry of Justice, 2015b). This indication alone is suggestive of problems that are pervasive and enduring, and therefore the therapist is likely to meet higher levels of complexity than might be found in the general, at liberty, population.

In our experience, we have had to adapt to working with individuals, largely men, who present with complex problems. We have had to ensure our practice is sensitive to cultural needs and mindful of history in ways that are not typically considered in the REBT literature. Of utmost importance has been an ability to refine our means of helping men in institutional settings where they fear revealing anxious feelings to allow themselves to be 'vulnerable' with their therapist. This means that therapy can often be of a longer duration.

The Do's and Don'ts

The Do's

Pace

We established earlier that we believe the active-directive style of REBT is a distinct advantage when working with people within a forensic population. Also, that flexibility in the application of an active-directive style was key. We propose that therapists in working with this population do pay attention to the pace of the work. Therapists will need to be aware of additional problems of meta-emotions involving shame and anxiety, and holding hope at a time when it may well feel that hope is lost.

Thus, being mindful of the pace of therapy, checking with the client, noting when things are moving too quickly for them (evidenced by disconnection from content, avoidance of emotional distress, absence from the therapeutic process, feeling that change is 'too hard') and amending the pace of the work accordingly is essential. We believe that therapists cannot afford to ignore the pace of the work and apply their 'style as usual' approach. This would only have a negative impact on the therapeutic bond, and the consequent effectiveness of work will be reduced.

Emotional responsibility

As we have already noted, emotional responsibility is a prerequisite for meaningful therapeutic change. We have learned that it is erroneous and at times dangerous to assume that an individual has genuinely accepted emotional responsibility because they appear to be going along with the content of the sessions. We advocate testing the emotional responsibility explicitly and often. Simple questions, such as "who is to blame for your feelings in this specific situation?", can often help establish whether an individual accepts their emotional responsibility. In cases of limited, denied or absent emotional responsibility related to offending specifically, measures such as the Gudjonsson Blame Attribution Inventory – Revised (Gudjonsson & Singh, 1989) can be helpful. Either way, not checking on emotional responsibility can at best undo therapy and at worst place at others at increased risk.

The Don'ts

The stigma of offending

REBT is undersold in terms of the elegance with which its transdiagnostic approach can help with problems associated with stigma. Stigma can fuel social anxiety, shame, anticipated shame, and vulnerability to bullying. We have found that REBT is more than capable of helping individuals to formulate healthy responses to the experience of stigma. We make use of any learning about the model and philosophy already achieved and help people to apply this to the issues of anger at wider systems (for continuing to experience disadvantage) or more personal experience of anxiety and shame in, for example, disclosing criminal pasts to family, friends and loved ones.

The coercive system

It comes as little surprise that environments designed to rehabilitate offenders or treat mentally disordered offenders parallel aggressive and punitive actions (e.g. Hodge & Renwick, 2002). After Galtung (1969) and Farmer (1999) the concept of structural violence has been applied to penal establishments (e.g. Thomas-Peter, 2015). Simply put, offenders are themselves made subject to systems and cultures that permit neglect, abuse and prolonged disadvantage. From a lay perspective of punishment such behaviour might even be applauded and supported, but the evidence overwhelmingly suggests that punishment and incarceration do not reduce the risk of reoffending. In many ways acting on a punitive or abusive attitude as a prison officer or a nurse in a secure hospital will only exacerbate suffering and lead in

turn to burnout in the staff. Nobody appears to benefit from this, yet the likelihood is that structural violence is endemic in penal systems, and perhaps society more widely. The REBT approach lends itself well to address this within institutions. At a fundamental level, REBT holds that we cannot condemn ourselves, another, or conditions. Unconditional other acceptance is key to therapeutic progress, where the client can escape the sense of being judged or condemned. Therefore, this basic principle so elegantly defined by Ellis, lights the way to address problems with structural violence. We have found that supporting staff to unconditionally accept the individual, irrespective of their behaviour, can give them confidence in their relationship with the offender, reduce the distress they experience, and in turn improve the outcomes for the individual in their care.

Which Aspects of REBT Deliver the Most Benefit for Change and Which Don't

Which Aspects of REBT Deliver the Most Benefit for Change

In addition to the specific issues we have covered in this chapter, there are two aspects of REBT that we believe are of significant benefit in forensic populations. Curiously, they are also aspects that in their own right perhaps get less attention than they should in the REBT literature. The first of these is the importance of the preference and its relationship to the derivatives. Preferences are at the heart of human desire, motivation and nature. They are implicitly known and passionately felt. In our work with offenders, we have noticed how readily the notion of not abandoning passion is accepted. The advantage of being able to use a therapy that so explicitly discusses what is simply felt to be the case is immeasurable to the development and maintenance of therapeutic relationships. We feel the importance of the preference is too readily overlooked. Take for example the oft used example here of a man who is violent to his romantic partner. Let us assume his violence was the consequence of anger (and not instrumental gain). Let us also assume that the partner was perceived to have acted in a manner that the perpetrator of violence did not like, hated or despised. That in turn this preference is turned into a demand about how the other must act and for not doing as they must, not only is the behaviour intolerable, but also they are a bad person; anger and violence ensue. Rewind the above and pause at the word preference. Up until this point the perception is that the other has contributed most of the variance, they have acted in a way that is disliked. However, note the language here, the behaviour is most likely perceived because of the preference and it is then imbued with a sense of being bad (the behaviour) because it is so strongly disliked or in competition with other preferences (e.g. "I want to be left alone"). We are far more likely to attend to things we feel strongly about (liking or disliking) and so our preference not to be treated in certain ways leads us to scan for such 'mis' treatment. Helping an offender to understand this and how this relates to the demand

and subsequent derivatives can help sustain a sense of hope for change. We believe that this hope rests on realising that their preferences, however directed, are valid and their own and the therapy is not overtly seeking to change this. In fact, most people ultimately are able to accept that they do not have to have what it is they want, no matter how badly they may want or not want it.

One author (JJ) recalls running an anger group in the late 1990s with a colleague. After introductions, the group members were tasked with saying what they wanted from the group. They all took turns saying that they wanted to feel no anger, nothing. Curiosity followed about whether the group wanted to feel nothing in the presence of something, such as provocation, bullying, unfairness and so on. This led to much confusion. For so long the group had felt that their anger was the problem and for them the problem had to go away. They had all abandoned a model of healthy anger, the emotion of courage and protest. This is the second aspect of REBT that we believe offers most benefit. The HNEs, when felt sincerely, do not require new sets of skills to act differently. Implicit in the capsule of the HNE is the script for acting differently. This insight proves invaluable to many of our clients in forensic populations, as they immediately feel less lost, overwhelmed or misdirected.

Which Aspects of REBT Don't Deliver the Most Benefit for Change

We do not feel that there are any aspects of REBT, at least theoretically, that do not deliver benefit for change. In practice, we have observed elements of therapeutic style that are not helpful with forensic populations, such as an over-reliance on expansive or experimental homework assignments. Often, individuals are detained and a certain behavioural standard might be expected of them. Flamboyant shame attacks are not always well received in penal establishments. We have also noted that the application of REBT seems to stop after the goals of therapy have been addressed. To date, there has been less focus on living with a new philosophy, the practice of living according to preferences (and the healthy derivatives). Developments in line with positive psychology might help with this, assuming that such developments retain theoretical coherence.

References

Camilleri, J. A., & Quinsey, V. L. (2008). Pedophilia: Assessment and treatment. In D. R. Laws & W. T. O'Donohue (Eds.), *Sexual deviance: Theory, assessment, and treatment* (Vol. 2, pp. 183–212). New York: Guilford Press.

Canter, D., & Fritzon, K. (1998). Differentiating arsonists: A model of firesetting actions and characteristics. *Legal and Criminological Psychology, 3,* 73–96.

Clark, D. (2000). *Theory manual for enhanced thinking skills*. Prepared for the Joint Prison Probation Service Accreditation Panel.

DiGiuseppe, R., & Tafrate, R. C. (2007). *Understanding anger disorders*. New York: Oxford University Press.
Dryden, W. (2002). *Fundamentals of rational emotive behaviour therapy: A training handbook*. London: Whurr.
Dryden, W., & Branch, R. (2008). *The fundamentals of rational emotive behaviour therapy: A training handbook* (2nd ed.). Chichester, West Sussex: Wiley.
Ellis, A. (1956). Rational psychotherapy. In *Presented at the Annual Conference of the American Psychological Association*, Chicago, 31 August.
Farmer, P. E. (1999). Pathologies of power: Rethinking health and human rights. *American Journal of Public Health, 89*(10), 1486–1496.
Galtung, J. (1969). Violence, peace, and peace research. *Journal of Peace Research, 6*(3), 167–191.
Granhag, P. A., & Stromwall, L. A. (2004). *The detection of deception in forensic contexts*. Cambridge, Cambridge University Press, UK.
Gudjonsson, G. H. (2003). *The psychology of interrogations and confessions: A handbook*. Chichester, West Sussex: Wiley.
Gudjonsson, G. H., & Singh, K. K. (1989). The revised Gudjonsson blame attribution inventory. *Personality and Individual Differences, 10*(1), 67–70.
Hodge, J. E., & Renwick, S. J. (2002). Motivating mentally disordered offenders. In M. McMurran (Ed.), *Motivating offenders to change: A guide to enhancing engagement in therapy*. Chichester, West Sussex: Wiley.
Kassinove, H., & Tafrate, R. C. (2002). *Anger management: The complete treatment guidebook for practitioners*. Oakland, CA: Impact Publishers.
Knight, R. A., & Prentky, R. A. (1990). Classifying sexual offenders: The development and corroboration of taxonomic models. In W. L. Marshall, D. R. Laws, & H. B. Barbaree (Eds.), *Handbook of sexual assault: Issues, theories, and treatment of the offender* (pp. 23–52). New York: Plenum.
Maiuro, R. D., Cahn, T. S., Vitaliano, P. P., Wagner, B. C., & Zegree, J. B. (1988). Anger, hostility, and depression in domestically violent versus generally assaultive men and nonviolent control subjects. *Journal of Consulting and Clinical Psychology, 56*(1), 17–23.
Martinson, R. (1974). What works? Questions and answers about prison reform. *The Public Interest, 10,* 22–54.
Ministry of Justice (2013). *The factors associated with proven re-offending following release from prison: findings from Waves 1 to 3 of SPCR*. London, Ministry of Justice.
Ministry of Justice. (2015a). *Statistics on women and the criminal justice system 2015*. London: Ministry of Justice.
Ministry of Justice. (2015b). *Associations between being male or female and being sentenced to prison in England and Wales in 2015*. London: Ministry of Justice.
Ministry of Justice. (2016). *Black, Asian and minority ethnic disproportionality in the criminal justice system in England and Wales*. London: Ministry of Justice.
Ministry of Justice. (2017). *Impact evaluation of the prison-based Core Sex Offender Treatment Programme*. London: Ministry of Jusitce.
Mullen, P., Pathé, M., & Purcell, R. (2008). Stalking typologies and classifications. *Stalkers and their victims* (pp. 58–68). Cambridge: Cambridge University Press.
Nellis, A. (2016). *The color of justice: Racial and ethnic disparity in State prisons*. Washington DC: The Sentencing Project.
O'Leary, P., Day, A., Foster, G., & Chung, D. (2009). Resistant or ready? The challenges of male readiness for offender programs. In A. Day, P. O'Leary, D. Chung, & D. Justo (Eds.), *Integrated responses to domestic violence: Research and practice experiences in working with men*. NSW: Federation Press.
Ross, R. R., Fabiano, E. A., & Ewles, C. D. (1988). Reasoning and rehabilitation. *International Journal of Offender Therapy and Comparative Criminology, 32*, 29/35.
Trower, P., Jones, J., & Dryden, W. (2016). *Cognitive behavioural counselling in action* (3rd ed.). London: Sage.

Thomas-Peter, B. A. (2015). Structural violence in forensic psychiatry. In D. A. Crighton & G. J. Towl (Eds.), *Forensic psychology* (2nd ed.). Chichester, West Sussex: Wiley.

Ward, T. (2002). Good lives and the rehabilitation of sexual offenders: Promises and problems. *Aggression and Violent Behavior, 7,* 513–528.

Walen, S. R., DiGiuseppe, R., & Dryden, W. (1992). *A practitioner's guide to rational-emotive therapy* (2nd ed.). New York: Oxford University Press.

Wessler, R., & Wessler, R. L. (1980). *The principles and practice of rational-emotive therapy*. San Francisco: Jossey-Bass.

Winogron, W., Van Dieten, M., & Gauzas, L. (1997). *Controlling anger and learning to manage it*. Toronto: Multi Health Systems.

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