

CHAPTER 9

Rational Emotive Behavior Therapy (REBT) Theory and Practice

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Abstract

Rational emotive behavior therapy (REBT) is a cognitive-behavioral approach to case conceptualization and treatment. It was created by Albert Ellis and is centered on the idea that our cognitions (more specifically, irrational thinking) are a major determinant of emotional and behavioral distress with all three variables operating in concert to create and maintain disturbance. REBT promotes the use of a range of cognitive, emotive, and behavioral tools to help assess, scrutinize, and change unhelpful processes. It has been found to be effective with a broad spectrum of presenting concerns and is taught and practiced internationally.

Key words

Albert Ellis, cognitive-behavioral therapy, disputing, irrational beliefs, low frustration tolerance, rational emotive behavior therapy (REBT), self-acceptance

Introduction

People are disturbed not by things, but by the view they take of them.

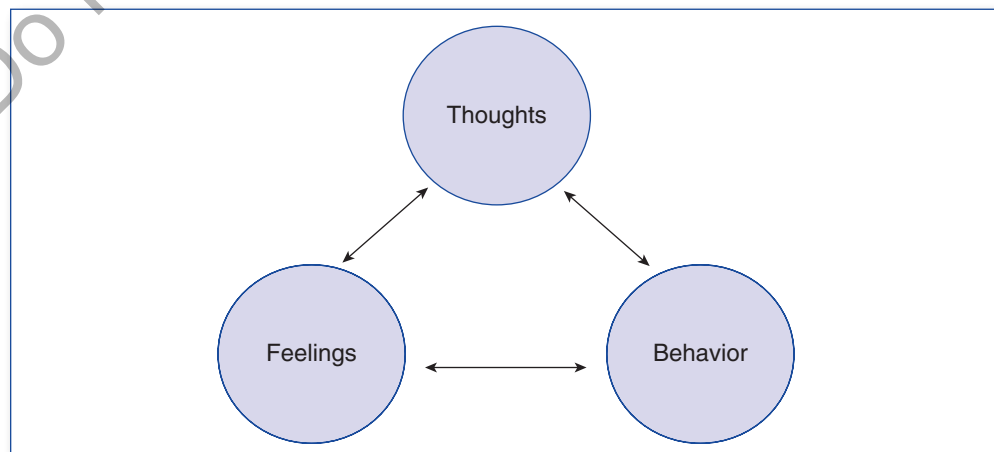
—Epictetus, Greek philosopher associated with the Stoics, 55–ca. 135

Rational emotive behavior therapy (REBT) is based on the premise that our cognitions, emotions, and behaviors are an integrated system and that when we are disturbed, it is because we think-feel-act in dysfunctional, self-defeating ways. Therefore, we are able to function more successfully, however we define that, by focusing on changing our thinking, feelings, and behaviors to be more aligned with how we want to operate in the world. This process of change is brought about through an active collaboration between the REBT therapist and client. The clinician collaborates with the client to identify, evaluate, and respond to dysfunctional thoughts and beliefs while introducing a variety of techniques to aid in changing thinking, feelings, and behaviors (Dryden & Ellis, 2001).

For example, Jon “freaks out” when faced with social gatherings. The level of anticipatory anxiety he experiences often leads him to avoid them. The more he avoids such gatherings, the harder it is for him to get himself to go out. This avoidance creates disruptions that he views as problematic in his friendships and romantic relationships. He also doesn’t like how he thinks and feels about himself for his increasing avoidance and anxiety. To attain his stated goal of “going out even when I don’t feel like it,” so that he is less uncomfortable when going out, reaps the benefits of engaging in social activities, and becomes more accepting of himself, the therapist will help Jon address thoughts, feelings, his primary behavior of avoidance, and the interplay among the three systems (Figure 9.1). The core theoretical elements and the therapeutic processes for addressing these three systems are described in more detail later in the chapter. We then discuss the evidence base for REBT, how it incorporates common factors in psychotherapy, and its use in specialized situations.

Historical Introduction

FIGURE 9.1 Interplay of Thoughts, Feelings, and Behaviors



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REBT was developed by Albert Ellis, who is considered the grandfather of cognitive-behavioral therapy (CBT). REBT was probably the first formal system in the CBT genre (Hollon & DiGiuseppe, 2010). Ellis was a central figure in articulating and emphasizing the primacy of cognitions and shifting psychotherapy in this direction. CBT is an umbrella term used to describe several approaches to psychotherapy, many of which are detailed in this book, with some basic commonalities. Foremost among these are three fundamental assumptions:

- Cognitions are one of the most important determinants of human emotion and behavior;
- cognitive activity may be monitored and altered; and
- desired behavioral and emotional changes may be made through changing cognitions (Dobson & Dozois, 2001; Ronen, 2007).

Ellis was instrumental in transforming psychotherapy into what he considered to be a more effective, efficient approach to helping people by focusing on relationships and the interplay among people's cognitions, emotions, and behaviors (Ellis, 1957).

By his own account, Ellis began his career in the helping professions in the early 1940s and developed an early interest in the problems of romantic and sexual relationships (Ellis, 2009). He started the LAMP (Love and Marriage Problems) nonprofit center to provide advice on these issues and discovered that he was able to help those who sought his assistance quite quickly. When he found that no formal training was available at the time related to relationship counseling, he decided to pursue a doctoral degree in clinical psychology and subsequently trained as a psychoanalyst at the Karen Horney school. By the early 1950s, Ellis had two distinct practices. One practice focused on helping clients with relationship and sexual problems by using a more active, directive, and psychoeducational model informed by his lifelong study of philosophy. He concurrently maintained a more traditional psychoanalytic practice. Ellis became increasingly discouraged with what he considered to be the slow pace of psychoanalysis. He believed that he helped clients in his marital and sex therapy practice more thoroughly and quickly than he did with psychoanalysis, by encouraging them to scrutinize their thinking (Ellis & Dryden, 1987). Initially, Ellis thought that he might need to dig deeper into his clients' pasts before they would relinquish their disturbances. Yet he found that even after clients gained insight into the origin of their disturbances, many still failed to improve. Ellis concluded that insight alone led to change in only a small percentage of individuals.

Ellis recognized that he interacted differently with clients in his marital and sex therapy practice by actively teaching those clients to change their attitudes. His ongoing interest in philosophy had led him to read the works of the great Asian and Greek thinkers, including Gautama Buddha, Confucius, Lao-Tzu, Marcus Aurelius, Epicurus, and Epictetus. He realized that they had seen what psychoanalysts and behaviorists ignored, that we contribute greatly to our own dysfunction through our unhelpful thinking. When freed from the constraining psychoanalytic role, he asked questions and advised his clients based on these philosophical works. Ellis contemplated the



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Stoic philosophers' notion that people could choose whether to become disturbed or, in the words of Epictetus (90 B.C.E./1865), "Men are not disturbed by things, but by the view which they take of them" (from the *Enchiridion*). He used philosophy as the foundation for his new therapy and always credited classical and modern philosophers as the source of his ideas. In 1955, Ellis articulated his new psychotherapy theory in a paper delivered at the annual convention of the American Psychological Association.

The theory and approach was originally named *rational therapy* because of the specific focus on cognitions. Ellis later recognized that this title underemphasized the important role of emotions in the system and renamed it *rational emotive therapy*. Ultimately, the name was changed to *rational emotive behavior therapy* (Ellis, 1994) at the urging of Ellis's longtime friend and colleague, Ray Corsini. While Corsini was revising his classic psychotherapy textbook (Corsini, 1994), he noticed that REBT therapy sessions often included behavioral interventions and homework assignments. To accurately capture the elements of the approach, Corsini strongly encouraged Ellis to rename the therapy to reflect all of the elements of what was practiced. Ellis died in July 2007 at age 93, and his profound professional contributions to the field of psychotherapy and CBT live on through ongoing REBT practice, research, training, and education.

Core Theory of REBT

As mentioned earlier, REBT has strong philosophical underpinnings. Disturbance is viewed largely (but not completely) as a function of our perceptions, evaluations, and attitudes regarding life events, which are components of our personal philosophies.

Basic Theoretical Principles

The fundamental ideas of REBT theory can be condensed into seven basic principles:

1. Cognition is the most important determinant of human emotion and emotional disturbance. REBT posits that people feel what they think. Past, present, or anticipated future events and other people may serve as triggers but do not inherently *make* us "feel good" or "feel bad." We create those feelings ourselves, although we are not always conscious of doing so. Two people can be in the same situation but have very different reactions based on how they perceive and what they tell themselves about the situation. All of us have seen this happen. Consider the wide range of reactions people have when stuck in unexpected traffic. It is the way we look at a situation and the meaning we give it that are the most direct sources of human emotional responses.



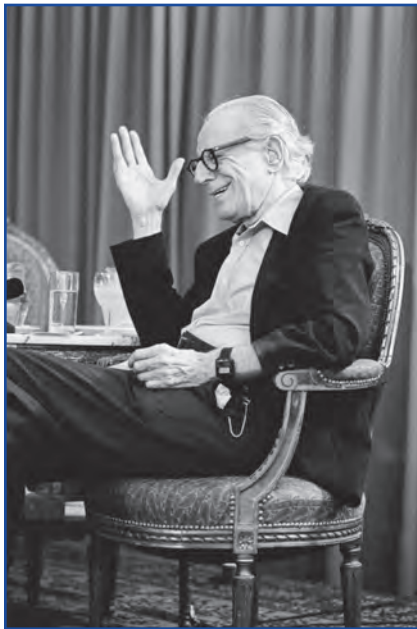
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Albert Ellis Conducting Psychoanalysis at Age 37 in 1950

2. Irrational beliefs are a major determinant of emotional and behavioral distress or disturbance. Dysfunctional negative emotional states and other aspects of psychopathology result from irrational belief processes, which can be characterized by exaggeration, oversimplification, overgeneralization, unexamined illogical assumptions, and faulty deductions, but mostly from absolutistic ideas as well as demands that reality should or should not exist.
3. The most effective way to change dysfunctional disturbed emotions and behaviors begins with an analysis of our thoughts. If unhealthy distress is a product of irrational beliefs, then the best way to conquer it is to identify and change these beliefs.
4. Multiple factors, including past experiences, genetics, and environmental influences, are antecedents to creating and holding irrational beliefs and psychopathology. Ellis proposed that humans have a natural predisposition to think both rationally and irrationally (Ellis, 1976, 1985, 1994). Evidence for the global, species-wide tendency for humans to think irrationally receives support from the ubiquity of irrational beliefs. One's culture, background, or genetic tendencies furnish the specific content of these beliefs.
5. Healthy negative emotions are a crucial human experience. Emotions signal the existence of a problem that requires attention and action. Unlike most theories of psychotherapy, REBT distinguishes between two different types of negative emotions: rational negative emotions that are helpful, healthy, functional, and adaptive, and irrational negative emotions that are unhelpful, unhealthy, dysfunctional, and maladaptive for the individual. Most often, people experience healthy and unhealthy emotions together, although they can be unaware of the mixture. The healthy negative emotions lead to functional, adaptive behavior, and the unhealthy negative emotions result in dysfunctional, maladaptive behavior. The distinction between the two sets of emotions is essential and suggests that clinicians direct interventions for change to the unhealthy, maladaptive negative emotions while working to reinforce the healthy, adaptive emotions. These unhealthy emotions (and maladaptive behaviors) result from irrational beliefs, whereas the adaptive negative emotions result from rational beliefs.
6. Like the other cognitive psychotherapies in this section and the theories focusing on client actions, REBT emphasizes *present influences* on emotions and behavior rather than *historical influences* on beliefs, emotions, and behavior. REBT posits that although heredity and environmental conditions influence the acquisition of psychopathology, they are not the primary focus in understanding its current maintenance and continuation. People maintain their disturbance by continued self-indoctrination or self-rehearsal of their beliefs. The rehearsal and continued adherence to irrational beliefs, not how they were acquired, leads to the present emotional distress. Thus, if individuals reevaluate their former thinking and change it in the present, their current functioning will also change. Negative historical events can lead to disturbance because a person may have learned to think irrationally about those events and has actively rehearsed those thoughts over time. Ellis often attributed a quote to Sigmund Freud (1965) concerning this point: "The past is only important because you continue to carry it around with you." However, you don't have to understand where past problems came from to actively work to change them in the present. Clients can waste years

trying to pinpoint the event or moment in time when their disturbance began without making any positive changes in the present.

7. Although beliefs can be changed, this change is not easy. Irrational beliefs change to rational beliefs by active and persistent efforts to recognize, examine, and revise one's thinking, as well as efforts to feel and behave counter to the irrational beliefs. Therapy works to reduce, but not eliminate, emotional disturbance and to increase positive experiences and the achievement of one's personal goals. The process requires some trial and error and lots of practice!



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Albert Ellis Discussing REBT in His Eighties

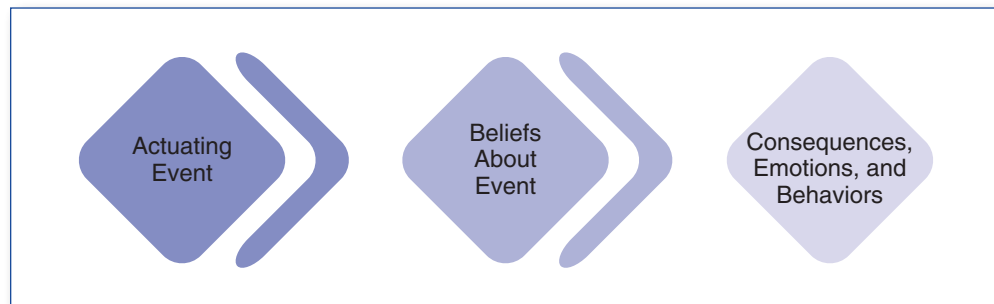
The ABC(DE) Model of Disturbance

REBT was the first to formulate the famous ABC model in case conceptualization of disturbance. Ellis (1962) identified the A as the *activating event* (or *adversity*), which is usually an actual or perceived obnoxious or unfortunate trigger. The C represents the dysfunctional and unhealthy emotional and behavioral *consequences* (see Figure 9.2). The B is the client's *beliefs*. Beliefs consist of two parts: rational and irrational beliefs. It is the presence of irrational beliefs and the absence or weak endorsement of rational beliefs that are the focus in REBT.

Rational beliefs are helpful, flexible, adaptive, and consistent with social reality; they help us reach our goals; and they have functional outcomes (healthy feelings and adaptive behaviors). They are our wants, preferences, and desires. Irrational beliefs, by contrast, are rigid, dogmatic, inflexible, unhelpful, maladaptive, and inconsistent with social reality, and they usually get in the way of goal attainment. They are our demands (our shoulds, needs, and musts), and they have dysfunctional outcomes (unhealthy feelings and maladaptive behaviors). Figure 9.3 shows how rational versus irrational beliefs lead to different consequences.

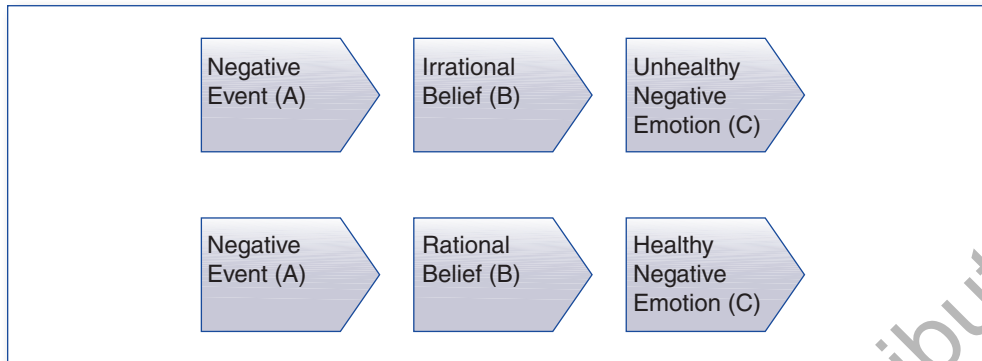
REBT emphasizes the importance of helping to create and support clients' rational beliefs so as to influence the emotional and behavioral consequences in a more helpful direction. Wanting what we want is always okay because as long as it remains a desire, then we have flexibility around how we

FIGURE 9.2 The ABC Model of Disturbance



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FIGURE 9.3 Consequences of Rational Versus Irrational Beliefs



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manage ourselves when we don't get what we want. In those situations, we are more likely to respond effectively. However, as soon as we turn our preference into a *need*—unless it is food, shelter, or clothing, which we do need to survive—then we have very little flexibility around how we manage ourselves when we don't get to have it. If I believe strongly (and irrationally) that I *need* it and I can't have it, then it really is a life-threatening catastrophe and I will react accordingly. One of the points that REBT makes with clients is that even when they are in their most dysfunctionally upset state, their reactions make perfect sense *based on what they're telling themselves about the situation*. The question becomes whether what they're telling themselves is rational when scrutinized and tested. This is done through *disputation* (D), a form of challenging one's beliefs. After disputation, the goal is to assist clients in internalizing with deep conviction the new cognitive, emotional, and behavioral consequences of the rational view. This is what we call the new *effects* (E) in the ABC(DE) model.

Ellis (1996a) suggested that three of the basic human demands (irrational beliefs) that tend to fuel a great deal of dysfunction are variations of the following:

- I absolutely must perform well and be approved of by (significant) others, or I am an inadequate and worthless person. (self-demandingness)
- Other people absolutely must treat me fairly and considerately, or they're rotten individuals. (other-demandingness)
- Conditions under which I live absolutely must be comfortable and must not be painful or frustrating, and when they're not comfortable, it's awful, I can't stand it, and the world's a rotten place. (world-demandingness)

Essentially, four primary types of irrational beliefs contribute to disturbance: demandingness beliefs, awfulizing or catastrophizing beliefs, discomfort intolerance beliefs, and self- and other-downing beliefs. Demandingness and catastrophizing beliefs are primary. Discomfort intolerance beliefs and self- and other-downing beliefs are secondary in the sense that they are derived from demandingness (Dryden, 2012).

If we refer back to the case of Jon, the activating event (A) is anticipation of a social gathering and the irrational consequences (C) are the emotion of anxiety and the

behavior of avoidance. Jon's prevailing beliefs (B) about the anticipated social gathering are that he will be awkward and disliked, which will (irrationally) prove he's a loser and be terrible and embarrassingly awful to the point where he won't be able to stand it. We begin to see versions of the first and last demands listed above in the way Jon interprets and evaluates his situation. Jon also has rational beliefs about his social anxiety, which is part of the reason he's come to counseling. These rational beliefs include that he wants to be able to function in social situations and that he would be better off just doing it and seeing how it goes. However, these reasonable beliefs are not nearly as strong as the irrational beliefs that going to social gatherings will prove he's a loser and be terrible and awful and therefore should be avoided.

REBT Values and Goals

The writings of REBT include a theory of psychopathology, a theory of psychotherapy, and a personal philosophy. As mentioned previously, Ellis's incorporation of philosophy left its mark on REBT and the theory supporting it. Nowhere is this more obvious than in the values espoused by REBT and the influence of these values on what the theory posits as adaptive and maladaptive. The goals of REBT, which are to minimize dysfunctional distress and enhance satisfaction, functioning, resilience under duress, goal attainment, and joy in the process of living, are consistent with those values. Ellis and Bernard (1986) outlined the twelve basic REBT values that represent the overarching goals of the approach:

- *Self-interest.* Emotionally healthy people put their own interests at least a little above the interests of others. They will sacrifice their goals to some degree for those for whom they care, but not completely.
- *Social interest.* Most people choose to live in social groups comfortably and happily. Therefore, they would be wise to act morally, protect the rights of others, and aid in the survival of the social group in which they live.
- *Self-direction.* Although humans would do well to cooperate with others, it is best for us to assume primary responsibility for our lives rather than to demand that others take care of or provide for us.
- *Tolerance.* Human adjustment and social cohesion are encouraged and helped by allowing oneself and others the right to be wrong or different. It is appropriate to dislike and discourage obnoxious behavior or others who infringe on the rights of others. However, it is unnecessary to damn the person for doing it.
- *Flexibility.* Healthy individuals think and act flexibly. Rigid, biased, and invariant rules lead to disturbance.
- *Acceptance of uncertainty.* We live in a world of probability and chance; absolute certainties do not exist. Healthy individuals strive for a degree of order but recognize that complete predictability and security are unattainable.
- *Commitment.* Most people are happier when vitally absorbed in something outside themselves. At least one strong creative interest and some significant interpersonal involvement seem to provide structure for a happy life existence.
- *Risk-taking.* Emotionally healthy people take risks and have a spirit of adventurousness in pursuing what they want, without being foolhardy.

- *Realistic expectations.* People are unlikely to get everything they want or to avoid everything they find painful. Healthy people strive for the attainable and not for unrealistic perfection.
- *Self-responsibility.* Rather than blaming others, the world, or fate for their distress, healthy people accept responsibility for their own thoughts, feelings, and behaviors.
- *High frustration tolerance.* REBT defines frustration tolerance as the ability a person has to preserve equanimity and persevere when faced with perceived obstacles because it is in their best interests to do so. It is central to the theory and practice of REBT (Harrington, 2011). Paraphrasing Reinhold Niebuhr and Alcoholics Anonymous, healthy people recognize that they are likely to encounter only two sorts of problems: those they can do something about and those they cannot. The goal is to modify the obnoxious conditions we can change, and learn to tolerate those we cannot change. Low frustration tolerance (LFT) is the inability to do this. It is also referred to as discomfort anxiety or “short-term hedonism.” LFT often results in immediate pleasure-seeking or avoidance of a perceived obstacle or difficulty. Procrastination, which most of us have engaged in, is a classic example of LFT. Common self-statements associated with LFT are “it’s too hard,” “things should be easier,” “I can’t stand it,” “it’s not fair,” and others. High frustration tolerance (HFT) is accepting, but not necessarily liking, the reality of what is and choosing to persevere in the service of long-term goals because it’s in our best interests. Helping clients increase their frustration tolerance is often a therapeutic goal in REBT.
- *Unconditional self-acceptance.* Healthy people freely accept themselves unconditionally, rather than measuring, rating, or trying to prove themselves. Many people’s tendencies are to give themselves and others positive ratings when they do well. Inevitably then, the opposite is true. When we or others do poorly, we tend to give ourselves or others negative ratings. The problem is in rating the entire self rather than the behavior. We learn and practice that there are behaviors that make us “bad” and behaviors that make us “good.” You can hear this idea reinforced any time a parent tells a child that he or she is a “good[/bad] boy[/girl],” depending on what the child just did. REBT strongly encourages and teaches unconditional self-acceptance and unconditional other acceptance.

Unconditional self-acceptance posits that we all have worth by virtue of our very existence and that worth does not fluctuate, no matter what. I may do things that are positive and negative, and it is fine to rate those behaviors. However, if I rate my entire self as “good” or “bad” based on how I operate in the world, then I am setting up myself to fail. After all, no matter who I am, I won’t be able to maintain my “goodness” indefinitely, and if I’m “bad,” I really give myself only one option for how to behave. It is a myth that guilt makes us behave better. REBT defines guilt as “not only did I do badly, but I am a bad person.” In this way, guilt contributes to patterns of continued bad behavior. Appropriate regret, by contrast, allows us to maintain our worth, while evaluating how we behaved, not liking it, and making a different choice next time because we leave ourselves the option to do so. Clients sometimes find it counterintuitive that they stand a much better chance of effecting positive change or making reasonable decisions if they accept themselves, others, and the world exactly as they are.

We refer to these values as “responsible hedonism” (DiGiuseppe, Doyle, Dryden, & Backx, 2014). These values and goals represent the foundation of several aspects of REBT. They contribute to the ABC model that seeks to help people successfully navigate adverse situations. They support the idea that cognitive and behavioral inflexibility represents the nature of disturbance and demonstrate the role of demandingness as the core irrational belief. They support the idea of unconditional self-acceptance as an important cognitive target outcome of REBT. In addition, they support the idea of “other acceptance” in avoiding conflict and aggression. They set the groundwork for an REBT of positive psychology in the sense that they encourage maximum satisfaction through alleviating or decreasing upset over the things we cannot or choose not to change and promoting focus on those areas that allow us satisfaction, enjoyment, and senses of achievement and belonging, keeping in mind that long-term goals often require effort and perseverance.

Most things that will bring joy and a sense of accomplishment require some practice or work. Attaining competency in a sport, an art, a professional endeavor, or another activity usually requires time, energy, and effort. REBT helps clients to engage in positive activities that help them work toward their goals and to decrease thinking, behaving, and feeling that blocks their practicing or engaging in those activities. It has been our clinical experience that often frustration intolerance beliefs block attaining self-growth; “no pain, no gain,” as the saying goes. REBT aims to help clients strive to live consistently with their own values and maximize their strengths so as to reach their identified goals that bring satisfaction, a sense of competency, and opportunities for joy.

Levels of Cognitions and Disturbance

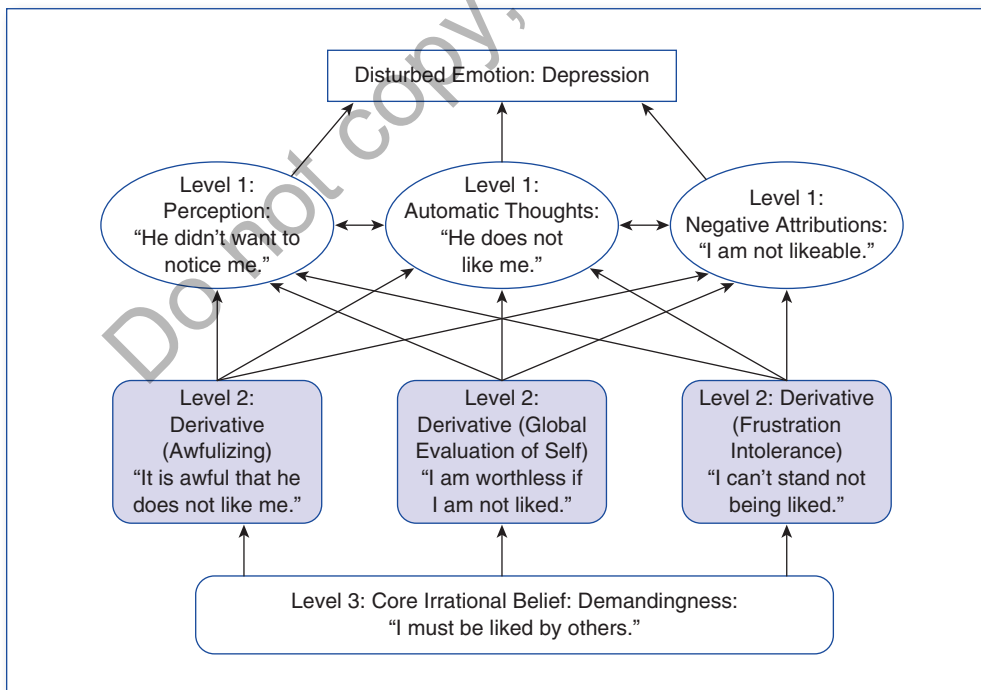
REBT proposes that at least three levels of cognitions lead to emotional arousal and disturbance (see Figure 9.4). The first level of thoughts that occurs immediately is what William James (1890/1950) referred to as the stream of consciousness. Most people have what amounts to a consistent monologue going on in their heads throughout their waking hours. These initial, first-level cognitions are inferential in nature. All humans have their own, unique perceptions of reality. Inferential cognitions are the conclusions one draws from these perceptions. For example, suppose you are walking down the street and see a coworker approaching on the other side of the street. You wave your hand in greeting, but your gesture is not returned. You might infer from this event that your coworker didn't see you. Or, you might infer that your coworker saw you and decided not to greet you. You could go even further and infer that the absence of a greeting has some interpersonal meaning; perhaps the coworker is upset or angry with you, he or she does not like you, or no one at work likes you. Many of these cognitions may be incorrect inferences, which can take the form of negative perceptions (e.g., “He doesn't like me.”). These inferences can be tested by collecting evidence for and against your conclusions to determine if they are true. Many of these inferential cognitive constructs have been associated with emotional disturbance and psychopathology (Beck, 2005).

The second-level cognitions are largely evaluative and are referred to in REBT as derivative irrational beliefs: These are awfulizing; global evaluation of self, other, or world; and frustration intolerance. REBT recognizes that these evaluative cognitions are more central to emotional disturbance than are first-level inferential cognitions. The first-level inferential cognitions are correlated with psychopathology not because they are causative, but because most disturbed people also hold these deeper levels of beliefs

that evaluate and give importance to the first-level inferences, making them more significant in the development of emotional disturbance. The three types of second-level beliefs evaluate the significance of the possible reality portrayed in the inference, the worth of the persons involved if the inference is true, or one's appraisal of one's ability to cope with or tolerate the perceived situation. Awfulizing is an exaggeration of the negative consequences of a situation to an extreme degree, so that an unfortunate occurrence becomes "terrible." Global evaluations of human worth, either of the self or others, imply that human beings can be rated as entire beings, and that some people are worthless, or at least less valuable than others. Frustration intolerance (also known as low frustration tolerance) stems from demands for ease and comfort, and reflects an intolerance of discomfort. We call these beliefs derivatives because REBT posits that they are psychologically deduced from the more core schematic irrational beliefs.

According to REBT, the third level of cognition is referred to as schematic demands or our core irrational beliefs. These are tacit, sometimes unconscious, broad-based schemas. Many REBT and CBT therapists use the term *unconscious* to mean thoughts or beliefs that are out of our awareness, though they can be accessed. Irrational beliefs are derived from the more central imperative demands, which are thoughts about the way reality should be. With these thoughts, people construct a philosophy about the world as they want it to be, not necessarily as it is. REBT posits that rigid thinking and the inability to accommodate to new information is the foundation of emotional disturbance. REBT

FIGURE 9.4 The Three Levels of Cognitions Influencing Emotional Disturbance



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also maintains that the ability to be cognitively flexible, to adapt to new situations, and to incorporate new information into personal schemas represents the core of psychological adjustment.

Schemas help people organize their world and influence aspects of thought such as (a) the information to which a person attends, (b) the perceptions a person is likely to draw from sensory data, (c) the inferences or automatic thoughts a person is likely to conclude from the data he or she perceives, (d) the belief a person has in his or her ability to complete tasks, (e) the evaluations a person makes of the actual or perceived world, and (f) the solutions that a person is likely to conceive to solve problems. Irrational demandingness beliefs or schemas influence other hypothetical cognitive constructs that are mentioned in other forms of CBT, such as perceptions, inferences, or negative automatic thoughts, and global, internal attributions of cause. Thus, REBT proposes that the demandingness beliefs are the cause of the other dysfunctional thoughts such as negative automatic thoughts, erroneous attributions, and overly negative evaluations.

The discrimination among inferential cognitions, evaluative cognitions, and imperative or schematic cognitions (irrational beliefs) sets REBT apart from other forms of CBT. REBT acknowledges the importance of inferential processes and might use techniques to change these distorted cognitions. However, REBT focuses more on the second- and third-level cognitions. According to REBT, even if you think negative automatic thoughts, you can protect yourself from emotional disturbance about such potential realities if you think about them rationally and give up the demand that such events must not happen.

Let us look at another example. Suppose you get up to give a speech in front of a group of colleagues and you experience tremendous anxiety. You observe one person yawning and a few others looking around the room. You then draw inferences: “Maybe they don’t like what I have to say. They think that I’m boring.” Those beliefs could be true or false, but it is the evaluation of their possible truth that is the focus in REBT. According to REBT, the negative automatic thought (“They don’t like what I have to say”) or the belief in a lack of effectiveness (“I’m boring them”) are not sufficient to directly produce emotional disturbance. Disturbance, in REBT, arises when you evaluate these inferences as horrors or catastrophes or rate yourself entirely because of them. Your more central evaluative beliefs may be something like the following:

- “I must please them and earn their approval.” (demandingness and need for approval)
- “If I bore them, I am a worthless, boring person.” (global ratings of worth)
- “It is awful that people think of me as a boring presenter!” (awfulizing or catastrophizing)

A model of irrational beliefs is shown in Table 9.1. On the horizontal dimension are types of irrational processes and on the vertical dimension are the content about which the person thinks irrationally. This grid leads to hypotheses concerning which irrational beliefs are most involved in specific disorders. For example, irrational global ratings of the self most likely play a major role in depression, whereas irrational global ratings of others could lead to anger and contempt. Irrational beliefs about comfort with our emotional experiences have been proposed to play a prominent role in agoraphobia (Burgess, 1990). Awfulizing beliefs lead to anxiety. Frustration intolerance irrational beliefs have been considered to be a crucial factor leading to addictive behaviors (DiGiuseppe & McNerney, 1990).

TABLE 9.1 Model of Irrational Beliefs

Irrational Process						
Belief Content		Demandingness	Frustration intolerance (FI)	Awfulizing	Self-worth ratings	Other-worth ratings
	Social relationships	Demanding about affiliation	FI about affiliation	Awfulizing about affiliation	Self-condemning about affiliation	Other-condemning about affiliation
	Achievement	Demanding about achievement	FI about achievement	Awfulizing about achievement	Self-condemning about achievement	Other-condemning about achievement
	Comfort	Demanding about comfort	FI about comfort	Awfulizing about comfort	Self-condemning about comfort	Other-condemning about comfort
	Fairness	Demanding about fairness	FI about fairness	Awfulizing about fairness	Self-condemning about fairness	Other-condemning about fairness

REBT Theory of Emotions

As noted previously, REBT makes a theoretical distinction between unhealthily disturbed and dysfunctional emotions and healthy, adaptive, functional negative emotions. Because REBT is based so strongly on Stoic philosophy, and because Stoic philosophy is often misrepresented to mean unemotional, Ellis included this distinction in the theory. Adaptive functioning and successful psychotherapy do not eliminate negative emotions.

Many psychotherapists conceptualize therapeutic improvement as a *quantitative* shift in the emotion. According to this model, emotions differ along a continuum of their intensity of physiological arousal and phenomenological experience and the more intense they are, the more dysfunctional. Often psychotherapists ask clients to rate their emotions on the Subjective Units of Distress Scale (SUDS) developed by Wolpe (1990) or something similar. Psychotherapy is deemed successful if the rating shows a lower score, representing a less intense experience of the emotion.

Ellis (1994; Ellis & DiGiuseppe, 1993) proposed a different conceptualization in which emotions have two separate continua, one for the disturbed emotion and another for the nondisturbed emotion. When people access rational beliefs instead of irrational ones, they actually experience a qualitatively different emotion that differs in strength. The emotions generated by rational beliefs remain in the same family of emotions as the unhealthy disturbed emotion (e.g., sadness versus depression). However, they differ in many aspects, such as phenomenological experience, social expression, problem-solving ability, and the behaviors they generate. Ellis posited that irrational thinking leads to depression, dysfunctional anger, guilt, or anxiety; rational thinking leads to sadness, annoyance, regret, and concern or remorse, respectively (see Table 9.2).

REBT therapists (DiGiuseppe & Tafrate, 2007) believe that clients can learn adaptive emotional scripts, not just to change the intensity of their feelings, but also to change the quality and consequences of the feelings. REBT therapists use words carefully to describe healthy, adaptive, functional emotions and to help clients choose which emotions they could feel in place of their maladaptive, dysfunctional, disturbed emotions.

TABLE 9.2 Emotions Resulting From Irrational and Rational Beliefs

Irrational		Rational
Depression	vs.	Sadness
Anger	vs.	Frustration/annoyance
Guilt	vs.	Remorse
Anxiety	vs.	Concern

Dryden (2008) suggested further that there is some accuracy to both the more traditional model of intense disturbed emotions and Ellis’s notion of two separate levels of emotional intensity. Dryden noted that very intense sympathetic physiologic arousal (regardless of whether it is a functional negative emotion or a dysfunctional negative emotion) causes cognitive constriction. Continued arousal leads you to focus more on the topic about which you are experiencing the emotion(s). This restriction of focus gets in the way of your problem-solving abilities. Perhaps a functional, adaptive emotion can be only so strong before the sympathetic arousal of the emotion results in restricted concentration and leads to dysfunctional reactions. In Dryden’s revised model, intense rational emotional reactions can also lead to decreased problem-solving abilities and possibly dysfunctional reactions. However, disturbed emotions that result from irrational beliefs are still disturbed even when they are of low intensity. Consider the Yerkes-Dodson (1908) law. The Yerkes-Dodson law holds that a certain amount of arousal toward something will help you succeed, but if the arousal reaches too high a point, it begins to impede performance. So if you want to do well on a test, you had best be concerned about studying. However, there comes a point at which, if your appropriate concern about doing well on the test becomes a self-imposed “need,” it will create high levels of sympathetic physiologic arousal that may interfere with your performance and lead to dysfunctional attention, problem solving, and adaptive performance skills. Essentially, you will shoot yourself in the foot. So instead of studying well for the test and being prepared,

TABLE 9.3 A Comparison of Wolpe’s, Ellis’s, and Dryden’s Models of Emotional Intensity

	Wolpe’s SUDS/Traditional Model
Functional	0-----100 Dysfunctional
	REBT Model
Functional	0-----100
Dysfunctional	0-----100
	Dryden’s revised REBT Model
Functional	0-----50/75 → Possibly dysfunctional
Dysfunctional	0-----100

you may start staying up all night “cramming” and consuming a great deal of caffeine, which ultimately will have a negative impact on your performance. Table 9.3 displays Wolpe’s traditional model of emotions, Ellis’s theory, and Dryden’s proposed revision.

REBT Therapeutic Process

REBT employs a variety of techniques to help clients identify and achieve their goals. It is an active-directive approach that is client driven and begins with a general assessment of the presenting concern(s) and related history. REBT is a psychoeducational approach, and practitioners are transparent about the theory and interventions. The goal is for clients to learn to successfully identify and address irrational thinking, feeling, and behaving on their own. REBT therapists strive not just to help clients feel better, but also to become better. Getting better entails feeling better, continuing to feel better, being much less likely to disturb themselves, and being able to generalize the skills to other situations as needed (Ellis, 2001). Interventions are cognitive, behavioral, and emotive in focus and chosen for use with a particular client based on an array of factors, including the client’s past change experiences, preferred learning styles, motivation for change, and stated goals (Ellis & MacLaren, 2005). REBT therapists incorporate hundreds of different strategies into their practices, all with the purpose of helping clients identify, evaluate, and change their thinking, feeling, and behaving in positive ways. One shoe does not fit all, and some interventions will fall flat with some clients whereas others will be successful. This is why it is so important for therapists to be knowledgeable and comfortable with a variety of approaches so that they have other options if their “go to” strategies don’t work with particular clients. The next section describes some classic REBT therapeutic techniques.

Psychoeducation

One of the first things we do is explain and discuss the REBT theory of emotional and behavioral disturbance and make sure clients are on board with the idea that they have a role in maintaining their dysfunctional thoughts, emotions, and behaviors. Generally, REBT therapists explain the ABC model to their clients. For many clients, the idea that, although they may have little control over many aspects of their lives, they can control their reactions is appealing and even empowering. For others, especially those who have a long-standing habit of blaming others, their past, or circumstances for their misery or bad behavior, this can be an uncomfortable concept. That being said, there isn’t much else an REBT clinician can do to help a client until he or she is satisfied that the client is willing, at least experimentally, to work within the ABC framework. And although REBT is an efficient model, this first phase may take time and a variety of approaches. Educating the client about REBT may continue to require attention throughout counseling. A variety of REBT books, worksheets with REBT self-help forms, lectures, videos, and other resources are used to supplement and enhance ongoing client education.

Goal Identification

Goal identification and setting is also an important element of the REBT therapeutic approach, not just at the beginning of the counseling relationship but throughout. We

focus on articulating short- and long-term goals and helping the client assess the compatibility between the two. Specificity in identifying goals provides clarity for next steps. For example, if a client reports that she'd like to be "happier," we won't really be able to help that client until we have a thorough understanding of the thoughts, feelings, and behaviors that may be getting in the way and what the client would like to change that would serve the longer-term goal. Dryden, DiGiuseppe, and Neenan (2003) cautioned the REBT therapist, when engaged in goal-setting with clients, to question goals that indicate clients want to feel neutral or positive about negative events or if they report a desire to feel less dysfunctionally upset. These are likely not reasonable or attainable goals. As mentioned previously, REBT does not suggest an absence of negative emotions but rather functional negative emotions because it is important that we know when things aren't going the way we want them to.

A crucial distinction is made in REBT between the *practical solution* and the *elegant solution*. Clients often want to change the activating event. They want their partners to be more helpful, their jobs to be less stressful, their siblings to be easier to get along with, their chronic medical conditions to go away, or the world to change in some other way so that they can be less upset or inconvenienced. This is the practical solution, which may, in some cases, be appropriate and achievable depending on the situation. However, REBT's goal is to help the client with the elegant solution of changing one's core irrational beliefs and emotive and behavioral reactions to the activating event. The beauty of the elegant solution is threefold: (a) A practical solution may not exist, (b) problem solving to achieve a practical solution is more effective when the client is not irrationally disturbed, and (c) the elegant solution arms the client with a successful response to a potentially activating situation so that he or she is less likely to be derailed by the situation.

A primary reason REBT focuses on core irrational beliefs rather than questioning clients' perceptions of situations (which is a distinction between REBT and other CBT approaches) is so that clients are prepared, regardless of whether or not their perceptions and inferences are accurate. For example, if our client Shana reports that her friend Lucy has not been returning her texts and perceives that it means Lucy is angry with her, we could question Shana's perception and explore alternative explanations for Lucy's behavior. Shana may even walk away from counseling convinced that she has misperceived the situation, believing that Lucy is not angry with her and feeling better about it. However, if it turns out that Lucy really is angry at Shana, we have not adequately helped her prepare for this possibility by addressing the deeper issue of what it means to Shana if Lucy is angry at her and identifying the rational and irrational beliefs involved. Helping Shana to effectively cognitively, emotively, and behaviorally manage even her worst-case scenario is REBT's elegant solution.

ABC Assessment

Once the goals have been established tentatively and the client understands and adopts the ABC model, we begin to systematically identify beliefs that are causing emotional and behavioral consequences for the client. Generally speaking, most clients don't come into counseling, at least not initially, presenting their irrational beliefs. They are most likely to present consequences or activating events. It becomes the REBT therapist's role to help clients map out the ABC process that they create for themselves.

If a client presents a consequence, then we ask for the activating event and vice versa. Once we have assessed a specific activating event and consequences, we then identify the belief(s). Many counselors who are less skilled with the REBT approach will continue to collect activating events and consequences rather than moving to the beliefs. Those therapists end up with a good description of what's going on for the client, but not an explanation of what can be changed.

Most people, when they describe their reactions, will attribute their consequences to the activating event. For example, it is not uncommon to hear people say, "he made me really angry" or "that causes me to be depressed." When they begin counseling, many REBT clients are introduced for the first time to the idea that they play a large role in creating their reactions. REBT counselors make sure to reinforce this in the way they phrase comments and questions. For example, if a client says, "She made me feel guilty," we are likely to respond with some variation of, "How did you *make yourself* feel guilty about your interaction with her?"

Assessment of beliefs is accomplished through *inference chaining* and *conjunctive phrasing*. Inference chaining is a technique whereby inferences are linked to determine which triggers the client's irrational beliefs. Conjunctive phrasing is another technique to assist clients in uncovering their irrational beliefs by completing the statements that contain them. For example, if a client says, "I might not pass the exam . . .," the therapist could respond with "and if you don't . . ." or "and that would mean . . .," to which the client might reply with an irrational belief such as "I'm a failure." REBT therapists are concerned with drilling down from automatic and inferential thoughts to the core irrational beliefs that are likely the cause of the dysfunctional upset. Clients are generally much more aware of their inferential thoughts about triggers but can be helped to dig deeper. This conversation can also help reiterate points made earlier about irrational and rational beliefs and their consequences. Clients may present what sound like rational beliefs because of the words they use to describe what they're thinking. Thus, REBT counselors work rigorously with their clients to understand their terms and experiences. When clients, for example, report that they feel "guilty," the REBT therapist cannot assume this is an irrational emotion. It may be a functional response that is more aligned with appropriate regret rather than globally self-downing. More discussion is required to clarify the quality and consequences of the emotion for the client. Through this process, the rationality or irrationality of the emotion will become evident.

Let's go back to the case of Jon and his social anxiety for an example of inference chaining.

Therapist: When you think about attending a social gathering, what do you get yourself anxious about?

Jon: Well, I may say something dumb.

Therapist: And that would mean . . . ? (conjunctive phrasing)

Jon: Then people will think that I'm dumb.

Therapist: And what if they do? (inference chaining)

Jon: That would suck. (an inference)

- Therapist:* If you generally want people to like you, then it certainly wouldn't be a positive experience. But if you just thought, "Oh well, if they don't like me, that sucks," I don't know that you'd feel anxiety. It sounds like there's something else attached to it. Let's think about that. This last party you thought about going to, when you pictured it in your head, it sounds like you thought people wouldn't like you?
- Jon:* Yes, I had this image of sitting by myself in the corner with no one to talk to.
- Therapist:* And what did you think when you pictured that image?
- Jon:* I'm such a loser. This totally sucks. I can't stand it. How do I get out of here?
- Therapist:* OK, so this seems like more than "this sucks," right? I'm hearing two other things now: "I'm a loser" and "I can't stand it." (irrational beliefs of global evaluation of self and low frustration tolerance)
- Jon:* Right.
- Therapist:* So, is it surprising that when you think about attending a social gathering and assume people won't like you—which will prove you're a total loser and be so uncomfortable that you "can't stand it"—that you start to feel anxious?
- Jon:* Not when you put it that way, no.
- Therapist:* And does it make sense that once you've gotten to that point, it makes sense to you that it'd be crazy to put yourself through all of that, so you'd better not go?
- Jon:* Absolutely. Like I said, that's usually what ends up happening.
- Therapist:* All right, so let's see where we might be able to change some things to help you reach your goal.

REBT postulates that people can hold irrational thoughts about their disturbed emotions and behaviors that lead them to become disturbed about their disturbances. One can be depressed about one's depression, or anxious that one could become anxious. REBT therapists are trained to explore and address meta-emotional and behavioral problems if relevant to the presenting concern (Dryden et al., 2003). These secondary emotional states can escalate a normal, healthy, adaptive emotional experience into a disturbance that can become an escalating spiral of consequences becoming activating events in an extended emotional-cognitive-behavioral experience. This occurs because people hold the irrational beliefs that they cannot stand or are intolerant of the discomfort of their emotional states and that they must not be uncomfortable. Ellis made the distinction between *ego anxiety* and *discomfort anxiety*. Ego anxiety results from beliefs that one might be worthless because of some flaw. Discomfort anxiety results from the beliefs that one cannot stand the feelings that are part of normal existence. The rational alternative belief is that emotions are part of life that inform us that a problem requires our attention and that we need to think about solutions and take action if we are to adapt. With this distinction in mind, meta-emotional disturbances distract the person from thinking about the thoughts that lead to the first disturbed emotions. Therefore, therapy preferably focuses on the meta-emotional disturbance first.

For example, when asked how Jon feels about his anxiety and avoidance, he says it “gets him down” about himself and his future. Upon further scrutiny, it becomes clear that Jon is demanding of himself that he shouldn’t have this problem and rating himself globally because he does. Specifically, he often tells himself to “man up” and then condemns himself as a failure when he doesn’t. For Jon, the issue of self-acceptance also becomes central to helping him attain his counseling goals.

There has been a great deal of recent attention paid to mindfulness in psychotherapy literature that bears mentioning in relation to REBT. Mindfulness activities are often geared toward helping individuals become aware of thoughts, feelings, and sensations but not reacting to them, the idea being that often our reactions may unnecessarily take us down roads of distress that can be avoided by observing and accepting rather than reacting. One of the first activities an REBT therapist may suggest for a client is simply paying attention to the thoughts that follow an activating event or precede a consequence identified by the client as dysfunctional. This awareness is crucial to any further cognitive intervention from an REBT perspective, as we cannot choose to be good consumers of our thinking if we aren’t fully aware of what that thinking entails.

Disputing

As irrational beliefs are discovered, the primary cognitive intervention in the REBT process is disputing. Disputing is an active approach to helping clients evaluate the helpfulness and efficacy of the irrational beliefs in their belief system (Ellis, 1996a). It is geared toward helping clients generate an elegant solution to their concerns. REBT therapists often use a more didactic style to explain the ABC model and the difference between rational and irrational beliefs. When it comes to disputing, the Socratic, or questioning, approach is often most effective as it encourages clients to examine their thinking and some of their core beliefs. Guiding clients through this process is seen as far more effective than simply explaining it. Most people don’t typically look at their prevailing belief systems to evaluate how well they are working for them, even when they routinely experience dysfunctional feelings and behaviors around the same types of situations or issues. Disputing offers an opportunity to do just that. Disputing becomes the “D” in the ABC(DE) model.

Five primary disputing approaches are included in REBT:

- *Functional.* How is it helping you? Is believing this helping you reach your goals? How is this belief affecting you? The functional dispute asks clients to evaluate the practical applications of a particular belief and whether or not it serves them.
- *Empirical.* Where is the evidence? The empirical dispute invites clients to examine the factual components of their beliefs or, in other words, to look at whether or not their beliefs are consistent with social reality.
- *Logical.* Where is the logic? How does it follow that because you’d like it to happen, or be that way, it must? Irrational beliefs involve illogical leaps from wants and preferences to needs, shoulds, and musts. The logical dispute asks clients to test the logic of their beliefs.
- *Philosophical.* Despite this problem, can you live a satisfying life? Often people become so focused on the problematic areas of their lives that they stop paying attention to the aspects of their lives that are neutral or going well. This can result in the problem’s becoming bigger and bigger in the client’s mind so that it starts to

define his or her existence. There are times when clients will not be able to change the activating event, such as a disability or a past experience, or when they will have decided that the benefits of staying in the situation outweigh the consequences. The philosophical question suggests perspective.

- *Friend.* What would you tell a friend in this situation? Give people a degree of separation from a problem and they are often able to be far more reasonable and rational about an approach or a solution.

As an example, let's look at Jon's irrational belief that he won't be able to stand the discomfort of a social gathering:

- *Functional.* How does it help you to believe that a social gathering will be so uncomfortable that you won't be able to stand it?
- *Empirical.* Where is the evidence that you won't be able to stand it? (*Note.* Jon would likely respond that he has evidence that it's uncomfortable, which REBT acknowledges and supports.)
- *Logical.* Where is the logic? How does it follow that because it might be uncomfortable, you won't be able to stand it?
- *Philosophical.* Despite the possibility that you may continue to be uncomfortable in social situations, can you lead a satisfying life?
- *Friend.* What's the best advice you would give to a friend who is struggling with this problem the way you are? Would you tell them that if they went to a party and no one talked to them, they'd be a completely worthless loser?

Rational Coping Statements

Another cognitive approach in REBT is to help clients develop rational coping statements. They have identified how they would like to feel and behave, and they have examined their irrational beliefs through disputing so that they understand the unhelpfulness of these beliefs. REBT recognizes, however, that you can't just take something away without replacing it with something else. Rational coping statements are not just an attempt to put a positive spin on things. They are statements that address the client's personal philosophy in meaningful and rational ways. It is preferable that clients create their own rational coping statements to be consistent with their own voices and gain additional buy-in, but the REBT therapist may also play a role in suggesting and helping test it out. Jon's rational coping statement might be, "I don't like being uncomfortable, but I can stand it and I might even have some fun." These new rational coping statements lead to the new effective rational emotional and behavioral consequences—the "E" that completes the ABC(DE) model.

Other Therapeutic Techniques

Rational emotive imagery

Rational emotive imagery is an emotive intervention that serves two functions: to help clients identify how they'd like to feel in any given situation, and to allow clients to experientially explore a more functional approach to creating that feeling for

themselves. Clients are asked to close their eyes and mentally place themselves in the difficult situation for which they are seeking help and to create the intense, dysfunctional emotion they've been experiencing. They are asked to let the REBT therapist know when they have accomplished this, and then they are instructed to work toward changing the targeted emotion to the other, rational response that they identified as the goal. Clients cue the therapist when they've been able to accomplish this, and a discussion of how they were able to make the transition follows, with attention paid to the specific wording and any other strategies the clients used to make the transition from the targeted emotion to the desired emotion.

Shame-attacking exercises

Ellis created shame-attacking exercises to help clients who engage in globally self-downing and worry about what other people think. The idea was that after working to dispute and replace the irrational beliefs with rational coping statements in session, therapists would instruct their clients to deliberately go out and do something foolish (not dangerous) in public. This would allow clients to test the newly created beliefs and also potentially allow them to collect evidence that despite appearing foolish or stupid in public, they could still live satisfying lives.

Homework

The use of homework or between-session assignments is considered paramount to the short- and long-term success of counseling in REBT. Rather than using the counseling session exclusively to focus on their concerns, clients are strongly encouraged to make use of the time they have outside of the counseling session to explore, reinforce, and practice what they are discussing and discovering in therapy. Homework assignments can be cognitive, behavioral, or primarily emotive in nature, depending on the client and the nature of the concern.

While not an exhaustive list of cognitive, behavioral, and emotive techniques used by REBT therapists, Table 9.4 provides other common intervention strategies used in REBT.

TABLE 9.4 Additional Therapeutic Interventions Used in REBT

Cognitive	Behavioral	Emotive
Modeling	Reinforcements	Forceful coping statements
Referencing (cost-benefit analysis)	Penalties	Forceful recorded disputing
Psychoeducational assignments	Skills training	Role playing
Recording therapy sessions	In vivo desensitization	Reverse role playing
Stop and monitor	Acting on rational beliefs	Humor

SOURCE: Adapted from Ellis & MacLaren, 2005.

Expected Therapeutic Outcomes

The overall outcome anticipated by REBT is that clients will think, feel, and behave more consistently with who they want to be. This, in turn, will allow them to experience more satisfaction and enjoyment in life, as they will not be expending energy being unnecessarily upset.

Changes in beliefs

Since the primary goal of REBT is to target irrational beliefs for goal-driven change, one of the intended potential outcomes is a change in the client's beliefs to reflect a decrease in irrational beliefs and an increase in or strengthening of rational beliefs. Beliefs are assessed in two main ways: in the therapy session by a skilled REBT clinician and through standardized assessment tools. Each method has its utility. Approaches to in-session assessment of beliefs were discussed earlier in this chapter. Ultimately we look for clients to more rapidly identify their own rational and irrational beliefs after they have been immersed in the REBT approach and subsequently create their own disputing processes. Over time, the rational beliefs become stronger and more viable and become more obvious in the client's thought processes and reactions to activating events.

Standardized measurements of beliefs have developed over time. According to Macavei and McMahon (2010), the most widely used, valid, and up-to-date standardized measures for irrational and rational beliefs in adults are the following:

- The Attitude and Beliefs Scale 2/General Attitude and Beliefs Scale (ABS-2/GABS)
- The Shortened General Attitude and Belief Scale (SGABS)
- The Survey of Personal Beliefs (SPD)
- The Common Beliefs Survey-III (CBS-III)
- The Irrational Beliefs Inventory (IBI)
- The Evaluative Beliefs Scale (EBS)
- Child and Adolescent Scale of Irrationality

Good examples of beliefs items from the ABS-2 that can help identify the rationality or irrationality of someone's thinking and potential areas for intervention appear below:

- "If important people dislike me, it shows what a worthless person I am." This is an irrational self-downing belief about affiliation.
- "If I do not perform well at things that are important, it is a catastrophe." This is an irrational, awfulizing belief about achievement.
- "I want to be liked by certain people, but I realize I do not have to be liked by them." This is a rational preferential (nondemanding) belief about affiliation.

These measures or statements might be used in an initial assessment, during sessions around a particular presenting issue, and in the treatment process to assess change in beliefs or thinking about a newly presented concern.

Changes in emotions

REBT therapists anticipate that a modification in beliefs will also result in a change in emotions and behaviors for clients so that they react more consistently with their desired goals. In terms of assessment of rational and irrational emotions, promising preliminary

work is being done on a 10-item measurement tool called the Functional and Dysfunctional Negative Emotions Scale (FADNES) to assess functional and dysfunctional emotions (Mogoase & Stefan, 2013). When clients make progress in changing their belief systems, the resulting changed emotional and behavioral outcomes are displayed in the counseling sessions. Clients will report gains in experiences outside of counseling in terms of navigating situations far more effectively than they have in the past. When they describe their responses to new activating events, it becomes clear to the REBT counselor that their affect has shifted and they are better able to problem solve successfully. There are hundreds, perhaps thousands, of standardized measures for emotions and behaviors that can be used to assess and track progress, depending on the nature of the presenting concerns.

Changes in frustration tolerance and self-acceptance

REBT also focuses particularly on helping clients with two issues that seem to be pervasive in counseling clients. Although not all clients experience both of them, it is rare to run across a client who has not experienced at least one. These two goals are to increase frustration tolerance (decrease frustration intolerance) and to create unconditional self and other acceptance (decrease self and other rating), as described earlier in this chapter.

Take, for example, Erin's situation. Erin is an intelligent, educated, gainfully employed woman. She is married and has a young child. She says that she would like to be physically healthy, have a strong relationship with her child, and have a positive relationship with her spouse. She does not enjoy exercise or monotonous activities or tasks that she deems boring because she doesn't have a keen intellectual interest in them, even though her child might enjoy them. Neither does she like to do chores around the house. Someone with high frustration tolerance would recognize that even if he or she doesn't enjoy these things, they are important to do in service of bigger goals; therefore, he or she would do them at least some of the time. Erin, who suffers from global low frustration tolerance, does not participate in any of the activities she doesn't enjoy very often and when she is frustrated, which is often, she tends to overeat (to self-soothe in the moment) and lash out at her spouse and child. As a consequence, Erin does not make any progress toward her stated goals and continues to struggle with poor physical health, a weak relationship with her child, and a contentious relationship with her spouse.

Erin says that she's desperate to change her life and deeply committed to her stated goals. When asked how she thinks and feels about herself for being in such poor physical health, she responds that she hates it and herself and sees herself as a failure. During a discussion about the importance of unconditional self-acceptance in allowing her to work toward her goals, she maintains that she can't possibly accept herself the way she is. She actually appears visibly horrified by the idea. The challenge for Erin is that as long as she chooses to hate herself and consider herself a failure, she's highly unlikely to change because we tend to take care of only what we value.

Research and Evidence Base in REBT

Although Ellis and many others have written prolifically about how REBT can be used effectively with a range of clinical problems, and there are thousands of cases in which it has, the outcome research specifically supporting the use of REBT has not been as prolific as it has for

some of the other cognitive-behavioral approaches. That being said, REBT was created to be an evidence-oriented therapy. According to Dryden and David (2008), meta-analyses that have evaluated the efficacy of REBT show that it is useful for a variety of clinical diagnoses and clinical outcomes. They noted it is equally effective for clinical and nonclinical populations, in a wide age range (9–70 years), and for males and females. In addition, they stated that higher numbers of REBT sessions correlate with better results and that higher-quality outcome studies have shown greater REBT effectiveness. One study in which the REBT intervention was designed to change only irrational beliefs showed that the two other levels of thoughts were also changed (Szentagotai, David, Lupu, & Cosman, 2008).

REBT has been applied successfully in a variety of settings, including individual, couple, family, and group therapy as well as educational settings (Ellis & Dryden, 2007). It is also used with the full spectrum of presenting concerns, including depression, anxiety, relationship issues, substance abuse, eating disorders, anger, personality disorders, chronic pain and medical conditions, complicated grief, and many others. Although REBT has been criticized over the years for its lack of empirical research (Terjesen, Salahany, & Sciotto, 2009), many meta-analyses published under the general heading of CBT also include REBT studies (David, 2013). David (2013) cited several large-scale meta-analyses that specifically summarized REBT clinical trials. Those meta-analyses showed that REBT works for a large spectrum of disorders in both adults and children.

According to Gavita and Calin (2013), REBT has shown effectiveness with both internalizing and externalizing problems in children. There is also good evidence suggesting that including REBT as an educational component can teach children and adolescents to identify and dispute unhelpful thinking so as to promote functional emotional reactions (Banks, 2011; Banks & Zionts, 2009).

Research has linked irrationality to anger, anxiety, guilt, and depression (Cristea, Montgomery, Szamoskozi, & David, 2013), and a change in irrational beliefs has been shown to reduce a variety of clinical conditions, including anxiety and depression (David & Lynn, 2010). Evidence suggests that REBT may be as effective as medication in the treatment of nonpsychotic major depressive disorder (David, Szentagotai, Lupu, & Cosman, 2008) and that interventions that focus specifically on developing rational thinking may be more effective than other approaches in treating depression (Jackson, Izadikah, & Oei, 2012). REBT has been effective in decreasing performance anxiety in athletes (Turner & Barker, 2013) and was tested in rigorous clinical trials for medically related disorders (David, 2013). In recent years there has been renewed interest in REBT research. Specifically, it has been suggested that REBT research should focus on further theory development and increasing the effectiveness of REBT's clinical applications (David & Lynn, 2010).

As noted earlier, many of the overarching values and goals of REBT can be related to facets of positive psychology. Values of unconditional acceptance (e.g., of self, others, and life) and high frustration tolerance, for example, as well as some of the other values and goals (e.g., flexibility, social interest, commitment) suggest potential research questions related to factors involved in resiliency, human optimization and happiness, health promotion, and rational living. Holt and Austad (2013) found many similarities between REBT and Tibetan Buddhism related to overcoming difficulties and living more fulfilling lives. Despite REBT's demonstrated effectiveness in clinical work, more research on the use of REBT for human optimization and health promotion is in order (David, 2013).

Common Factors and REBT

Since the advent of the empirically supported treatment movement, a common criticism of CBT generally has been that it is manualized and does not focus on the therapeutic relationship or the client as an individual. Anyone who practices a form of CBT effectively and outside of rigorous research methodology constraints understands that, despite a uniformity in theory and approach, every client is different and that the relationship is formed through the clinician's keen interest in and ability to begin helping the client right away. The therapeutic relationship is optimally experienced as a two-way effort focused on helping the client feel and get better. REBT is a transparent form of psychotherapy, and clients are educated from the very beginning of treatment about the theory of disturbance, what they can expect, and the change processes involved in the approach. The therapist is an expert in the approach, but the clients are experts on themselves and this acknowledgment from the start helps create the collaborative working relationship that has been related to positive therapeutic outcomes (see Chapter 3 for more information on the therapeutic alliance). Clients' beliefs or willingness to experiment with the idea that they play a role in creating and maintaining their disturbance is a critical component of REBT. For many clients, this creates a sense of relief and empowerment that promotes their own efforts to change. As discussed in Chapter 3, these client actions are an important part of the evidence-based change process.

From an REBT perspective, there is very little that builds the relationship more than the client's leaving the first session believing that he or she has already begun to be meaningfully helped. Thus, the therapeutic alliance is generated in the active collaboration between client and REBT therapist in helping the client get better and work toward his or her goals. In this way, REBT therapists utilize the common factors of the therapeutic alliance as well as the client's perceptions of early improvement and the expectations for continued change. A truly skilled REBT therapist is able to use the approach flexibly and expertly based on the specific needs of the client and understands that one method or tactic does not fit all.

As discussed previously, REBT does not focus much on early childhood experiences or the past except as it relates to problems that are occurring in the present. There are times when it may be helpful for clients to understand where and when they developed the belief systems that have become problematic for them. In fact, there are times when beliefs were developed for functional reasons but have since outlived their usefulness. For example, someone who grew up in a verbally or physically abusive home may have learned appropriately that when emotionally charged situations arise, it is best to become quiet and try not to be seen or heard. In an abusive environment, this made good sense and may have kept the individual a little safer. However, if he or she employs the same thinking and behaving in an adult, partnered nonabusive relationship when emotional situations arise, it may become problematic. In these types of instances, it is often quite clear why the client might have originally created what is now seen as dysfunctional thinking, feeling, and behaving. However, in many instances the origin of the beliefs may not be readily accessible. In these cases, focusing on the here and now is deemed to be more useful to the client, since speculating about the development of the beliefs and patterns can be time consuming and unproductive in creating useful and meaningful change for the client.

Clients are also asked regularly for feedback about their treatment experience and progress. This feedback is then incorporated into the therapeutic process in a direct, honest, and appropriate manner to optimize the client's therapeutic experience and progress. Similar to findings supporting the importance of the therapeutic alliance and client action, substantial research supports the collection of client feedback (Lambert & Shimokawa, 2011).

A cautionary note about REBT, and perhaps all psychotherapies, is that it does require expertise to practice it effectively. The vast majority of therapists will claim some use of CBT in their practice, but most have had little, if any, formal training. The theory is relatively straightforward, but people are complicated. Therapists who claim to practice REBT but have not been trained properly may not explain the ABC model well or thoroughly; they may assess activating events and consequences but never get to the meat of the irrational beliefs; or they may dispute rational instead of irrational beliefs and generally alienate clients. It takes concerted, supported practice to become skilled at REBT. Dryden and David (2008) cited findings that the higher the therapist's level of training, the better the results of the REBT.

Cultural Factors in REBT

REBT is appropriate for use with individuals from many cultures because of its emphasis on helping clients reach their goals by supporting preferences, desires, and wants and decreasing or eliminating absolutistic and dogmatic thinking. REBT, as opposed to other CBT approaches, accepts the inferences reported by clients and does not seek to change their perception of reality, but rather attempts to equip them with mechanisms for being as successful as possible within whatever contexts they exist. REBT works from the premise that when faced with adversity, we often have three options: to lobby for change, to accept, or to avoid. One of the REBT therapist's goals is to help clients become less clinically disturbed about their reality so that they are able to evaluate options carefully and make informed, self-preserving decisions based on what they want.

Note that an emphasis on acceptance of reality is not considered an endorsement of that reality. In other words, it isn't that clients are encouraged to like something that isn't working for them or is actively working against them. Women find themselves unfairly marginalized and objectified; some cultures insist that members adhere to highly inflexible standards; and many people don't fit comfortably into prescribed categories of gender, race, or sexual orientation. REBT never seeks to dispute or invalidate those experiences or even diminish the importance they may play in a client's life.

As an example, Ellis (1996b) described a live therapy demonstration with a female Japanese student studying in the United States who was being pressured by her parents, in a culturally appropriate way, to return home and marry. Her preference was to stay abroad and continue her studies. The REBT approach discussed the cultural "wrongness" of doing so and the consequences to her if she chose a countercultural option, as well as the consequences of behaving according to her parents' and culture's preference. The client would gain clarity of her options while working toward unconditional self-acceptance, regardless of her ultimate decision, and high frustration tolerance for whatever consequences she chooses. REBT has become an internationally practiced

system of psychotherapy with practitioners, researchers, and affiliated training centers throughout the United States and in Argentina, Australia, Bosnia, Canada, Columbia, England, France, Germany, Greece, Japan, Israel, Italy, Mexico, Netherlands, Peru, Romania, Serbia, and Taiwan.

It was commonly known that Albert Ellis considered himself an atheist and on many occasions he commented on the irrationality of zealously embracing religious belief systems without the availability of empirical evidence to support them. Not surprisingly, Ellis's concerns about religion primarily had to do with the devout and dogmatic adherence to beliefs dictated by some faiths. However, he also believed that the flexible adoption of some religious and spiritual practices and ideas could be beneficial to individuals (Ellis, 1996a). It has been suggested that given REBT's focus on beliefs, it may be one of the more religion-congruent approaches to counseling (Johnson, Ridley, & Nielsen, 2000). Pies (2011) pointed out that rabbinical Judaism and REBT share many fundamental assumptions and "teachings" such as the importance of self-awareness and examination and the notion that happiness and unhappiness are internally caused. Johnson (2013) argued that REBT can help address marital issues with religious individuals in a way that supports the couples' religious values but decreases disturbance associated with any religious issues within the relationship.

The emphasis on unconditional self-acceptance means that clients often find a good match with this approach as it does not require that they subscribe to any specific way of thinking or seeing the world. Rather, it helps them evaluate how well their personal philosophies are working for them and, if they are not, what they might change that would be less disruptive or more helpful to them. Although REBT emphasizes the role of irrational thinking, there is no "right" or "wrong" way to be. It is simply a question of what will work for clients in the context in which they choose or are required to exist.

Specialized Applications of REBT

REBT in Crisis Situations

Therapists are not going to do much in the way of elegant disputing when clients are in the midst of a crisis. People under duress might not be generally able to access their thinking enough to be able to engage in that kind of REBT. If they are engaging in irrational thinking, they are likely to have catastrophizing thoughts. Challenging the catastrophizing thoughts soon after a trauma can understandably be perceived as unempathic, however, so we do not recommend it. In addition to basic psychological first-aid strategies, the use of rational coping statements can be quite useful in the short term. This might include helping clients to rehearse rational statements about their frustration tolerance. This is also a time when we focus on clients' strengths and capacity for resiliency. Also, clients might have a wide range of emotions after a trauma. A particular client's emotions might not match those of other people or might not be what the client thinks he or she should be feeling. In such a case, we would recommend that the therapist help the client to accept that there is no "right" or "correct" emotion to feel in a crisis. We would encourage the client to accept the way he or she feels and stop thinking there is an emotion one should feel. This would have the effect of validating the client's emotion.

Once the crisis is over, we might begin to implement some of the more elegant aspects of REBT to help the client evaluate and perhaps create the meaning he or she chooses to make out of the experience.

REBT in the Managed Care Environment

Given REBT's emphasis on goal setting and targeted interventions for distress reduction, as well as its demonstrated applicability to a wide range of commonly presented concerns, it is well-suited for the managed care environment. Goals and interventions are regularly discussed and easily articulated for any care conversations or required documentation. Results are often seen quite quickly, which means shorter treatment periods and the possibility of more time between sessions, as deemed clinically appropriate. As mental health benefits become less robust and clients' abilities to pay out of pocket decrease, we are asked in the world of psychotherapy to increasingly do more with less. REBT is a proven, efficient approach to helping many clients achieve real and lasting change.

REBT, like any psychotherapy approach, cannot be all things to all people and is not suited to all clients. Clients who are more interested in discussion and insight than change, for example, might be better off with a different approach. Clients who desire change, but do not believe that they contribute to their own unhappiness and are unwilling to experiment with that idea, will generally not benefit much from REBT.

Conclusion

In 1995, Albert Ellis predicted that 50 years after his death (which occurred in 2007), REBT would be "alive and kicking" in theory and practice especially in the areas of preventive education, self-help materials, self-help groups, and psychotherapy (Weinrach et al., 1995). At this writing, it is eight years after the fact and so far his predictions seem prescient, as REBT and its techniques continue to be a theory and practice of choice for many.

Additional Resources

The Albert Ellis Institute (www.albertellis.org) is located in New York City. Its website provides listings of available training offerings, professional resources, videos of training sessions, current research activities, and REBT-approved therapists and supervisors around the world. The institute and its website also list affiliated training center locations worldwide. The website also has links to professional certificate training approved by the REBT International Training Standards Policy and Review Committee (ITSPRC). Other information related to REBT is available through social media forums on LinkedIn and Facebook.

The *Journal of Rational-Emotive & Cognitive Behavior Therapy* is published four times a year and is available online or in print (www.springer.com/psychology/journal/10942).

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