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# THE ASSOCIATION FOR RATIONAL EMOTIVE BEHAVIOUR THERAPY

## **Aims:**

- To promote and develop the science of Rational Emotive Behaviour Therapy (REBT)
- To maintain a register of members
- To maintain a register of accredited practitioners
- To facilitate registration with the United Kingdom Council for Psychotherapy and other relevant organisations
- To promote the interests of the members of the Association in their professional activities
- To publish a journal for the academic and professional advancement of Rational Emotive Behaviour Therapy
- To publish a Newsletter and/or other literature and maintain a website for the purposes of distributing information and advancing the objects of the Association and keeping members and others informed on subjects connected with REBT
- To recognise or accredit training courses and/or institutions
- To run training events and conferences for the purpose of continuing professional development of members and other professionals
- To carry on all such activities as may be conducive to the aforementioned aims

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# Editorial

## Ten volumes reflecting UK REBT

Stephen Palmer  
Co-Editor

Another year, another journal. Welcome to Volume 10 of *The Rational Emotive Behaviour Therapist*. This journal is the main publication of The Association for Rational Emotive Behaviour Therapy, formerly The Association for Rational Emotive Behaviour Therapists, and has reflected the work of many of our members over the years. We continue to publish state of the art articles and papers written by well-known REBTers.

This year has been very eventful for the Association. We became a company limited by guarantee and held a stimulating Continuing Professional Development (CPD) event on the day of our Annual General Meeting. Recently we achieved one of our very early goals as we now have our first United Kingdom Council for Psychotherapy registered REBT psychotherapists. They were registered via the Association and not through other psychotherapy bodies.

Next year we can celebrate ten years of the Association. We are hoping to have a bumper international edition of this journal with authors from as far as the antipodes. And, of course, we can run more CPD events.

Season's Greetings.

## REBT's Situational ABC Model

Windy Dryden

Rational Emotive Behaviour Therapy (REBT) is an approach to counselling that can be placed firmly in the cognitive-behavioural tradition of psychotherapy, meaning that it particularly focuses on the way that we think and behave when understanding our emotional responses. REBT was founded in 1955 by Dr Albert Ellis, an American clinical psychologist who brought together his interests in philosophy and psychology which are still present in this approach over 45 years on. One of the hallmarks of REBT is that it holds that people can be taught and can learn the principles of good mental health.

In this article, I will present a situational version of REBT's 'ABC' model that Albert Ellis REBT first introduced over 45 years ago. There have been many versions of the ABC model (e.g. Grieger & Boyd, 1980; Walen, DiGiuseppe & Dryden, 1992; Wessler & Wessler, 1980; Woods) and before I present my situational ABC model, let me summarise its main features:

- It roots the ABC components in a specific situational context, thus underscoring that people tend to disturb themselves most in specific situational contexts:
- It puts forward the view that the A that triggers B is best described as the critical A
- It thus distinguishes between a critical A and the situation in which the critical A occurs
- It makes clear that Cs can be emotional, behavioural and cognitive in nature
- It is very explicit in differentiating rational beliefs from irrational beliefs by making clear the different components of each
- It does not intend to be comprehensive and thus, for example, does not deal with core irrational beliefs and their core rational equivalents. It does

not do so because these core beliefs are general in nature and span different situational contexts.

I will briefly describe the model in basic form before discussing each element in greater detail.

'Situation':

We do not react in a vacuum. Rather, we think, feel and act in specific situations. The term 'situation' in the 'ABC' model refers to a descriptive account of the actual event to which we respond emotionally and behaviourally.

'A' = Critical activating event:

Within this specific situation, when we have a significant emotional reaction it is usually to a key or critical aspect of this situation. This is known as the critical activating event (henceforth known as the critical A).

'B' = Belief:

It is a major premise of REBT that while our emotions are usually about a critical A, this A does not cause our emotional reaction. Rather, our emotions are primarily determined by the beliefs that we hold about the critical A.

'C' = Consequences of the beliefs at B about the activating event at A (there are three such consequences: emotional, behavioural and thinking).

When you hold a belief about a critical A, you will tend to experience an emotion, you will tend to act in a certain way and you will tend to think in certain ways. These three consequences of this A x B interaction are known as emotional, behavioural and thinking consequences respectively.

Let me now discuss each of these elements in greater detail.

## **Situation**

As I said earlier, emotional episodes do not take place in a vacuum. Rather they occur in specific 'situations'. Such 'situations' are viewed in the 'situational ABC' model as descriptions of actual events about which you form inferences (see below). 'Situations' exist in time. Thus they can describe past actual events (e.g. My boss asked me to see her at the end of the day), present actual events (e.g. My boss is asking me to see her at the end of the day) or future events (e.g. My boss will ask me to see her at the end of the day). Note that I have not referred to such future events as future actual events since we do not know that such events will occur and this is why such future events may prove to be false. But if we look at such future

'situations', they are still descriptions of what may happen and do not add inferential meaning (see below).

'Situations' may refer to internal actual events (i.e. events that occur within ourselves, e.g. thoughts, feelings, bodily sensations, aches and pains, etc.) or to external actual events (i.e. events that occur outside ourselves, e.g. your boss asking to see you). Their defining characteristic is as before: they are descriptions of events and do not include inferential meaning.

## **'A'**

As I said above, 'A' stands for a critical activating event. This is the aspect of the situation about which you experience an emotional reaction. Let me make a number of points about 'A'.

*i) An 'A' is usually an inference and needs to be differentiated from the 'situation' or actual event about which it is made.*

An inference is basically an interpretation or hunch about the 'situation', whereas the 'situation' is purely descriptive. Let me provide you with an example to make this distinction clear.

Imagine that you receive a message from your boss to the effect that she wants to see you at the end of the day. You think that this means that she is going to criticise your work. The situation or actual event here is: 'My boss wants to see me at the end of the day', while your 'A' is: 'My boss is going to criticise my work'. As can be seen from this example the 'situation' is a description of the facts of the matter whereas the 'A' is a critical or key inference that you have made about the 'situation'. It is critical because it is the aspect of the situation to which you have an emotional response. When you have a significant emotional response to an event or 'situation', the 'A' represents the personalised inferential meaning that you give to the situation.

*ii) Inferences that usually comprise the 'A' can be true or false and as such when you make an inference you need to evaluate it against the available evidence.*

In the above example, it may be true that your boss is going to criticise your work when you go to see her at the end of the working day or it may be false. All you can do is to consider the available evidence and come up with the 'best bet' about what is going to happen at the meeting with the boss. This involves considering such factors as: a) what has happened in the past when your boss has asked to see you; b) the quality of the work that you recently submitted to your boss; and c) how critical or otherwise your boss is in general.

iii) An 'A' can also be about a past, present or future event.

When you have an 'A' about a past, present or future 'situation' or actual event you give that event inferential meaning. Thus:

Past 'situation' = My boyfriend did not return my call

'A' about past 'situation' = This proves that he doesn't care for me

Present 'situation' = My father is discussing the value of saving regularly

'A' about present 'situation' = My father is criticising me for overspending

Future 'situation' = The hospital will contact me with the results of my blood test

'A' about future 'situation' = The blood test will show that I am ill.

iv) An 'A' can be about an event external to you or about an event internal to you.

The defining characteristic of this 'A' is again its inferential nature.

For example:

External 'situation' = Letter with a cheque in it has gone missing

'A' about external 'situation' = Somebody has stolen my cheque

Internal 'situation' = Intrusive thought about hitting someone

'A' about internal 'situation' = I am losing control

## 'B'

Beliefs are attitudes which can be rational (or healthy) or irrational (or unhealthy). You can hold beliefs about descriptive 'situations', but more often you will hold beliefs about the critical 'A's that you make about this more objective 'situation'.

## Rational Beliefs

REBT argues that there are four basic rational beliefs which have the following five major characteristics:

- a) flexible or non-extreme
- b) conducive to your mental health
- c) helpful to you as you strive towards your goals
- d) true
- e) logical

Now let me discuss the four rational beliefs put forward by REBT theory.

i) *Full preference*

Human beings have desires and for desires to be the cornerstone of

healthy functioning, they take the form of a full preference. A full preference has two components. The first component is called the asserted preference. Here you make clear to yourself what you want (either what you want to happen or exist or what you want not to happen or exist). The second component is called the 'negated demand'. Here you acknowledge that what you want to occur or exist does not have to occur or exist.

In short, we have:

Full preference = 'asserted preference' component + 'negated demand' component

*ii) Non-awfulising belief*

When your full preference is not met it is healthy for you to conclude that it is bad that you have not got what you wanted. It is not healthy to be indifferent about not getting what you desire. As with a full preference, a non-awfulising belief has two components. The first component may be called 'asserted badness'. Here you acknowledge that it is bad that you have not got what you want or that you have got what you don't want. The second component is called 'negated awfulising'. Here you acknowledge that while it is bad when you don't get your desires met it is not awful, terrible or the end of the world.

In short, we have:

Non-awfulising belief = 'Asserted badness' component + 'Negated awfulising' component

*iii) High frustration tolerance (HFT) belief*

When your full preference is not met it is healthy for you to conclude that it is difficult for you to tolerate not getting what you want, but that you can tolerate it. An HFT belief also has three components. The first component may be called 'asserted struggle' because you recognise that it is a struggle to put up with not getting what you want. The second component is called 'negated unbearable'. Here you acknowledge that while it is a struggle to tolerate not getting your desires met it is not intolerable. The third component is called the 'worth tolerating' component and points to the fact that not only can you tolerate not getting what you want, it is worth doing so.

In short, we have:

High frustration tolerance belief = 'Asserted struggle' component + 'Negated unbearable' component + 'Worth tolerating' component

*iv) Acceptance belief*

When your full preference is not met it is healthy for you to accept



this state of affairs. There are three types of acceptance belief: a self-acceptance belief where you accept yourself for not meeting your desires or for not having them met; an other-acceptance belief where you accept another person or other people for not meeting your desires and an acceptance of life conditions belief where you accept life conditions when they don't meet your desires.

There are three components to an acceptance belief which I will illustrate with reference to a self-acceptance belief. The first component is called the 'negatively evaluated aspect' component. Here you recognise when you have not met your desires or that your desires have not been met by others or by life conditions and you evaluate this particular aspect negatively. The second component is called the 'negated global negative evaluation' component. Here you acknowledge that while you may have acted badly, for example or experienced a bad event, the whole of you is not bad. The third component is called the 'asserted complex fallibility' component. Whereas in the second component you negated the view that you are a bad person, for example, here you assert what you are: a complex fallible human being.

In short, we have:

Acceptance belief = 'Negatively evaluated aspect' component + 'Negated global negative evaluation' component + 'Asserted complex fallibility' component

## **Irrational Beliefs**

REBT argues that there are four basic irrational beliefs which have the following five major characteristics:

- a) rigid or extreme
- b) conducive to psychological disturbance
- c) unhelpful to you as you strive towards your goals
- d) false
- e) illogical

Now let me discuss the four irrational beliefs put forward by REBT theory.

### *i) Demand*

REBT theory holds that when you take your desires and turn them into rigid demands, absolute necessities, musts, absolute shoulds and the like, you make yourself emotionally disturbed when you don't get what you believe you must. Even when you do get what you believe you must,

you are still vulnerable to emotional disturbance when you hold a rigid demand at the point when you become aware that you might lose what you have and need.

A rigid demand has two components. The first is known as the asserted preference and is the same as the asserted preference component of a full preference. Again, you make clear to yourself what you want (either what you want to happen or exist or what you want not to happen or exist). The second component is called the 'asserted demand'. Here you take what you want and you turn it into a 'rigid demand' (e.g. 'I want to do well in my examination and therefore I have to do so').

In short, we have:

Rigid demand = 'asserted preference' component + 'asserted demand' component

*ii) Awfulising belief*

When your rigid demand is not met then you will tend to make the extreme conclusion that it is awful, horrible, terrible or the end of the world that you haven't got what you insist you must have. As with a non-awfulising belief, an awfulising belief has two components. The first component is the same as that in the anti-awfulising belief – 'asserted badness'. Here you acknowledge that it is bad that you have not got what you want or that you have got what you don't want. The second component is called 'asserted awfulising'. Here you transform your non-extreme evaluation of badness and transform it into an extreme evaluation of horror (e.g. 'Because it would be bad if I were to fail my exam, it would be horrible were I to do so').

In short, we have:

Awfulising belief = 'Asserted badness' component + 'Asserted awfulising' component

*iii) Low frustration tolerance (LFT) belief*

When your rigid demand is not met, you will tend to make the extreme conclusion that you cannot bear not getting what you demand. Unlike an HFT belief which has three components, An LFT belief tends to have only two components. The first component is again known as the 'asserted struggle' because you recognise that it is a struggle to put up with not getting what you must. The second component is called 'asserted unbearable'. Here you acknowledge that it is not just a struggle to put up with not getting your demand met, it is intolerable. Since you think

that you cannot put up with not getting your demand met the issue of whether or not it is worth tolerating does not become an issue. You can't tolerate it and that's that.

In short, we have:

Low frustration tolerance belief = 'Asserted struggle' component + 'Asserted unbearability' component

*iv) Depreciation belief*

When your rigid demands are not met you will tend to depreciate yourself, depreciate others or depreciate life conditions. Thus, there are three types of depreciation belief: a self-depreciation belief where you depreciate yourself for not meeting your demands or for not having them met; an other-depreciation belief where you depreciate another person or other people for not meeting your demands and a depreciation of life conditions belief where you depreciate life conditions when they don't meet your demands.

There are two components to a depreciation belief which I will illustrate with reference to a self-depreciation belief. The first component is called the 'negatively evaluated aspect' component. Here you recognise when you have not met your demands or that your demands have not been met by others or by life conditions and you evaluate this particular aspect negatively. The second component is called the 'asserted global negative evaluation' component. Here you give yourself a global negative rating for not meeting your demands, for example. Thus, you may acknowledge that you have acted badly and then evaluate yourself as a bad person for acting badly.

In short, we have:

Depreciation belief = 'Negatively evaluated aspect' component + 'Asserted global negative evaluation' component

**'C'**

'C' stands for the consequences that you experience when you hold a belief at 'B' about 'A'. There are three major consequences which I will consider separately, but which in reality occur together.

*Emotional 'C's*

When your critical 'A' is negative and you hold a set of rational beliefs at 'B' about this 'A', your emotional 'C' will be negative but healthy. Yes, that's right; negative emotions can be healthy. Thus, when you face a threat,

it is healthy to feel concerned and when you have experienced a loss, it is healthy to feel sad. Other healthy negative emotions (so called because they feel unpleasant but help you to deal constructively with negative life events) are: remorse, disappointment, sorrow, healthy anger, healthy jealousy and healthy envy.

When your critical 'A' is negative, but this time you hold a set of irrational beliefs at 'B' about this 'A', your emotional 'C' will be negative and unhealthy. Thus, when you face a threat, it is unhealthy to feel anxious and when you have experienced a loss, it is unhealthy to feel depressed. Other unhealthy negative emotions (so called because they feel unpleasant and they interfere with you dealing constructively with negative life events) are: guilt, shame, hurt, unhealthy anger, unhealthy jealousy and unhealthy envy.

#### *Behavioural 'C's*

When your critical 'A' is negative and you hold a set of rational beliefs at 'B' about this 'A', your behavioural 'C' is likely to be constructive. Such behaviour is constructive in three ways. First, it will help you to change the negative event that you are facing if it can be changed. Second, it will help you to make a healthy adjustment if the event cannot be changed and third it will help you to go forward and make progress at achieving your goals.

When your critical 'A' is negative, but this time you hold set of irrational beliefs at 'B' about this 'A', your behavioural 'C' is likely to be unconstructive. Such behaviour is unconstructive in three ways. First, it won't help you to change the negative event that you are facing if it can be changed. Indeed, such unconstructive behaviour will often make a bad situation worse. Second, it will prevent you from making a healthy adjustment if the event cannot be changed and third it will take you away from pursuing your goals.

#### *Thinking 'C's*

When your critical 'A' is negative and you hold a set of rational beliefs at 'B' about this 'A', your subsequent thinking (or thinking 'C') is likely to be constructive. Such thinking is constructive in two ways. First, it is realistic and allows you to deal with probable outcomes. Second, it is balanced and recognises, for example that you will get a range of positive, neutral and negative responses to your behaviour. As a result these thinking 'C's enable you to respond constructively to realistically perceived situations.

When your critical 'A' is negative, but this time you hold a set of irrational beliefs at 'B' about this 'A', your subsequent thinking (or thinking

'C') is likely to be unconstructive. Such thinking is unconstructive in two ways. First, it is unrealistic in that you will tend to predict the occurrence of low probability, highly aversive outcomes. Second, it is skewed in that you think, for example, that most people will respond to you negatively, a few may respond to you neutrally but nobody will respond to you positively. As a result these thinking 'C's interfere with your ability to respond constructively to realistically perceived situations.

## Summary

Let me summarise below what I have discussed in this article.

### **Situational ABC Model of Psychological Health**

Situation = Objectively described event

Negative Critical 'A' = Aspect of the situation to which you respond emotionally, behaviourally and cognitively

'B': Rational belief = Full preference  
Non-awfulising belief  
High frustration tolerance belief  
Acceptance belief

'C' = Consequences  
Emotional (healthy negative)  
Behavioural (constructive)  
Thinking (realistic and balanced)

### **Situational ABC Model of Psychological Disturbance**

Situation = Objectively described event

Negative Critical 'A' = Aspect of the situation to which you respond emotionally, behaviourally and cognitively

'B': Irrational belief = Demand  
Awfulising belief  
Low frustration tolerance belief  
Depreciation belief

'C' = Consequences  
Emotional (unhealthy negative)  
Behavioural (unconstructive)  
Thinking (unrealistic and skewed)

## References

Grieger R & Boyd J (1980). *Rational-emotive Therapy: A skills-based approach*. New York: Van Nostrand Reinhold.

Walen SR, DiGiuseppe R & Dryden W (1992). *A Practitioner's Guide to Rational-emotive Therapy*. Second edition. New York: Oxford University Press.

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Woods PJ (1991). Orthodox RET taught effectively with graphics, feedback on irrational beliefs, a structured homework series, and models of disputation. In M E Bernard (Ed.), *Using Rational-emotive Effectively: A practitioner's guide*. New York: Plenum.

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# Cognitive and Organisational Models of Stress that are suitable for use within Workplace Stress Management/Prevention Coaching, Training and Counselling settings

Stephen Palmer

## Abstract

In the United Kingdom (UK), the Health and Safety Executive (2001) published guidelines on workplace stress prevention. Rational Emotive Behavioural Coaching and Training (REBCT) is a psycho-educational model which is suitable for corporate stress management and stress prevention workshops and seminars (Palmer, 1995a,b; Neenan and Palmer, 2001). This paper highlights two models of stress that are suitable for use within REBCT stress management workshops.

## Introduction

Since the mid 1990s, there have been many incidents of work-related stress (WRS) cases in the UK, costing employers many hundreds of thousands of pounds in compensation payouts, not including the legal costs (Palmer, 1995b). Hence, employers have become far more motivated to tackle WRS. However, there is still a tendency to tackle WRS at the level of the individual and not at the organisational level.

There are three levels of organisational interventions:

*Primary:* Remove hazard or reduce employees' exposure to it or its impact on them, e.g. risk assessment, stress audits, job redesign, restructuring, improved communications;

*Secondary:* Improve the organisation's ability to recognise and deal with stress related problems as they occur, e.g. health promotion policies, training

(stress/time/assertion), coaching, reward orientated management style, healthy lifestyle;

*Tertiary:* Help employees cope with and recover from work related problems, e.g. stress counselling, medication, surgery, outplacement counselling, employee assistance programmes.

Rational Emotive Behaviour Therapy (REBT) and REBT based stress management interventions, which concentrate on the employees' appraisal of situations/potential stressors, and irrational/unhelpful beliefs are useful at both the second and third intervention levels (Ellis *et al*, 1997). However, preventing employees from becoming stressed in the first place would be one of the main goals for using REBT in organisations, as well as being able to recognise the true source of stress (i.e. whether the pressures come from an internal or external source) (Palmer, 1995b). At the primary level, those employees who hold inflexible and rigid beliefs, especially about performing extremely well under all conditions, are more likely to suffer from higher levels of stress than employees who hold more flexible beliefs and realistic standards. For example, 'perfectionists' tend to be less productive and attain lower standards of work due to their anxiety about failing (Palmer, 1995b).

## **ABCDEF Model**

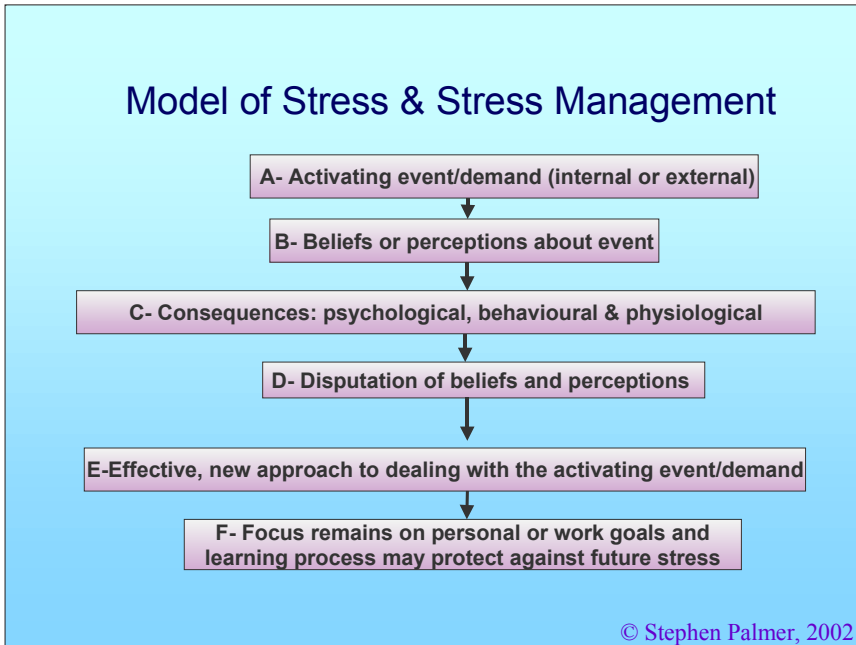
When teaching the REBT model of stress and stress management it is recommended to concentrate not only on the usual ABCDE part of Albert Ellis's now famous model of emotional disturbance (Ellis *et al*, 1997), but also to include the focus on the future (F), in other words, what the employee has learnt from the process to ensure that they are less likely to become stressed by a similar event in the future. This is one of the important aspects of stress prevention as opposed to stress management. In the UK, the HSE (2001) focus on the prevention or elimination of WRS hazards rather than their management so it is crucial that coaches, consultants, trainers and therapists who are working across primary, secondary and tertiary intervention levels are aware of this issue.

Figure 1 is the ABCDEF model of stress, stress management and stress prevention that is used within the REBT psycho-educational approach for organisational work (Palmer, 2001; Palmer, 2002).

Strictly speaking, the usual five column ABCDE forms used within REBT are not accurate according to the model of stress depicted in Figure 1 because at 'C', the consequences include the psychological response.

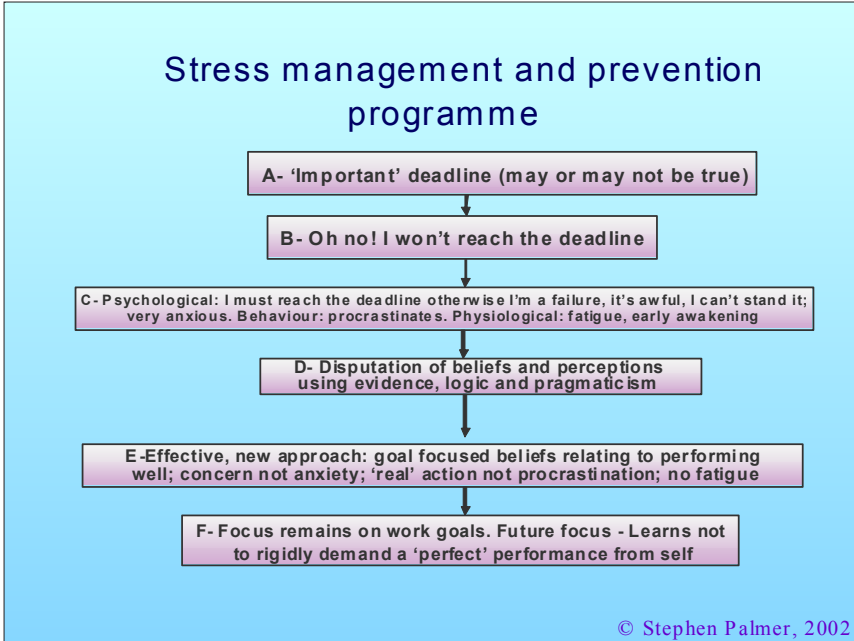


FIGURE 1



Normally within REBT, these are noted as unhealthy emotions such as anxiety or damning anger. However, in reality, the psychological response includes the unhelpful (irrational) beliefs triggered, not by the 'A' but by the negative perceptions at 'B' relating to 'A'. This is clearly depicted in Figure 2. Often the individual awfulises at 'B' as they perceive the situation as threatening (e.g. 'Oh no'; 'Oh God'; 'Oh shit'). The awfulising is often summarised in one or two words. It is interesting to note that awfulising would be considered a derivative in REBT theory as it is derived from a rigid demand (Ellis *et al*, 1997). However, this model of stress would imply that the immediate cognitions are more likely to be a so-called derivative and not a demand such as 'I must perform well', which tend to be activated later in the stress sequence. Assuming the person perceives the situation at 'A' as threatening at 'B', only then do they trigger the full stress response at 'C', the psychological, behavioural and physiological consequences. This is easy to demonstrate to individuals either in one-to-one coaching/therapy or in group stress management by connecting a person up to a Galvanic Skin Response (GSR) biofeedback monitor. They are asked to think of a previous stress scenario and as they imagine the situation in their mind's

FIGURE 2



eye, the very first words that they report using are usually awfulising. In under a second, the GSR responds. This is a very persuasive demonstration that shows the cognitive model of stress in action and the importance of 'D', the disputation of unhelpful (irrational) beliefs at both 'B' and 'C'.

Once the model of stress has been explained, the stress management, coaching or therapy then progresses in the usual REBT manner (see Palmer *et al*, 1998; Neenan and Palmer, 2001a,b).

Palmer (1995a,b) found that some of the key unhelpful (irrational) beliefs that triggered stress in employees were:

**Demands:**

- I must do better
- You must treat me better
- My working conditions must be better
- People must like me

**Derivatives:**

- I won't do well and that would be awful
- I can't stand my working conditions
- If people don't like me, I am pretty worthless

Palmer (1995b:52) reported that attendees of a stress management workshop found the following techniques and strategies useful in reducing stress:

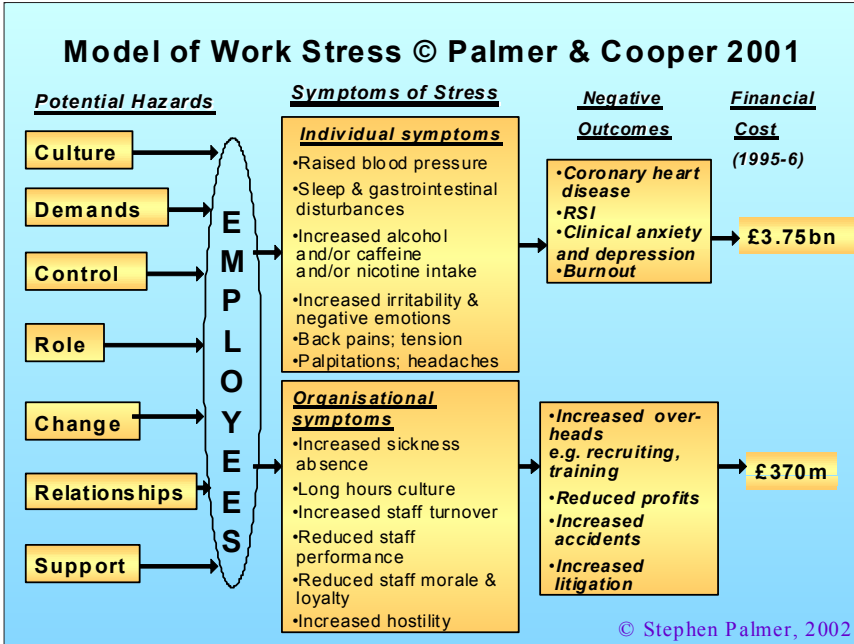
- Learning about stress and discussing it with colleagues
- Learning to 'de-awfulise' stressful situations using the 0 to 99.99% badness scale
- Learning not to rate themselves by their actions using the 'Big I, little I' dispute
- Learning how to become less 'musty', i.e. relinquishing their musturbatory beliefs
- Recognising and challenging 'all-or-nothing' thinking
- Learning and using relaxation techniques including imagery techniques
- Realising that the company will still go on after their own death and the latter would go almost unnoticed by senior management anyway

Recently, Palmer ran a workshop which was attended by some of the original delegates from the organisation referred to in this case study (at least eight years on). Two out of three of the delegates were still using the cognitive techniques and the relaxation exercise. They were able to teach the cognitive techniques to the new managers in the group who had observed their calmness in a typical stressful work environment. However, this is only an anecdotal report from Palmer and elicited by a group discussion with the course delegates so should be treated with caution.

## **Organisational model of stress**

In the UK, as the HSE (2001) have developed a recommended approach to tackling WRS, it is important to educate managers, supervisors and other relevant staff with an organisational model of stress. In fact, it is ill-advised only to promote a cognitive model of stress as it does not place the legal burden of responsibility upon the employer to tackle organisational hazards. A suitable model of stress was developed by Palmer and Cooper (Palmer, 2001; Palmer *et al*, 2001) who have incorporated the information from the HSE (2001) guide. The seven key stress-related potential hazards reported by the HSE have been included (see Figure 3). The HSE recommend that a five-step WRS risk assessment is undertaken to assess and deal with these hazards. These issues can be discussed during a stress management or prevention workshop with managers and other relevant staff attending.

FIGURE 3



## Conclusion

This paper introduced two models of stress and stress management/prevention that can be used by suitably trained consultants, coaches, trainers, counsellors, facilitators and therapists. The use of the organisational model of stress is appropriate for the UK as it corresponds to the HSE (2001) document relating to WRS. In the light of the recent developments in the UK regarding WRS it may be an error in organisational stress management workshops not to include the legal responsibility that employers, including managers, have towards their staff regarding WRS. Palmer and Cooper's model of stress emphasises these responsibilities. There is little published research on the effectiveness of cognitive stress prevention techniques taught to a non-clinical population. This is an area that needs further research to back up the claims of the many optimistic stress management practitioners.

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## Some Innovations in the Teaching of Unconditional Self-Acceptance and Unconditional Other-Acceptance

Jim Byrne

### Introduction

In this article, I will review the process that I went through when learning how to teach Unconditional Self- and Other-Acceptance (USA/ UOA). In addition, I will outline some innovations which I created.

### Background

When I began my private practice as an REBT therapist, in January 1999, I was concerned about the question of how to teach Unconditional Self- and Other-Acceptance (USA/UOA). I had, of course, studied Ellis (1962/ 91 and 1994), Dryden (1996) and Miller (1994). The main teaching points that I wanted to present to my clients were as follows:

- Never rate your 'self'. Only rate your acts and your deeds. (To 'rate' yourself means to 'esteem' yourself. 'Esteem' and 'estimate' have the same Latin root – *estimare*, meaning 'to put a price on'! How can you put a price on your aliveness, your 'you-ness'? You can't!)
- Give up *demanding* that you must be loved, liked or accepted. Only *prefer* to have those results. You won't die if you are unloved or unaccepted.
- Get rid of your perfectionistic goals and aims. It is normally good to aim high, because it normally benefits you. It is therefore sensible to go for effectiveness, efficiency, success, and so on. However, this is a reason to *prefer* good performances from yourself. It does not justify *demanding* such performances.
- When other people look down on your acts, traits and so on, do not make the mistake of thinking that they are looking down on 'you'. They

can't even see 'you' – meaning your *essence or aliveness*. They can only see some of the results of some of your acts, deeds and traits, etc. It is OK for them, and you, to be *disappointed* by your performances, traits, or whatever they (and you) are looking down upon. But it will harm *you*, by overly upsetting you, if you *identify* those performances with your *essence*; your 'you-ness'.

- If you break your own moral code, or fail to live up to it, then that is just tough stuff. It's not the end of the world! The fact that you have a moral code, and try to live up to it, makes you a normal human. The fact that you sometimes fail to live up to your moral code, or even that you sometimes actively and knowingly break it, is further evidence that you are a fallible, error-prone human. Making yourself feel guilty about such failings will not improve the situation. If you stick to your *preferential philosophy* – of wanting, wishing, desiring, etc. – you will only feel remorse, which will allow you to also feel 'self' confident, and to plan to act better in the future. (If you feel guilty, then you are 'should-ing' on yourself. You'd better give up all absolute 'shoulds' about your preferences and wishes, and about your moral code.)

- When significant others act against your best interests, or criticise or castigate you, be alert. Don't conclude that they *should not* have done this, and that this makes you a *pitiable victim*, and the world a *rotten place*, because that will produce *depressive hurt* in your body and mind. Instead, tell yourself this: 'I am disappointed that they deal with me in this regrettable way – which they *should* have done – but it does not say anything about my 'self', or essence at all! I am *disappointed*, but *not hurt*!' (For a series of questions on disputing 'shoulds', see Appendix 'B' of Byrne [2001]).

- Give up all forms of *ego anxiety*. If your 'ego' is threatened, then a *story you made up about yourself* is what is being threatened. (Note: This was the point at which I began to realise that it might be difficult to teach this subject, because the human ego is a *selective extract from part of the individual's personal history*. It's their *story* about who they think they 'are'! And it's always largely fictional! But since they are *identified with* their ego image, they think their ego image 'is' they themselves!) What can anyone accurately say about your 'self'? Only this: You seem to have what Erwin (1997) suggests could be called 'a virtual self'; it seems to comprise 'aliveness' (Ellis, 1962, p. 148), and a 'capacity to be aware' (Byrne, 2002, pp. 44–46). (Note: Again I noticed that it would probably be difficult to teach individuals that a part of their essence is a sense of *I-ness*, which *seems to be present*, here and now. [Ellis,

1962, p. 148]). The *'self'* in you is identical to the *'self'* in me, and in all human beings. Therefore, what is there about your *real 'self'* about which you'd better be anxious concerning threats and dangers? There isn't anything to be anxious about! Your *essence* cannot be affected, sullied, shrunken, deformed, distorted, dulled, dampened, or otherwise assailed or assaulted. It is beyond danger for all time. (Note: Here I noticed that there is no visible or 'concrete' referent to which the concept of 'the self' refers. This makes it a highly abstract concept, which can be as slippery as an eel, and difficult to hang on to. [Again, Ellis, 1962, forewarned about this problem].) It is only if your capacity to form a personal viewpoint foolishly *identifies with* your ego image (or self concept), or with negative aspects of your reputation – rather than identifying with *your aliveness and your capacity to be aware* – that you or anyone else can induce anxiety in you about *your 'identity'*.

So, these were my main intended teaching points, and my few expectations of difficulty.

## Problems of teaching USA/UOA

Initially, the vast majority of my clients seemed to find the idea of unconditional self-acceptance (USA) relatively easy to grasp, and easy to use in their lives. They quickly got over their problems of ego anxiety, shame, guilt and depression about personal failings. However, I gradually realised that a significant minority of clients slipped back to self-rating almost immediately. During follow up conversations, and reflection on this problem, I identified three areas of difficulty:

- Firstly, some clients seemed to find the REBT concepts of *self* and *essence* to be so remote from their normal way of thinking about 'themselves' that it wasn't easy for them to integrate these concepts into their daily thinking. (See Appendix 'D' of Byrne [2002]).

- Secondly, in order to learn these concepts, clients were obliged to learn how to 'teach themselves' to think differently about themselves. This is a *skill area*, and proved to be susceptible to the 'stages of learning a new skill' – whereby individuals move...

... *from* being unconscious of the fact that they don't know how to teach themselves to think more rationally about themselves ...

... *to* the next stage which is to become *consciously incompetent* in this area! (O'Connor and Seymour [1990]). (See Figure 4 below.)

Being at the stage of conscious incompetence is demotivating, and some



individuals were prone to quit immediately, or quite early on, in order to avoid the discomfort of experiencing themselves as being 'incompetent' and 'stuck'. (See Appendix 'F' of Byrne [2002].)

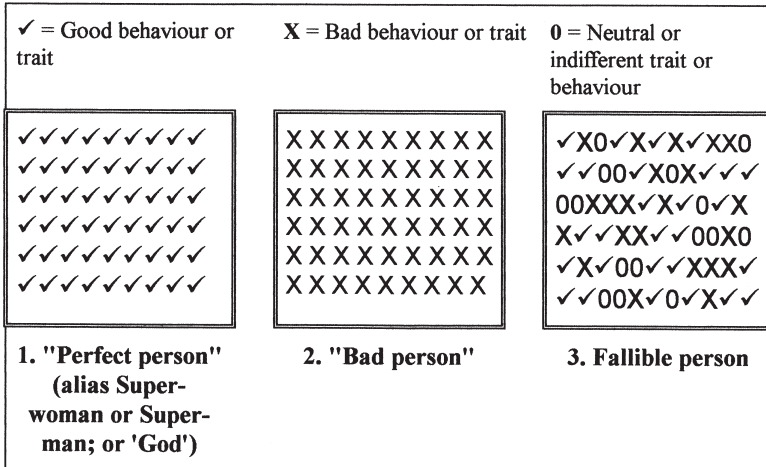
- Thirdly, I did not have a satisfactory range of teaching aids, including visual aids, for my teaching role. And especially teaching aids which would cover the whole range of distinctions related to the 'self'. (See Appendices 'A', 'B', 'C' and 'E' of Byrne [2002].)

### My Solution

Although all three of the problems described above are interrelated, I set about solving my problems as follows:

(a) *Teaching aids*: I began by focusing on teaching aids. The first aid that I found useful was Figure 1, from Palmer (1997). Most of my clients could immediately see that they were a fallible person, because they do all sorts of good, bad and indifferent things; and that they could not realistically ever aim to be a 'perfect person'.

FIGURE 1: Which one is a real person?



The second aid that I began to use was the OK-corral, from Stewart and Joines (1991), which is shown in Figure 2. I used this aid to teach clients to move away from positions 2, 3 and 4, each of which contains a 'not-OK' evaluation, of themselves and/or others. I wanted to encourage my clients

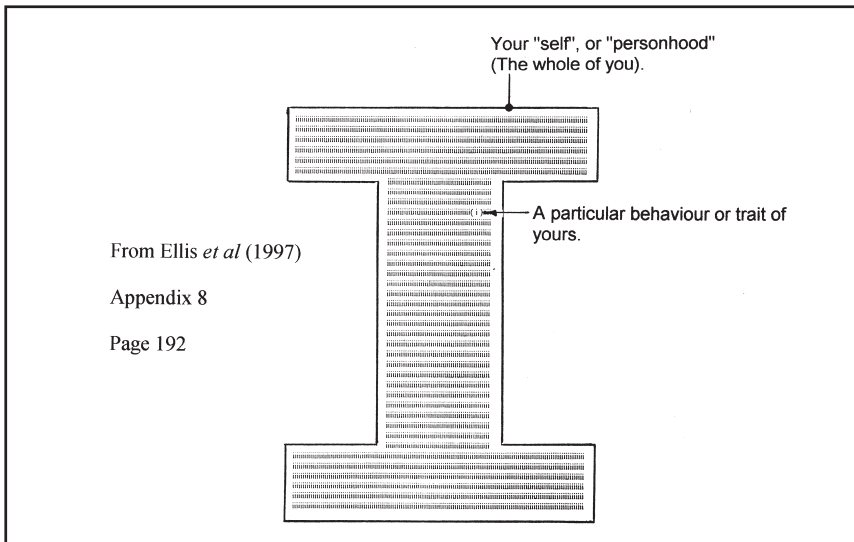
to train themselves to always try to be in 'box 1': accepting themselves and all others as being OK – 'just because you're alive, and just because you choose to accept yourselves and see yourselves as being OK'. (Ellis, 1989.)

FIGURE 2: The OK Corral

		Your Decision About Others	
		OK	Not-OK
Your Decision About Yourself	OK	1. I'm OK - You're OK	2. I'm OK - You're Not-OK
	Not-OK	3. I'm Not-OK - You're OK	4. I'm Not-OK - You're Not-OK

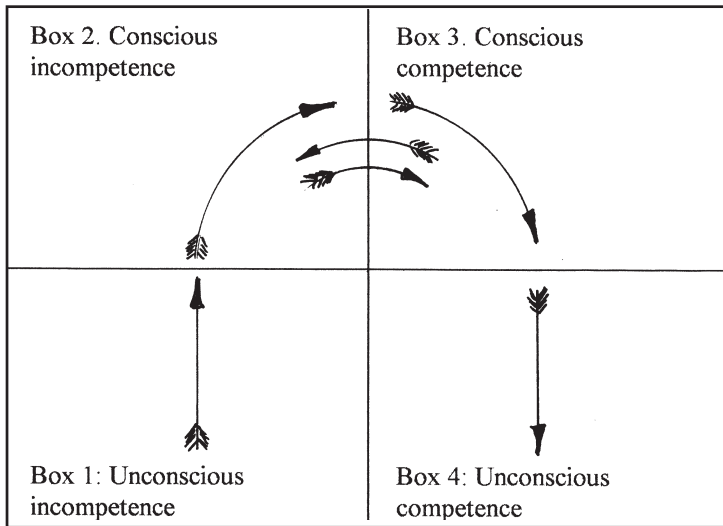
I then went back to Palmer (1997) and Ellis *et al* (1997) and made a special effort to learn how to use the Big-I/Little-i diagram, as shown in Figure 3. (Coaching in the use of this diagram is included in the homework assignment in chapter 4 of Byrne [2002].)

FIGURE 3: The Big-I/Little-i Diagram



(b) *Stages of learning*: Once I was using the Big-I/Little-i diagram regularly and effectively, my success rate increased; but there was still a small minority of individuals who did not seem to be able to achieve USA; and frequently UOA, especially for their ex-marriage partners! I then moved on to the next stage. This is the problem of how clients are to *teach themselves* the skill of working at changing their self concept, which is a problem for many clients; though some are better than others at facing up to the challenge. For the purpose of helping clients with this problem, I used the model shown in Figure 4.

FIGURE 4: The Stages of Learning a New Skill



(Inspired by O'Connor and Seymour, 1990. Drawn by Jim Byrne.)

Once clients are made aware of the fact that they are not unconditionally self-accepting, and that they have not yet succeeded in applying the ideas we have been discussing, they move up from box 1 to box 2, in Figure 4. In other words, they become conscious of their own incompetence in this area. This can clearly become a 'noxious A', or a stimulus which they can use to trigger irrational beliefs about their self-efficacy; resulting in emotional over-upsets. Regardless of whether the result is ego-anxiety or discomfort anxiety, or some form of self-downing, one of the most likely responses is to *quit trying to change what they identify with*; to abandon their homework; and to go back to sleep. But, unless they persist

with the skilled task of trying to learn these new ideas and skills, they will *never* make it into box 3. Indeed, if they are ever to change, they have little choice but to keep moving back and forth between boxes 2 and 3, for quite a long period of time, before the new learning becomes firmly fixed in their long term memory. (This is the process of ‘over-learning’.) After a sufficient amount of repetitive learning, they slip down into box 4. This is when they become unconsciously competent in managing their self-perceptions, and can quickly track down the source of any ego upset, and sort it out.

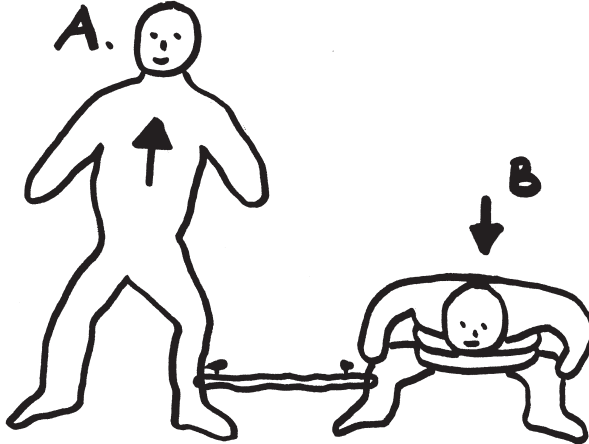
(c) *A realistic model of the self*: The next stage in the evolution of my approach came as I realised that, even when they knew the Big-I/Little-i model, some clients still had difficulty refraining from rating themselves and significant others – especially difficult spouses or partners, and hostile ex-spouses or ex-partners. Gradually it dawned on me that some of these clients seemed to have a model of the self which fitted with their game of top-dog/under-dog. (This is shown in Figure 5.)

Figure 5 is a simple model, which was suggested to me by the flip-flop nature of some clients’ self-concepts: OK (inflated) one minute; and not-OK (deflated) the next. It has just three elements. It has two inflatable ‘beings’, labelled ‘A’ and ‘B’. They are assumed to be connected at the ankle by a hollow tube. The way I understood the model in Figure 5 was as follows. Person ‘A’ becomes fully inflated, as an ‘upright’ top-dog, by putting person ‘B’ down, thus almost fully deflating them. The only way person ‘B’ can be re-inflated (in this model), to become a fully upright top-dog again, would be to put person ‘A’ down, thus almost fully deflating them. After a while I voiced this hypothesis to particular clients who confirmed that they did, indeed, seem to operate as if they were connected to their partner or ex-partner by a tube, and that at any one time only one of them could be ‘fully inflated’, because there seemed to be insufficient ‘air’ (or goodwill; or ‘esteem’) to maintain both individuals in a fully-inflated ‘equal-dog’ relationship.

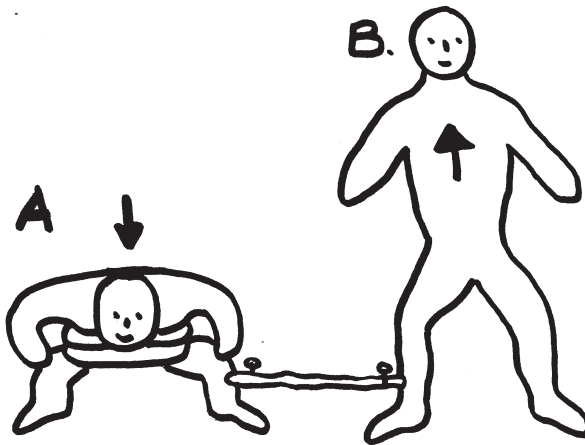
I now had a visual metaphor with which I could work – or rather to *work against* – in order to teach my clients a new approach to managing their ‘self’, and the ‘self’ of their current or ex-partner. What I next developed was a *non-deflatable visual metaphor* for the human self. This I described as a huge steel letter-I, made from rolled steel joist (RSJ), which is the type of long steel girder that builders use to support the full weight of a floor in the construction of buildings. It is a very strong steel. I asked my clients to imagine the kind of structure shown in Figure 6.

FIGURE 5: The Inflatable Top-Dog Model

**Part 1:** Person 'A' is 'up' because they have downed person 'B'.



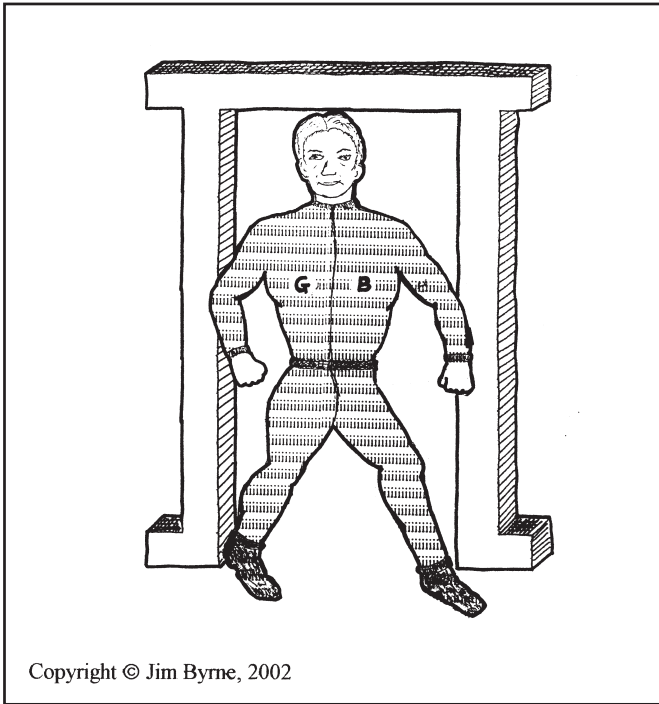
**Part 2:** Person 'B' gets themselves re-inflated by downing person 'A'.



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The model in Figure 6 comprises a Big Steel Letter I surrounding an individual human, who is wearing a white tracksuit, divided down the middle, on which is written, in the form of billions of Little i's, their personal traits and behavioural history (classified into B for Bad and G for Good).

FIGURE 6: The Big Steel I



This Big Steel I is not in any way connected to the 'self' of any other person, including partners or ex-partners. It stands alone. It is also uncrushable; unbendable; non-deformable. It is an ideal representation of human essence, because it cannot crumple or be crumpled! It cannot shrink or collapse. It also cannot be stretched or increased in any way. (The only reason the 'beings' in Figure 5 can be inflated or collapsed is that they are *mistakenly identified with* their traits and behaviours.)

My first teaching in this new phase involved walking around my office, in the presence of a client, and asking them to visualise a Big Steel I surrounding my body, like a full body 'halo'.

JB: 'This Big Steel I, which we imaging surrounding my body, is an accurate representation of my essence, my aliveness, or what is common to all humans. Can it be inflated, expanded, deformed, deflated, increased, or enhanced in any way?'

Client: 'No. It does seem to be fixed for all time.'

I would then kick a piece of furniture and ask:

JB: 'Isn't that a bad act?'

Client: 'Yes.'

JB: 'And does it affect my Big Steel I?'

If the client looked at all doubtful, I would reach up over my head, and behave as if I was desperately struggling to pull down the top cross beam of the Big Steel I. Then I would ask: 'Can it be reduced in height?'

Client: 'No!'

JB: 'And can I or you bend or deform it, in retaliation for that bad act?'

Client: 'No way.'

JB: 'And will it melt from the heat of my embarrassment, or the heat of your anger, if I do a bad act?'

Client: 'No!'

JB: 'And if you tell me I'm a bad person for kicking the furniture, will my essence, or Big Steel I, be affected in any way?'

Client: 'Not likely.'

Next, I repeated this process with a Good Little i – which normally involved something like my watering a 'thirsty' house plant. Again, the client would agree that this does not make my Big Steel I bigger, taller, better or more acceptable.

I then added the use of the white tracksuit as a place for the client to write Bad (or Good) Little i's, which did not affect the Big Steel I. I asked my clients to imagine that all humans wear a white tracksuit, divided down the middle, with a 'G' for Good on one side, and a 'B' for Bad on the other.

JB: 'Now imagine I am wearing a white tracksuit, as a place to record the Good and Bad Little i's which represent my traits and behaviours. Now, if I kick this table, where does this Bad Little i get recorded?'

Client: 'On the side of your tracksuit marked 'B' for Bad.'

JB: 'Could I write it on my Big Steel I?'

Client: 'No. It's not part of your essence, or aliveness.'

I experimented with this model with a few of my clients, including married couple clients, and had considerable success in developing sustainable USA. It also worked well in producing Unconditional

Acceptance of Others (UOA).

One of my clients (let's call her Jackie) had problems with rage towards her ex-partner (let's call him Henry). Jackie used to take their daughter (Alice) to Henry's flat every Friday teatime, and collect her again on Sunday evening. During these 'hand-over' meetings, Jackie experienced Henry as 'trying to wind me up'. He would talk to her 'disrespectfully', with his back turned; leave the room and not come back for 'an unreasonable amount of time'; lose Alice's clothes, school work, and so on. In response, Jackie would experience murderous rage, and on at least one occasion, considered killing Henry.

I then developed the big steel I model further, until I produced the Big Golden I. This occurred because I wanted to give Jackie a model of her ex-husband's essence, as distinct from his bad behaviours, so she could focus in on his essence even while he was behaving very badly. So I developed the Big Steel I into the Big Golden I by having it (in imagination) chrome plated to a high gloss – so it would shine and be unscratchable – and then having it gold plated, so that it could not be tarnished by any animal, vegetable or mineral substance. I then trained Jackie to imagine she was actively shining Henry's Big Golden I, with a soft yellow duster, while he seemed to be trying, deliberately, to wind her up. Each time he behaved badly she was to write a Little i, in her imagination, on the side of his imaginary white tracksuit marked 'B' for Bad, which she was to project on to him; but at the same time she was to imagine polishing his Big Golden I! In this way she found very quickly that she could stay calm under the most intense or protracted provocation, and that Henry soon stopped trying to wind her up. (Her anger might have been Henry's 'reward' for his crummy behaviour. Take away the 'reward' and the behaviour may often become extinguished.)

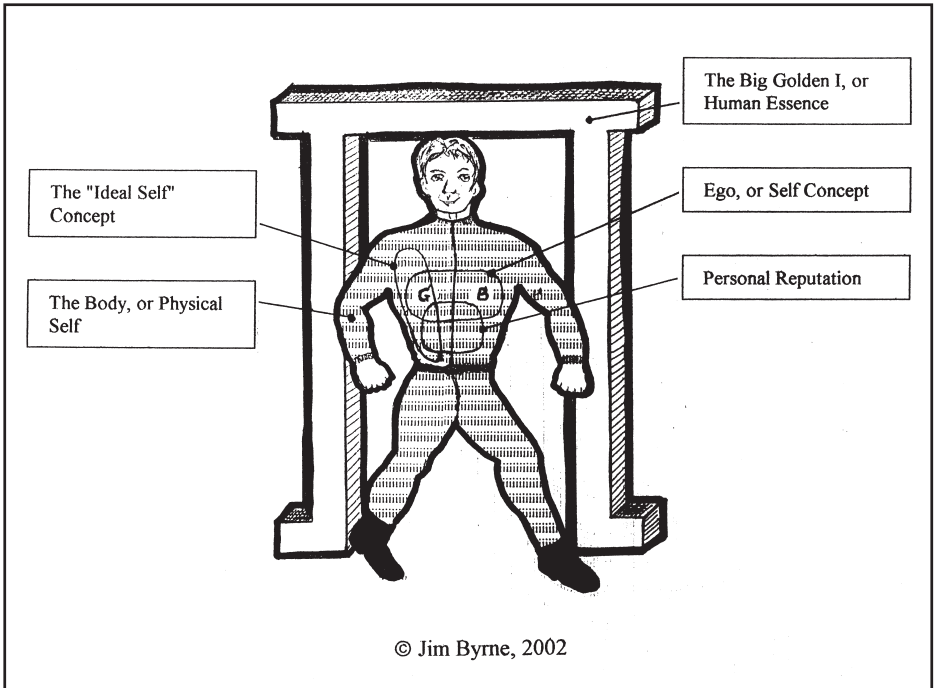
Once Jackie was able to extend Unconditional Other Acceptance (UOA) to Henry, she also found it much easier to Unconditionally Accept herself (USA).

Figure 7 shows the range of elements of the Big Golden I model. These include: the body, or physical self; the essence, which includes aliveness, the capacity to be aware, and the capacity to form a personal viewpoint (or I-ness); the ego, or self-concept, or what the individual thinks s/he is; the personal reputation, or what others think of the individual; and the ideal self, or self-ideal, or what the individual thinks s/he 'should be'!

In introducing the Big Golden I to my clients, I would tell them:



FIGURE 7: The Big Golden I



‘In simple terms, your essence is not your body or your mind; (or, more precisely, not your body-mind). It is principally the *aliveness* which underpins your body and mind (or body-mind). You cannot see it or touch it, any more than you can touch your mind or your energy. Just as many people were taught in school that they had a ‘soul’, which is invisible, I am now directing your attention to your essence, your aliveness – which is also invisible. And just as European artists developed the convention of painting a golden halo around the heads of Christian saints to indicate their ‘soul’, I have developed the technique of drawing a large ‘Golden I’ around the individual to indicate their essence.

‘But your essence is not just aliveness, otherwise you would have your essence in common with plants and insects, and be very unlike your present form. The additional elements of your essence, which make you distinctly human, include (a) *the capacity* to form a personal viewpoint – which means a sense of ‘I-ness’, or being ‘the one’ who is sitting reading this sentence; plus (b) *an ability* to reflect upon, and verbally articulate, your

culturally shaped and evolved personal viewpoint. This separates you not only from plants and insects, and less evolved animals; but also from non-human primates, like apes and chimps. This, then, is *human essence*, which is distinct from all other forms of living essence. (See Byrne, 2002, Chapter 5 and Appendix 'E'.)

'So your essence is aliveness; a capacity to be aware; and a capacity to form a personal viewpoint ('I am I. I am this one here, and now. I am not that one over there').'

The Big Golden I was an important innovation because the pre-existing teaching aids did not have a visual representation of the body, the ego image (or self concept), the reputation, the ideal self (or self-ideal), nor even of the essence, perceived as *aliveness*, *plus* (a) the capacity to be aware, *plus* (b) the capacity to form a personal viewpoint ('I am this one here, and now!'). So the Big Golden I presents a more developed, fully formed, definition of human essence than did Lazarus (1977), cited in Palmer (1997) and Ellis *et al* (1997). But this is still faithful to the basic theory formulated by Ellis (1962 and 1994).

## My USA/UOA Programme

I have now developed a structured programme for teaching USA/UOA – for I do not think it is possible to teach the one without teaching the other – and it falls into four parts, as follows:

- Managing the emotional over-upsets which prove to be confidence spoilers. (These are the ego disturbances of anxiety about poor performance, loss of face and loss of love; depression about personal failings or rejection; and guilt, shame and hurt.)
- Overcoming feelings of inferiority (and superiority). (This includes the question of OK-ness; and getting rid of the idea that 'I am an 'X' and I should be a 'Y'!')
- Distinguishing behaviours and essence. (Including the Big-I/Little-i model.)
- Learning the fuller range of distinctions related to the 'self' – including learning the Big Golden I model.

In my programme, each of these four stages takes at least thirty days of practical homework assignments, applied mainly in relation to self and others, normally symbolically. And I usually allow about 150 days for the whole programme to be completed, allowing for slippage in the completion of homework assignments.

I am currently running a five-month workshop, on the third Saturday of every month, based on the programme described above, which is also outlined in detail in Byrne (2002).

As far as I can tell, at this early stage of monitoring, the programme is proving useful and effective for most of its users.

## **The Philosophy and Skills of USA**

Overall, it seems to me that USA is *both a philosophy* (Ellis, 1962 and 1994) and *a set of skills* (Byrne, 2002) for achieving self-acceptance, no matter how well we perform, and no matter whether anyone else accepts us or not.

I have found in practice that USA is teachable, as illustrated above. USA is clearly learnable: and most of my clients have learned how to do it to a significant extent. USA also seems to be deployable (with UOA) in managing relationship problems, as illustrated by the case of Jackie and Henry. It seems to me to be high octane fuel for a saner life, and well worth the considerable effort involved in developing it.

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## Food for Thought: REBT and other psychological approaches to obesity

Philip Kinsella

### Abstract

Obesity is an increasingly serious health problem. REBT and other psychological approaches can help patients reach their weight goals but there is a high relapse rate. A group REBT programme is described and suggestions are made for improving treatments.

### Introduction

Obesity is an interesting health problem, where genetic, physical, environmental, cognitive, behavioural and emotional factors interact in complex ways. There is a huge literature on the subject and a surprisingly large amount of papers looking at psychological issues. Body Mass Index (BMI – defined as weight in kilograms divided by height in metres squared) has become the common measure of obesity. Men with a BMI >28 and women with a BMI >27 are considered overweight. Obesity is defined as a BMI >30. Severe or morbid obesity is defined as BMI >39 (Foster and Kendall, 1994). The prevalence of obesity is increasing; for example in America between 1976 and 1991 the figure increased from 25% to 33% of the population. Between 1900 and 2000 the prevalence has doubled despite a 5% reduction in calorific intake. The health costs of obesity in America are estimated at \$39 billion and there is a separate \$33 billion diet industry (Battle and Brownlee, 1996). Obesity has clear effects on morbidity and mortality. In summary, the risk of diabetes is increased between 2–10 fold, hypertension is doubled in those 20% overweight, strokes are increased 2.2–4.9% increasing with weight increase, gallbladder disease is commoner, particularly amongst women, respiratory disease, arthritis and gout are

increased and finally obesity is associated with high cholesterol which is a risk factor in heart disease. Regarding mortality, a review of all studies concluded that obesity doubled the risk of mortality (mainly from diabetes) compared to normal weight controls.

## **Psychological and REBT perspectives**

The key factor that leads to weight gain is energy intake exceeding expenditure and this is something that can be addressed in a psychological way.

Probably the most interesting area from an REBT perspective is the issue of cognitive processes in obesity. It is suggested that overweight patients engage in dichotomous thinking in terms of good and bad foods, or overgeneralised thinking such as 'one biscuit means I've blown it' or avoidance of thinking about their diet, e.g. 'I can't keep track of what I eat'. There is also likely to be a relationship between 'self-esteem' (as typically defined) and weight loss: Nir and Neumann (1995) found that the higher the level of 'self-esteem' the lower the amount of weight regain in follow-up. This may suggest that REBT treatments that put emphasis on self-acceptance would be helpful: it would be important to help the person realise that she cannot value herself purely on the basis of her weight. (Ellis, Abrahams and Dengelegi, 1992).

A paper by Faith (undated) describes the REBT approach in detail. She explains that the REBT approach is to become aware of unhelpful beliefs and behaviours that maintain poor eating habits. She identifies the first belief to be 'I must have my food when it is right there and I want it', and she clearly identifies this as a low frustration tolerance (LFT) belief. Patients are encouraged to say that they can tolerate not having it, the urge will pass, and they are advised to 'move away from the food'. The second belief is 'I must adhere to my diet perfectly. Any lapses are catastrophes and mean that I may as well give up dieting'. The person is encouraged to think that lapses are in fact normal and to be planned for. They are asked to consider whether one lapse means it is impossible to get back on track and whether the belief is consistent with reality. They are invited to consider that such unhealthy thinking is likely to lead to guilt and other unhealthy emotions that make it harder to reach goals. The third irrational belief is 'I am worthless because I am overweight'. This is obviously an example of self-downing and the part-whole error: it cannot be the case that a person's worth is based on one part of them, namely their weight. The final belief is

'I must lose weight and others must approve of my body'. It is clear that people have great difficulty in getting down to their desired weights, so this may not actually be possible. It would be better to set realistic goals and give yourself credit for even modest gains, which we know have health benefits. Behaviourally she recommends self-monitoring, 'exercise, exercise, exercise', planning meals and shopping lists and rewarding oneself for sticking to targets. Dryden and Steinberg's book *How to Stick to a Diet* (1996) is a comprehensive self-help book covering self-talk, behavioural change, mental imagery, emotional eating, motivation, low fat eating, exercise, sticking to a diet and case studies.

### **Treatment Effectiveness**

Looking at the effectiveness of approaches, there are various ways of treating obesity: medication, surgery, diets, psychological treatments and combinations of these. Surgery is only recommended for patients who have a BMI > 40, which is a minority group. Such surgery, which is usually these days a procedure to put a band round the stomach, results in substantial weight loss over the first six months, which is generally well maintained. So this is actually a good result but has to be weighed against the risks of an operation, which would be higher with the overweight. Drug treatment results in 5–10% loss of weight within the first six months, with weight levelling out afterwards. Weight is regained if the drug is stopped and there are concerns about the long-term effects of these medications. There are, however, various new preparations on or coming on to the market which may achieve better results (Cooper and Fairburn, 2001).

Foster and Kendall have reviewed the psychological outcome studies. Psychological treatment usually consists of the following elements:

- 1) self-monitoring of food intake, with the intention of helping patients counteract underestimation of consumption;
- 2) psycho-educational elements, for example in REBT that would be explaining the link between feelings, thoughts, behaviours and physiology;
- 3) stimulus control elements, in other words encouraging people not to have fattening foods in the house, to shop on a full stomach, to leave food on the plate, etc.;
- 4) motivational elements, to help people look at the advantages and disadvantages of weight control and help them use their motivation constructively;
- 5) dietary advice, provision of food/diet;

- 6) exercise, often helping the patient develop an exercise programme or sometimes providing this as part of the programme;
- 7) cognitive approaches – these have been a more recent development and are plainly aimed at helping patients challenge self-defeating thoughts; and
- 8) relapse prevention, helping the patient to put the approaches into place over the longer term.

Sometimes other elements are added. In terms of the effectiveness of these approaches, patients on average lost 0.5kg a week on a psychological programme plus a diet. The trend over time has been for an increase in presenting weights, longer treatment regimes (from 8 to 21 weeks), and longer follow-ups (16 to 53 weeks). The average attrition rate is 17% over 18 weeks, which compares well with commercial programmes (70% over 12 weeks). Approximately 65% of weight loss is maintained at 1-year follow-up but only 13% maintained a loss of 5kg at 5-year follow-up. It is a very common finding therefore that patients can lose weight in the short term but tend to put it on again in the longer term. This has led to critics saying that psychological approaches to this problem are not very effective.

What is being increasingly understood is that weight maintenance is a different process from weight loss. For example, weight loss is focused on avoiding fatty foods and exercising frequently in a time-limited way, whereas weight maintenance is more about having an active lifestyle, eating a sensible diet on an ongoing basis. It is also the case that the amount of reinforcers are diminished in this period as the person will receive a lot of compliments for losing weight, but none if they just maintain weight. There is evidence that an approach based on maintenance can be more effective (Perri *et al*, 1993).

## **REBT Treatment Effectiveness**

There is one study of REBT with obesity (Block, 1980) which has encouraging results. A group of 40 overweight adults were randomised to REBT, relaxation control (with a credible rationale that stress can lead to overeating) and waiting list control. The REBT approach helped patients to become aware of their thinking about eating and they were taught to think appropriately about it, and they were given homework on this. In the relaxation group they were taught 'deep muscle relaxation' and encouraged to practise it, and the therapists did not challenge irrational



beliefs during the group discussion. All groups, including the waiting list control, were given information about calorie control. The results were that all 40 participants completed the study (which is very impressive), and that the REBT group had significantly greater weight loss than the relaxation and waiting list group, and indeed managed to maintain that loss at 18 weeks follow-up. The main weaknesses of the study are a small sample and a short follow-up. The strengths are that there were two control groups, the sessions were taped for fidelity to treatment, and the therapists, whilst being competent in the therapy, did not have a particular REBT allegiance.

### **An REBT Group Treatment**

A group REBT programme has been completed for 10 significantly obese individuals based on Dryden and Steinberg's *How to Stick to a Diet*, and the outcome was evaluated. The patients' weights ranged from 106 to 207kg with a mean of 143.7kg. They were selected from the medical clinic having expressed an interest in REBT approaches. There were five sessions of treatment and two follow-ups. There was a mixture of didactic teaching, group exercises, individual exercises and discussion and the sessions lasted for 75 minutes. Sessions dealt with self-talk, emotional eating, the four types of irrational beliefs and the ABC model, the advantages and disadvantages of weight control, behavioural change, stimulus control and exercise. Weight change, attitude to the sessions and wellbeing were measured. There were not enough patients in the group to draw statistically meaningful results. The mean weight loss was 4.4kg. There was only a 0.05 possibility that the weight loss occurred by chance though it was impossible to say that the REBT intervention caused the weight loss.

My observations of the group were that one patient did not attend after the first session but everyone else attended other sessions: the more sessions people attended, the better they did. It was my impression that the more behavioural elements such as stimulus control were more readily learned and utilised. It was difficult to get the concept of irrational thinking and the four beliefs over in one session, though the concept of emotional eating was well understood by the group and excellent challenges were made. In general, homework tasks were complied with, though there was not enough time to check everyone's homework in detail. I very much believe that the aspect of group coherence and the support and practical help that the participants gave one another was helpful. It was useful to have the dietician there even as an observer as she knew all the patients

and this helped to break the ice. There was not any problem in encouraging the members to participate; in fact it was necessary to stop getting distracted into side issues. There were also a significant number of problems that came up for the members, such as relationship difficulties, physical illness and so on and it was difficult to properly address them within the time limit.

## Improving Treatments

Regarding future directions in research and treatment, the evidence shows that psychological interventions for obesity are effective in producing weight loss for a period, which will have health benefits, but there is a tendency for patients to regain weight. The important question to now consider is what can be done to improve treatments. Whether failure to maintain weight loss is due to loss of knowledge, skills, motivation or the aversive effects of these behavioural changes (such as hunger, stress or social pressure) is not fully understood. Biological orientated scientists interpret the failure to sustain change as evidence for biological determinants, and there may indeed be a limit on the effectiveness of psychological strategies (Jeffrey *et al*, 2000).

From what we have learned we can probably say what an ideal REBT treatment would be. It may be individualised or group, it would start with a detailed ABC analysis and the clear setting of realistic goals that should be the loss of 10% of body weight, it should start with vigorous and forceful challenges of LFT and self-downing beliefs which are frequently found. It would very forcibly emphasise that people are fallible and valuable human beings even if they do not reach their goals and indeed even if they remain obese. It would help the person realise that there are pros and cons around losing weight. It would include education about energy balance and particularly the importance of low fat diets; it would encourage patients not to have rigid demands about sticking to their programme but would encourage flexibility and preferences. It would have a very strong emphasis on regular activity, but would tailor it to the individual, and emphasise it should be lifelong. It would encourage the use of stimulus control elements. It would emphasise a stage of weight loss and one of weight maintenance. It would put great emphasis on the rational attitude to relapse. Looking at the issue of future research it would be useful to know whether this 'ideal REBT treatment' would be more successful than previous therapies. The key question is whether intensive work on LFT and self-downing beliefs leads to better outcomes.

## Relapse Prevention

The other key future research activity is to fully understand the cognitive, behavioural and emotional factors that occur in relapse. If these were understood better, then REBT treatments could be evolved that target them directly. With this in mind I have devised an REBT model of relapse that I intend to validate, and I shall describe it now. This is an attempt to understand the activating events for a relapse and the cognitive behavioural, emotional and physiological consequences. For example, the triggering event may be the patient weighing herself and either putting on weight or not making adequate progress towards her goals; she may then at a cognitive level engage in demanding thinking such as 'I must reach my ultimate goal or it's not worth it', the emotional response may be depression or frustration and the behavioural response may be to start overeating and stop weighing herself and so on. My research will attempt to understand the complexities of this process in an attempt to devise better psychological treatments.

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