THE RATIONAL EMOTIVE BEHAVIOUR THERAPIST

Journal of
The Association for
Rational Emotive Behaviour Therapy

Volume 12 Number 1, 2007

ISSN 1354 - 9960

The Rational Emotive Behaviour Therapist

Journal of
The Association for Rational Emotive Behaviour Therapy

Vol 12 No 1, 2007

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Journal of The Association for Rational Emotive Behaviour Therapy

Editorial

Developments in Rational Emotive Behavioural, Cognitive and Multimodal Approaches: Special Conference Issue

Our last conference on 24 November 2006 was an exciting and possibly historic experience. It was titled *Developments in Rational Emotive Behavioural, Cognitive and Multimodal Approaches: A Celebration of the Therapeutic Approaches Developed by Aaron Beck, Albert Ellis & Arnold Lazarus*. It was a special occasion as the conference was sponsored by the Association for Rational Emotive Behaviour Therapy and the Association for Multimodal Psychology, UK. The conference was held in Greenwich, London. It ended in a roundtable discussion celebrating the contributions of Ellis, Beck and Lazarus.

In this issue of *The Rational Emotive Behaviour Therapist*, the first five articles are papers that were given at the conference: 'Application of REBT with Muslim clients' by Rameez Ali, 'Fixed role therapy in a Multimodal context' by Dennis Bury, 'The power of Belief as a healer' by Irene Tubbs, 'The Multimodal assessment of cocaine' by Greg Scott and a 'Brief Report: A cognitive-behavioural self-help approach to stress management and prevention at work: a randomised controlled trial' by Stefania Grbcic and Stephen Palmer. What the conference highlighted was the cross-fertilisation of ideas and concepts between the three therapeutic approaches and their practitioners which has occurred over the past four decades.

The last paper, 'Is Guilt getting off the hook? Using REBT to develop new models of shame and guilt indicates that guilt may be more pathogenic than research suggests' is by Katherine Wright. This interesting paper addressing guilt was not part of the conference.

I am now working on our next issue of the journal. Case studies, book reviews, research, and papers focusing on REBT and CBT are welcome.

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Application of REBT with Muslim clients[1]

Rameez Ali

Abstract

This paper will demonstrate how Rational Emotive Behaviour Therapy (REBT) can be applied effectively to Muslim clients by non-Muslim REBT therapists. Since the events of 9/11 and 7/7 scrutiny has increased on Islam and Muslims in the West. The recommendations made by Layard for making talking therapies more accessible to the general public in Britain will mean there is a likelihood that non-Muslim REBT therapists will encounter Muslim clients in the NHS, or in the voluntary sector.

Key words: Rational Emotive Behaviour Therapy, Muslim clients, Five Pillars of Islam.

Islam

Islam is a monotheistic religion. Allah is the same God that is worshipped in Judaism and Christianity. Muslims revere all of the ancient Hebrew Prophets, such as Moses and Solomon, and also regard Jesus as a Prophet of Allah (though they disagree with most Christians regarding the divinity of Jesus). Muslims regard the Prophet Muhammad as the last of Allah's messengers. The Holy Quran is considered by all Muslims to be the literal and unaltered word of Allah.

The Quran consists of 114 chapters (known as 'Suras', with individual verses known as 'Ayats'), which cover a vast array of subjects and address myriad theological and social questions and issues. For Muslims the Quran is a cornerstone of everyday existence, and is used as a guide for all sorts of social, religious, familial, educative and governmental functions. The book itself has remained unchanged since its inception. The Quran is the common factor that unites all Muslims, although subsequently derived texts

1. Paper presented at the National Conference of the Association for Rational Emotive Behaviour Therapy in Association with the Association for Multimodal Therapy held in London, UK on 24 November 2006.

such as the Hadith (a collection of 'The Sayings of the Prophet') are similar to the Gospels in the New Testament. However, the emphasis, validity and veracity of such texts are arguable, while the Quran itself is regarded by all Muslims as being an unaltered word of Allah.

The Five Pillars

The core beliefs and practices of Muslims can be summarised in what are known as 'The Five Pillars of Islam'. These constitute:

1. The declaration of faith - this is the meaningful expression of belief in one God, and that Muhammad is his final Messenger.
2. Prayer - five times a day towards Mecca.
3. Alms - helping the poor and needy.
4. Fasting - for thirty days during the month of Ramadan.
5. Pilgrimage to Mecca - at least once in a lifetime.

Islam in the West

Although Islam began in Arabia, most Muslims in the world are not Arabs; only about 20% of Muslims live in the Middle East (Belt, 2002). Most Muslims living in the West live in the United States; 40% of Muslims live in South/Southeast Asia, and are particularly populous in countries such as Pakistan, India and Indonesia (Belt, 2002). The common thread that ties all of these Muslims together is the Quran, which is regarded as an unalterable, final and complete revelation from Allah, and is thus a source of social cohesion and brotherhood amongst peoples who would otherwise have little in common. Thus, conversion rates to Islam are high, dropout rates are low, and the percentage of Muslims who take their religious beliefs seriously and practise is high.

Islam in Britain

There are approximately 1.8 million Muslims living in Britain; the majority of these Muslims are British-born Asians of Bangladeshi or Pakistani origin, who live in large cities such as London, Birmingham and Manchester (Guthrie & Cave, 2004).

REBT position on religion

As cited by Johnson (1992) REBT is illustrated to be applicable with religious clients. The REBT model by Johnson (1992) can be modified to use with Christian clients and can be adapted to accommodate Christian values.

Albert Ellis (1992) in the same journal cites he no longer believes that religion causes emotional disturbance but *religiosity* is the cause of emotional disturbance, and thus has changed his opinion on religion.

Ellis (1992) REBT endorses views found in Islam, Christianity and Judaism. Ellis (1992) also states even though he is atheist, other REBT practitioners can follow any religious faith they wish to and it should not impact or impede their practice of REBT.

The application of REBT to Muslim clients

- Sura 13/Ayat 11 (13:11) of the Quran: '…Allah does not change the condition of a people until they change their own condition…'
- REBT: men are not disturbed by events but their beliefs about the events.

The assessment process would include the client's level of adherence to the fundamental principles of Islam. Does the client pray, fast etc; their family/Islamic background; as well as information on the client's level of Islamic understanding and application to their own life.

When assessing unhealthy negative emotions, ie depression, anxiety etc, the REBT practitioner needs to establish agreed terminology with the client, to help facilitate understanding between the client and therapist. An English translation of the Quran can be used. While certain emotional states such as anger are mentioned in the Quran, other emotions are not. In such cases, a clear and comprehensive assessment of the behavioural consequences can help facilitate an understanding of emotions associated with self-defeating behaviours.

A. Cognitive Methods

I. Rational coping statements

An REBT therapist can help the client to formulate rational coping statements by the use of metaphors, the use of Quranic/Islamic words and phrases, such as 'Inshallah' (God Willing). These phrases are present in all Islamic societies. The use of such phrases and metaphors can be adapted by an REBT therapist to develop new rational coping statements.

An example of a rational coping statement to develop high frustration tolerance (HFT) beliefs is illustrated by Ellis and Abrams (1984). These rationalising self-statements can be adapted to for a Muslim client: 'I always can stand what I don't like - if I strongly believe that I can stand it, Inshallah.'

II. Modelling

The REBT therapist can use metaphors for Muslim clients. The Quran can be used as a point of reference. This intervention can be applied to dispute the Must/Should beliefs WHERE IS IT WRITTEN. The REBT therapist can use examples of the Prophets Abraham, Moses, Jesus, Solomon, Muhammad. All Muslims revere these Prophets as the best of mankind and are regarded as the best role models.

B. Behavioural Methods

Using examples of fasting and praying, an REBT therapist can develop and incorporate these practices into behavioural methods to dispute Low Frustration Tolerance (LFT) beliefs.

Behavioural methods can help activity schedules for a depressed client. Praying five times a day at set times helps to facilitate motivation. Applying mindfulness techniques when praying or fasting can help to diffuse unwelcome thoughts or emotions.

Obstacles to effective REBT with Muslim clients

A. Client-based obstacles

In many societies stigmas are associated with people who are suffering from mental health problems. The REBT therapist can use Quranic examples of human fallibility. The REBT concept of unconditional self-acceptance can be applied and taught to the client.

The REBT concepts of unconditional life acceptance and unconditional self-acceptance can be applied in such instances.

Objections to psychotherapy

Most Muslim clients have limited knowledge of psychotherapy, and in particular cognitive-behavioural based psychotherapies such as REBT. They may presume that therapy has the purpose and intent of brainwashing them, or delving embarrassingly into areas of their psyche, personality and childhood that they believe should not be discussed with strangers. Thus, they might go to the local imam for support and advice, since they trust such an imam to offer support and provide advice. If the client wishes to discuss the application of REBT with their local imam they can do so. This can help to overcome any religious doubts or reservations about therapy.

B. Therapist-based obstacles

Lack of knowledge about Islam

The approach advocated by Dryden and Yankura (1997) recommends cross-cultural counselling techniques that recognise such limitations and the potential ignorance of the therapist. The therapist should be honest about such deficiencies, both within themselves and the client.

Other obstacles

Gender issues

There is segregation of men and women (and boys and girls) in most social environments such as school, prayer and other social gatherings. Coupled with the Islamic/cultural injunctions/constructions against promiscuity and socialising with the opposite sex, many young men and women may feel uncomfortable when working with a therapist who is of the opposite sex.

Getting sidetracked into unimportant issues

It is quite easy in preliminary sessions, where therapist and client are deciding on a mutually agreed interpretation/translation of religious texts, for the therapist and client to get unnecessarily bogged down in minute details which can spiral out of control and lead to arguments, endless debate, conflict, and thus ultimately defeat the purpose of the session in the first place.

Restricting oneself to an agreed translation of the Quran that the client chooses has the advantage of minimising the amount of research the therapist must undertake in order to understand the client's religious beliefs, and offers a point of reference.

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Fixed role therapy in a Multimodal context[1]

Dennis Bury

Abstract

Fixed Role Therapy is outlined from its historical basis and conclusions made about the range of techniques available from it. These are then considered as part of a multimodal format. Suggestions are made about suitable ways of engineering the procedure with clients and some examples are given. Forms for possible use are available as an appendix.

Key words: fixed role therapy, multimodal therapy, homework.

The establishment of the Fixed Role Technique is hardly assured. There have been relatively few examples of it over the years which have been published and none of these has had the benefit of a random control trial to maintain its efficacy. Nevertheless, it has some promise and perhaps in a multimodal format it may stand a better chance of achieving a trialed basis for evidential support.

There is no such thing as a 'multimodal Fixed Role Therapy'. Multimodal therapy is an approach which utilises techniques and strategic responses in order to meet the need for a technically eclectic provision to accommodate needs displayed in the multiple manifestation of upset and disturbance. The Fixed Role Technique [Therapy] is therefore in multimodal perspectives seen as a tool for responding to a specific need. Thus, firstly it will be beneficial to look at the history of the Fixed Role Technique to help us define it and establish the main ingredients before I go on to outline a 'multimodal' view of Fixed Role and look at the implications.

If asked to put in common language what the technique involves, one would say that it is a procedure in which a client tries out new behaviour or a new role which is different or even oppositional to one which has been

1. Paper presented at the National Conference of the Association for Rational Emotive Behaviour Therapy in Association with the Association for Multimodal Therapy held in London, UK on 24 November 2006.

dysfunctional. The therapist leads the client in designing the new role but they are together on the task of shaping it. The performance of the new role is something which then occurs outside the therapeutic hour, perhaps with the designation of 'homework'. The function of the technique will have different meaning depending upon which tradition the therapist represents. In this conceptualisation of the technique, though, the therapist will have a lot of choice depending upon the needs of the client.

George Kelly (1955) is usually credited with being its originator and he writes about it fully in his great volume *Theory of Personality*. As in everything, though, there were going to be antecedents and origins even. Where did it come from? Many think that the Role Enactment that occurs in Psychodrama [Moreno] was influential (Kipper, 1996). It was also certain that Behaviourism has a part to play (Kelly was very conscious of the proposals of Behaviourism and did not like them). In that arena, the process of Habit Reversal is salient, although any form of behavioural therapy role play can be seen as seminal - Behaviour Therapy has main techniques and Role Play is listed as one of them (Elliott, 1996). Doubtless, though, Kelly was wonderfully artistic in combining elements and creating new formats for this technique. In fact, informed commentators believe he used the technique himself in order to accomplish some tasks (Fransella, 1995; Raskin and Bridges, 2004). In his hands, Fixed Role Therapy procedure sprang from the 'diagnostic' position - although we should not equate 'diagnosis' with any DSM IV or ISCD type of assessment. Largely, the Kellyian assessment procedure takes the form of idiographic instruments such as the Self Characterisation, the Repertory Grid and, of course, narrative. Good accounts are given of the technique in many texts on Personal Construct Psychology and some journal articles (eg Adams-Webber, 1979 or Epting and Nazario, 1987).

Fixed Role is indicated by Kelly as being much helped by the Self Characterisation (Appendix 1). The function of the diagnosis was to determine how the person's system of constructs cohered. As Kelly (1955, p.324) noted, the overall "object of this kind of inquiry is to see how the client structures a world in relation to which he must maintain himself in some kind of role". Therefore, the client's personal construct system is the primary focus of this assessment, but a secondary focus is where the client places themself with respect to the personal categories and dimensions that make up their world (Winter, 1992). These writings tend to begin with phrases like 'Richard is' and they are extremely idiographic. The decipherment of

them is probably equally as broad, although Neimeyer (1993) has begun the work of producing a protocol in part derived from Kelly's original ideas. My own protocol is reproduced in Appendix 4 to give an idea of some ways in which the whole may be treated to measurement.

The second stage of the procedure involved moving from the diagnosis into choosing an 'orthogonal' role. Kelly was not keen on choosing behaviour change in a direct fashion and he stressed the importance of the client being able to come back to themselves once again. As part of this preparation stage the narrative was fixed by writing it out and learning the part. The next stage involved the enactment. This was conceived of as a period of two weeks, perhaps in response to the demand for more time limited approaches (Neimeyer et al, 2003).

- Four scenes of exposure in imaginal dimension of increasing meaningfulness and personalness
- Collection of implications

Of course, in the personal construct version Revision of Constructs is broadly the goal, not specific behavioural change. In fact, Kelly states that if the client comes up with something different, not conceived of by the therapist, then all to the good most probably. Not much Socratic leading here. I have perhaps given a rather soft version of Kelly's intention. In fact, Kelly conceived of the action phase as producing some 'shaking' of construction.

In 'Behavioural' Fixed Role (not much formal use of this title) the procedure is more clear-cut, although some similarities can be noted, for example the increasing exposure element which is present in Kelly's upping the meaningful situation of application:

Stage 1 Identifying goals
Stage 2 Learning Skills and honing
Stage 3 Active rehearsal
Stage 4 Change in cognitions and behaviour

Thus, Palmer and Dryden (1995) suggest a more procedural model in the rational emotive behavioural paradigm where the goal is to have the difficulties of undertaking the more rational behaviour - such as self acceptance - specified and modified. Dryden (1987) writes similarly. This type of intervention echoes earlier models such as Karst (1970).

The following table compares the two 'styles':

Behavioural	*Constructivist*
Reality based	Imaginally based

Specific behaviour	Identity or role
Specific cognitions	General constructs
Learning	Exploring
Quickly set up	Takes time
Outcome quick	Outcome needs time

The biggest dimension of difference is probably the specific behavioural focus versus the interest in overall *role* in the constructivist version. However, it needs to be noted that not all personal construct versions are adamant that we have to take an orthogonal approach. Viney (1981) suggests that her own usage of taking an exactly opposite role to the one which is dysfunctional brings good results.

Evidence for the efficacy of Fixed Role Therapy is limited in respect that there are no Random Control Trials indicating consistent outcomes with it. Anecdotal Reporting does indicate positive outcomes and has even been utilised in group settings to good effect, for example in marital therapy (Kremsdorf, 1985). There is a fair amount of Single Case reporting and these include topics such as depression, anxiety, performance and antisocial behaviour and accounts are given of these collectively in Winter (1992). There are additional reports coming through up to the present - for example usage of fixed role in developing management strategies in organisational help (Brophy and Epting, 1996). There are also derivatives of the basic techniques also emerging (eg Sewell, Baldwin & Williams, 1998) where Growth Group enactment of 'selves' is based on fixed role and enactment. Here, as in similarity with other accounts of the technique, the personal construct psychology focus is upon the creative aspects as opposed to definable outcomes. There is a current meta-level review of the efficacy of Personal Construct Therapy as a whole. Fixed Role is not isolated as an evidenced technique but is alluded to as one which incorporates other traditions and therefore features little in overall evidence considerations (Holland et al, 2007).

With an intention to change overall construction and role-even identity, Fixed Role Therapy is not easily measured and there are different styles of evaluating it. Perhaps, in total overview, there is not much evidence overall in terms of substance to call it a mainstream technique.

How might a Multimodal Therapist conceive of utilising the Fixed Role as a therapeutic technique? I suggest the following steps:

- Comprehensive assessment
- Choosing modality(ies)

- Deciding between Imaginal, Real or both
- Homework
- Implications
- Outcome related to original goals

Comprehensive assessment

In the Multimodal approach, there would be no direct entry into a Fixed Role procedure. Foremost comes the comprehensive assessment in Modal Terms. There has been considerable focus upon the Life History Inventory but examples of Lazarus's work indicate that this is not the sole source of help in assessment and he states that the reasons for undertaking the assessment are as follows:

- People have styles and experience.
- In any model of personality there is a need for providing cross-situational comprehensivity.
- The activity of the assessment helps the alliance because the client is involved in its production.
- The analysis is not merely confined to deficits but also indicates strengths as well. The Life History Inventory, for example, lists in all the modalities dysfunctional manifestations but alongside has a range of positive ones.
- The active work involved in the assessment lays the ground for negotiating when resistance is encountered.
- Personality seen as interrelating behaviours and such a comprehensive assessment attempts to look into all corners. (Lazarus, 1989; 1997)

The assessment utilises:

- Specific Inventories
- General Inventories
- Projective tests
- Interview Self Report Modality Tracking
- Observation

with the clear aim of making clear which modalities function well and which do not with the generation of a problem list. Multimodal therapy also considers suitability. Lazarus has some general conditions and these have similarities with those utilised in Cognitive Behavioural Ratings of suitability (Lazarus, 1997). By way of example, one would tend to be circumspect about individuals who have strongly addictive tendencies, those who have psychotic experience prevalent, various forms of antisocial

personality disorder. There are certain additional dimensions when it comes to Fixed Role technique owing to the nature of the procedure. The additional suggestions are:

1. that the patient can work independently
2. can tolerate an abstract sense of role
3. be unlikely to develop obsessional routines associated with the technique
4. have some tolerance for distress

The Fixed Role Technique will benefit from the full assessment because it is aimed at comprehensive change and works best when aimed at specific modalities.

Choosing modality

Multimodal Therapy utilises seven modalities. These are:

B Behaviour
A Affect
S Sensations
I Imagery
C Cognitions
I Interpersonal
D Health, physiology, body habits

Here is an exemplar description of a modality:

*By **behaviour** is meant generally being active, energetic, and busy. This means being often goal-oriented and choosing to act on a problem rather than studying it in depth first.*

This has been written with a positive orientation and is adapted from the Life History Inventory and also the Expanded Structural Inventory (Lazarus, 1997). Modalities can be described in terms of malfunction since the overall selection of responses to behavioural/multimodal dysfunction tends to be de-constructive but generally a positive creative slant is preferred in a Fixed Role context. The full modalities list is attached under Appendix 2.

The client needs to consider in multimodal application a framework for acting out an altered behaviour. Eleven permutations are possible:

- Focus on more than one modality [7]
- Could be accomplished imaginally or via exposure [2]
- Could be Kellyian in choosing 'orthogonal' dimensions or use direct opposite role [2]

It is useful if the person chooses a label for the overall intention; this can be global such as:
'Me standing up to persuasion'
'Me not being anxious'

Or specific, such as:
'Me when I am postponing worry at night'
'Me when I am tackling tasks in the office when they arise [versus "procrastinating"]'

Multimodal Fixed Role Therapy - Procedure Summary

1. Selection is from mode of choice as starting point
2. Degree of change is chosen
3. A general role is assigned to it by means of a label
4. Enactment is decided as imaginal or reality or both
5. Monitoring is by narrative report and self report
6. Outcomes consolidated and tried for useful elements - testable
7. Built into anti relapse procedures at a later juncture

A full layout of a chart is attached in Appendix 3 and its listing of the modality dimensions. I have set out a completed chart.

Now follow portions of selected examples. In this first example, the person has elected a role of 'letting go at leisure' so that they can feel less inhibited.

Example 1: 'Letting go at leisure'. Is going to enact the matter as a role rather than a specific behaviour and is focusing on specific thoughts as the main modality to experiment with. The means of monitoring will be a social anxiety subjective units rating and also narrative. The cognitions role is chosen because this was often the first modality to be noticed by the person in their description of incidents.

Area	*In this box please list all the implications for doing your new role or behaviours using the categories listed [see key]*
Behaviour	
Affect	
Sensations	
Images	

Cognitions	In my role as a 'letting go at leisure' I will concentrate on noticing and highlighting some of the dysfunctional thoughts I am having. I will also develop a capacity to stand back and observe them.
Interpersonal	
Drugs/Health	

The other sections are left to complete as well, if they seem to come into the equation. Here are a couple of examples of outcomes:

Example 2: The primary modality was Cognitions and the need to conform to top down models of performance [perfectionistic thinking styles]. The change was of someone who was 'happy being me' and the label was a new name of Rupert. Unexpectedly, the health behaviour modality received the main body of the action.

At the gym:

'I won't be hard on myself [stamina adaption]'

'Won't waste time thinking about my weight'

'Avoid punishment'

'Leave work on time to get there'

Example 3: The primary modality was of sensation. The label was someone who is 'positive' and having a new name of Julie. The enactment was largely of an imaginal nature. Change was experienced in a number of modalities – here is the interpersonal:

Interpersonal - '*I will think of my own needs before trying to make others happy. Will spend less time with people who make me miserable. I will not mind-read.*'

With respect to the end product, these outcomes are testable and inform persistence of changes. If there is reversion then this can be tracked using the various change identifications which have been noted. The re-enactment of the change target is available on paper for use in Relapse Prevention and the person can try out again being the label that they were.

The outcome was consistent with a Multimodal view that behaviours are part of the personality description as a whole and will reinforce each other.

Summary

The Multimodal Fixed Role Technique may offer an individually tailored but testable method of flexibly trying out new behaviours which replace old ones in a modality sensitive fashion.

1. It has the potential to be adaptive to a patient/client's needs by:
   - Corresponding to a rationalistic approach or more to a constructivist one depending upon the client's orientation in these matters (Winter).
   - Allowing a focus upon salient modalities and therefore can be very specific about aspects of the person's functioning.
   - It can be as intense or not as desired.
   - It can be brief.
2. It can assist with the prevention of Relapse by virtue of the accessibility of the actual materials used and subsequently recallable. Also, the experience is sufficiently dramatic to allow personal and reflective thoughts to bring it back to mind. Additionally, as a refresher it can be re-performed.
3. It requires no particular theory to 'make it work' and as such many different types of therapist utilising a multimodal approach will find that they can utilise it.
4. It is a procedure which is 'ripe' for testing and evidential research. The grounds for this lie in the link between troubles and outcomes.
5. In the representation of the procedure there is ample room for positive psychology and its linkage to creative therapy commends it as not confined to the merely 'corrective'.
6. The procedure may be fun to enact!

Appendix 1

The Self Characterisation

Self-characterisations are a way of finding out about an individual's constructions that are applied to the self. It makes interesting reading to look at George Kelly's (1955) original instructions for the self-characterisation:

'*In the space that follows, please write a character sketch of [John Smith], just as if he were the major character in a book, movie, or play. Write it as it might be written by a friend who knew him intimately and sympathetically, perhaps better than anyone really could know him. Be sure to write it in the third person. For example, start out by saying, "John Smith is ...".*' Providing no outline for the self-characterisation

is deliberate. From Kelly's point of view a format would structure the client and they would fail to discover their own view of themselves (Vincent & Le Bow, 1995; Neimeyer & Morton, 1997; Winter et al, 2006).

Appendix 2

Description of Modalities

By *behaviour* is meant 'generally being active, energetic, and busy. This means being often goal-oriented and choosing to act on a problem rather than studying it in depth first'.

High in the Physiology/Biochemical factors, are health conscious. They avoid unhealthy habits and take care of their bodies. They do not resort to substance use to cope - they harmonise with more natural methods and means.

High in the Sensory modality, are very tuned in to their physical sensations. They are keenly aware of smells, tastes, sights, kinaesthetics and sounds, similar to the conceptualisation of the strongly right brain-dominant individual. They live with an awareness of their environment through the senses.

High in the Cognitions/Thinking modality, consider themselves logical, rational and contemplative. They value reasoning.

High on the Imagery modality, are good at thinking in pictures. They may be more likely to fantasise or daydream and can often think three-dimensionally.

High on the Behaviours modality scale, are generally described as active, energetic and busy. They are often goal-oriented and often choose to act on a problem rather than studying it in depth first.

High in the Interpersonal modality, derive energy from interpersonal relationships. These are 'people persons' who like to socialise, mingle and be in groups.

High on the Affects modality, consider themselves emotional. They feel things deeply and rely on their emotions and intuitions.

Appendix 3

The Fixed Role for the Future Technique

This chart is to help you work out what supports and does not support your new role. Whether you imagine what it will be like or actually do it,

the aim is to capture in various categories the things which are helpful and you do differently as a result.

Tick box 1 if done as a real act; tick box 2 if done in imagination in some way or other; tick both if done in imagination and in reality in separate exercises.

Name of Role you are adopting ☐

Box 1 ☐ Box 2 ☐ Date: ☐

(Really doing it) (Imagining doing it)

Area	*In this box please list all the implications for doing your new role or behaviours using the categories listed [see key]*
Behaviour	
Affect	
Sensations	
Images	
Cognitions	
Interpersonal	
Drugs/Health	

Area Information Chart

Don't be alarmed if some areas become less as you contemplate or act out change. It may be the case that using a particular modality has been negative for you.

Area	*In this box you are being asked to list all the implications for performing or imaging your new role or behaviours using the categories written in the left hand column. Below is a description of the modalities*
Behaviour	By behaviour is meant generally being active, energetic and busy. This means being often goal-oriented and choosing to act on a problem rather than studying it in depth first. How much of a 'doer' will you find yourself to be? You list here some examples of how this modality will change for you - can be more or can go less depending on whichever is positive for you.

Affect	This modality means 'feelings'. Such people will consider themselves emotional. They feel things deeply and rely on their emotions and intuitions. These feelings may or may not be expressed. How much of a passionate person will you find yourself to be? You list here some examples of how this modality will change for you - this can be more or can go less depending on whichever is positive for you or just change both ways.
Sensations	In this modality if it were big for you, you would find yourself very tuned in to your physical sensations. Such people are keenly aware of smells, tastes, sights, kinaesthetics and sounds, similar to the conceptualisation of the strongly right brain-dominant individual. They live with an awareness of their environment through the senses. List some examples of how tuned in you might find yourself to be with your new role - can be more or can go less depending on whichever is positive for you or just change both ways.
Images	This is about thinking in pictures. They may be more likely to fantasise or daydream and can often think three-dimensionally. It's asking how much will you see changes and how much you are into imagery. In this one, you list some examples of how this modality will change for you - can be more or can go less depending on whichever is positive for you.
Cognitions	In this modality people consider how logical, rational and contemplative they are. They value reasoning as a guide to life. You list here some examples of how much of a thinker and planner you will become - or less, depending on whichever is positive for you.
Interpersonal	This the modality where someone may derive energy from interpersonal relationships. These are 'people persons' who like to socialise, mingle and be in groups (opposite is 'loner'). You are asked to evaluate how this modality of valuing people for friendship and gravitating towards them will change for you - can be more or can go less depending on whichever is positive for you.

Drugs/Health	This modality with the unlikely heading of 'Drugs/Health' is about Physiological and Biochemical factors leading to the creation of health conscious. In this there is an avoidance of unhealthy habits and a tendency to take care of the body. They do not resort to substance use to cope - there may be a harmonious link with natural methods and means. You list here some examples of how this modality will change for you - increasing health consciousness and reducing bad habits such as over-consumption and sedentary being.

Appendix 4

Example of a protocol for understanding self characterisation

PROTOCOL ANALYSIS

NARRATIVE & TEXTS

Locating Core and other Structures

Do the stories or statements contain any of the following?

Problems and saturation with difficulty

1. How much negative about Self
2. How much positive about Self
3. How much 'saturated' with problems is Self
4. Any stories about problems
5. Any solution stories to problems

History

1. Is there anything about the personal past
2. Is there anything about the future
3. Any link-up constructs between past and present

Science and Weltanschaung

2. How are things caused
3. How do things relate to themselves and Self
4. Any stories about Self and society at large
5. Any stories about the specialness of Self and the ordinariness of Self
6. Any stories about life itself

Self

2. How is Self represented
3. What about Self and others
4. Any stories about physical identity
5. Any stories about feelings
6. Any stories about competencies

Structure of Construing

1. First and last stories put together - are they connected
2. First and last statements about stories put together - are they connected
3. Between the first and last story is there a flow or is it made up of disjointed themes and narratives
4. What are the themes [in a word] between each story or incident [list them]
5. Any big contradictions between the major themes
6. Is there a dominant and repeated theme or topic
7. How many sub themes are there; are they connected or random

General Picture

We are wishing to find out if there are any roles that have an enduring presence through the stories - are there any dislocations, interruptions such as trauma or loss? Is there a core role for this person or is it dispersed and fragmented?

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The Rational Emotive Behaviour Therapist Vol 12 No 1 (2007)
Journal of The Association for Rational Emotive Behaviour Therapy

Power of Belief as a healer[1]

Irene Tubbs

Abstract

Whilst there has been, and still is, much debate regarding how central the power of thought is to activate self healing properties, there is still scant reference or research relating to how a 'belief' stimulated by 'thoughts' can act as both a physical and psychological inner healer. This article asserts that 'Belief' is a central and primary facet which will determine a person's ability to support their own health and wellbeing and, as presented at the AREBT conference 2006, demonstrate how it can be used within REBT, CBT and Multimodal therapy to strengthen a person's innate self healing properties.

Key words: self healing, health inhibiting beliefs, health enhancing beliefs, REBT, CBT, MMT.

Introduction

The main question is, 'does the mind have the power to create physical, emotional healers?' and if found to be so, what significant part does 'Belief' play to support such healing?

Before we review current research evidence supporting the power of Belief as a healer, within both Health and Psychological fields, let us reflect for a moment on the term itself. The descriptive word BELIEF is often used in everyday language to ask a question: 'Can you believe that?' or to make a statement: 'I don't believe it'. It is a core element of 'cognitive expression' which, as the dictionary informs us, can imply:

- a religious conviction
- a firm opinion (I believe he did it) (often associated with absolutes – Ellis)
- an acceptance (of a fact, statement etc)
- beyond belief (incredible)

1. Paper presented at the National Conference of the Association for Rational Emotive Behaviour Therapy in Association with the Association for Multimodal Therapy held in London, UK on 24 November 2006.

Research supporting the premise that 'Belief' can generate healing can be witnessed within current Health Provision. For example, Clinical Trial Research into the 'placebo effect' provides clear evidence that orthodox medicine recognises how a person's 'belief' can affect their response to any treatment.

Also known as 'non-specific effect' and the 'subject expectancy effect', the 'placebo effect', as distinct from the more correct term 'placebo response', although often attributed to Henry K. Beecher MD (1955), was actually first introduced by Graves in 1920 when he said, 'It is the subject that has the subject-centred response, not the administered substance, that generates the observed effect.'

In essence, the Latin placebo 'I shall please' is the phenomenon that a patient's symptoms can be alleviated by an otherwise ineffective treatment, since the individual 'expects' or 'believes' that it will work. The opposite effect, 'nocebo', the Latin meaning 'I shall harm', can occur where a patient 'disbelieves' in or has a negative attitude towards a treatment and may even experience a worsening of symptoms.

Because it has been recognised that a doctor's belief in the value of a treatment can affect their behaviour and thus what their patient believes, such trials are usually conducted in 'double blind fashion'. That is, not only are the patients made unaware when they are receiving a placebo, the doctors are made unaware too.

The outcomes are considered by professionals as either a remarkable aspect of human physiology (power of the mind) or an illusion arising from the way medical experiments are conducted. Supporters such as Kahn (2000), who published a meta-analysis of studies of 'investigational antidepressants', found a 30% reduction in suicide and attempted suicide in the placebo groups and a 40% reduction in the treated groups.

Some believe the placebo effect is psychological, due to a belief in the treatment or to a subjective feeling of improvement. Irving Kirsch, a psychologist at the University of Connecticut, believes that the effectiveness of Prozac and similar drugs may be attributed almost entirely to the placebo effect. Kirsch and Guy Sapirstein analysed 19 clinical trials of antidepressants and concluded that the expectation of improvement, not adjustments in brain chemistry, accounted for 75% of the drugs' effectiveness (Kirsch, 1998). 'The critical factor,' says Kirsch, 'is our beliefs about what's going to happen to us. You don't have to rely on drugs to see profound transformation.'

Others such as Hrobjartsson and Gotzcsche (2001, reviewed 2004) question the nature of the placebo effect. Their findings suggest that the placebo effect is largely patient reported 'subjective' improvements as opposed to clinically determined 'objective' effects. This is an aspect very important within the Talking Therapies, as the most important determinant of wellbeing is 'subjectively' voiced by the client.

Look at the most recent placebo evidence on the 'power of the mind' and decide for yourself. Is belief an illusion or primary evidence of how the mind, and in this instance 'belief', can lead to recovery?

Researchers from the University of California, Los Angeles (2002) used imaging technology to show that placebo treatment instead of medication can for receptive individuals actually change the way their brains work using a technique called 'quantitative electroencephalography' to examine the electrical activity of the brain. Their findings showed that patients who responded to a placebo showed increased activity in the brain's prefrontal cortex. In contrast, those who responded to medication showed suppressed activity in that area. The prefrontal cortex has been linked to working memory, information processing, behavioural organisation and attention.

Recently it has even been shown that 'mock surgery' can have similar effects (rarely double blind for obvious reasons). I came in one evening (2006) from working with clients, flicked with the television controls and came across a programme on BBC2 which was reviewing Alternative Therapies, in particular the effects of Belief. Whilst much of the programme reiterated what I already knew, I was mesmerised when they began to discuss a placebo trial in America whereby a number of patients all requiring knee surgery were taken into surgery believing they would be operated on. Half were, and the other half were cut open and sewn back up without anything being done. Most interestingly, a review the following year showed that those who had not had surgery had recovered as well and in many cases better than those who had been operated on. One particular placebo op. patient was interviewed and when asked why he thought the pain had gone he said, 'I believed the doctor when he told me the operation had gone well and I would now be fine'. His pain, he said, 'was real, in fact so bad at times that I couldn't walk. I'm amazed. I wouldn't have believed this was possible before, but it's worked'.

Experimentally induced pain

Stanford University, California, 2005 (written up in *New Scientist* magazine) used a specialist computer showing brain activity in the region that deals with pain, to monitor volunteers' abilities to endure heat on their palms. Within just three sessions, using the power of their minds (cognitive restructuring, eg 'I can stand the heat') whilst focusing on the screen, they could reduce the signals, effectively manipulating the brain to shut out pain.

Even within the normal strata of the medical field an individual's outcome of treatment is still seen to relate to a person becoming a believer in:

- Orthodox medicines
- The provider of a medicine/treatment, ie doctor, nurse etc.
- A person's 'belief' in their ability to behaviourally support such medical interventions
- Or, after exploration of orthodox medicine, to seek other alternative or self help processes to assist their own recovery

Belief within the psychological field (therapy)

Coming back to the essence of this article and our practice as psychological therapists, such placebo trial knowledge has resulted in research which has shown that two psychological disorders have very low placebo effects, namely schizophrenia and obsessive compulsive disorder.

Whilst there have been copious studies into how our 'primary senses', ie imagery, sound, taste, smell, touch, thoughts and movement (exercise), have the ability to become interrelated psychological and physiological self healers, which often stimulate a health inhibiting or health enhancing thought, for this article I am focusing on the power of 'thought' itself, which has been likened to the energy released from a 60 watt bulb.

Scientific research into the chemicals released when we think has further elucidated and clarified the consequential effects of a 'thought' on the health and wellbeing of an individual.

For example, immune system specialists from Birmingham University (2002) spent two years researching the effects of serotonin (a natural feel-good chemical seen as the brain's key to happiness) on a rare form of lymph cancer. They studied how it was able to enter diseased cells and reprogramme them so they self-destructed. The discovery about

serotonin, made by the body to regulate moods, also gives weight to 'mind over matter' theories of beating illness.

A further research project at Reading University (2003) studied the effects memories have in either stimulating or inhibiting the immune system. Through the taking of saliva samples before and after memories were evoked, it was found that when participants dwelt on distressing or stressful thoughts they were shown to have depressed levels of immune antibodies.

Psychologists/neuroscientists are aware that such persistent negative thoughts constantly release a chemical called Noradrenaline, which builds up in the body, creating Cortisol. (Whilst there to promote the growth of bones, it is also recognised as 'the' stress hormone, the level of which is tested by taking saliva samples.) Conversely, when a person thinks rational, healthy thoughts they harness the brain's ability to release Serotonin and, when combined with action, Endorphins, thereby enhancing the immune system's ability to fight disease.

In the context of 'Belief' within 'Therapy' we are referring to a person's tendency to believe (trust) in:

- their therapist
- the written word
- themselves (as in their ability to make changes)
- or indeed all three.

I believe that the foundation of therapeutic practice is to engage a client in strengthening their inner self-determining skills (beliefs) to activate, develop and maintain their own care.

Specifically within REBT, Ellis purports, "It is not a situation or activating event which causes physical, emotional, mental or behavioural outcomes. It is a person's often intensely practised 'irrational beliefs' which are the core indicators of healthy or unhealthy life experiences". As you know, Ellis emphasises the essential importance of disputing a person's self defeating beliefs into rational, evidence based alternatives which ultimately enhance their wellbeing.

Within CBT, belief is perceived as a core motivator for developing health enhancing thoughts, beliefs and practices. Beck and Burns both define 'core beliefs' as thoughts or cognitive distortions which fuel emotional disturbance. Neenan and Dryden (2002) describe CBT as "helping clients to develop alternative and more constructive view points to tackle their problems, by challenging and altering their 'beliefs'."

Within Multimodal Therapy, Lazarus uses his Basic ID (acronym for the human personality) to assess individuals within seven specific interactive modalities in order to achieve a thorough and holistic understanding of the person and their social environment; throughout the assessment stage and beyond to ascertain the individual's often deep-seated 'beliefs' relating to their interpersonal traits that have fuelled and continue to fuel health inhibiting thoughts, beliefs and behaviours.

I would suggest that the reason REBT, CBT and MMT are powerful arenas to review and assist the healing process is because all explore the 'power of thought, emanating from the brain' to either inhibit or enhance a person's wellbeing.

So what does comes first, the thought or the belief?

It is a little bit like the saying, 'what comes first, the chicken or the egg?' but I would maintain that a 'thought' is the initial stimulator for a belief to develop. Once developed any entrenched beliefs (persistent mass of similar or same thoughts which merge together to cement belief) fuel subsequent thoughts, ultimately encouraging health enhancing or health inhibiting thoughts, beliefs and practices.

This systematic approach to encouraging health enhancing thoughts, beliefs and practices was first muted by Palmer, Tubbs and Whybrow (2003) and Palmer (2004).

These cognitive or attitudinal blocks to change can be divided into the following definitions:

- Health Inhibiting Thought **(hit)** leading to Health Inhibiting Beliefs **(hibs)**
- Health Enhancing Thought (**het)** leading to Health Enhancing Beliefs **(hebs)**
- Behaviours that fuel Health Inhibiting Practices **(hips)**
- Behavioural change that fuels Health Enhancing Practices **(heps)**
- Thoughts that can result in poor performance (frequently work related) (**pits**)
- Thoughts that encourage belief in performance (evidential in nature) (**pets)**

Cognitive techniques such as Socratic questioning can also be used to help a client modify their thinking (Neenan & Palmer 2001).

Case Studies

Example 1

This client presented with severe depression related to arthritic pain. His thoughts as presented were:
hit 'I can't do it', 'I can't cope with this pain.'

leading to:
hib 'I'm never going to cope with this pain.'
hip He was very inactive.

Conversely, when evidence for these thoughts and beliefs were explored within therapy we found at times the opposite was actually physically occurring, which when linked to realistic positive thought changed his belief and active practice, ie he was able to think:
het 'This pain is bad, but when I make myself walk it eases.'
fuelling **hep** he walked more

leading to:
heb 'I can help myself to reduce the pain.'

Example 2: Disputing Must, Should, Have to and Ought

A client suffers with recurring panic attacks. After an argument with her partner she withdraws from the scene. On her return journey she begins to think:
hit 'I'm going to face a row when I get home, I just can't stand it.'
Physical & emotional outcome Tightness in chest, shallow breathing, fear of panic returning.
Fuelling hit 'Oh no, I mustn't panic now, I'm driving.'
Health inhibiting outcome Breathing becomes worse, has to pull over.
Behavioural hit 'I'll ring him and say I'm having a panic attack and then he won't be cross with me.'

Because of previous exploration of the physiology of panic attacks, effects of shallow breathing and adrenalin surges, she was able to trigger the health enhancing practices of deep breathing and constructive evidence based thoughts which resulted in the following:
het 'Slow down, deep breathe, it's only a panic attack, it won't stop me breathing.'
Behavioural hep 'Turn the radio on, listen to the music.'
Physical outcome Heart stops racing, breathing slows.

Fuelling hebs 'That's it, well done, it's going. I can stand this. I've felt it before but when I deep breathe I know I can take it away.'

A client with unrealistic expectations who having dealt with an anxiety attack believed he 'should' have conquered it for good:

Hit 'Why hasn't it gone yet, I should have been over it by now.'

Physical consequences Anxiety continues until his breathing is affected and he feels faint.

Behavioural consequences Begins to focus on heart racing and thinks

Fuelling hit 'I'm going to have a heart attack.'

Challenges with Hets 'Everyone gets anxious. I'm making it worse when I concentrate on what is happening in my body. Come on, do your counting, breathe in - one, two, three, and out - two, three, four, five. Slow down.'

Physical outcome Heart rate slows, anxiety drops, dizziness subsides.

Heb 'I prefer not to get anxious but I know I will when I'm pressured. It's part of my life, a habit really, but I can and am dealing with it.'

Imagery is a powerful tool to use alongside Hets, Hebs and Heps as it can decrease fear, release stress and tension, induce relaxation and stimulate a person's belief in their ability to create a physiological comforting change within their bodies.

One of the many imagery awareness raising tools I use is that of a spring**.** Many find such a descriptive image a useful tool to mentally review and sensorally become aware of what they are doing or thinking at that time, eg client with work pressure:

Hit 'I've got to get this done, otherwise they'll think I'm shirking.'

Physical and emotional outcome Tension, agitation, anger with self and others.

Imagery hit 'I'm really wound up.'

Het leading to Heb 'Here I go again, winding myself up. Come on, when you're tense you're slower. Right, I'm going to take a break, deep breathe, walk up and down the stairs and have a drink. Then I'm coming back to do my list of manageable chunks.' (tasks)

During the conference I also gave the audience an opportunity to practise a 'healing imagery' technique. I have used this process many times to encourage a person to believe in their own ability to support orthodox medicine or to act as a self healer to fight disease or smooth physical or emotional distress. For example, a client presented with distress because he could not sleep due to arthritis in his joints. He wanted to see a healing image of an oil can. I explained that tension is created when in pain and

encouraged him to use breathing to help him to relax. I then read out his chosen health enhancing script:

"Take as many breaths as you like. As you breathe in feel that wonderful oxygen enter your body, pushing any niggling discomfort out and away. With each breath feel a greater sense of comfort until you can clearly see your joints. See that oil can, full of rich, soothing, bathing, calming oil. Gently tip it up until the oil caresses those joints, soothing, calming, easing your pain. Repeat this with every joint." (I kept quiet at this point and allowed the client to enjoy the image.) After a while I said, "Your joints are now moving freely and without pain. Open your eyes."

In the next session, he said his joints were much better: he only needed to think of the oil can whenever he had pain and it eased. He had also been able to make love to his wife. Remember to encourage clients to use **hebs** to enhance the belief, eg 'That's better, I feel more relaxed, I'm ready to work again. That's oiled the works."

Conclusion

As therapists we need to address the power of inner belief when working with clients who present with health inhibiting thoughts and behaviours that are affecting their health. Having ascertained such patterns (habits) we can demonstrate how the power of 'belief', created through the establishment of evidence, can generate its own healing energy.

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The Rational Emotive Behaviour Therapist Vol 12 No 1 (2007)
Journal of The Association for Rational Emotive Behaviour Therapy

The Multimodal assessment of cocaine[1]

Greg Scott

Abstract

Multimodal therapy (MMT) originated with the work of Arnold Lazarus in the late sixties. MMT is the direct result of the recognition that while behaviour therapy was producing good results in the short term, longitudinal studies were less satisfactory and there was a high rate of relapse within clients (Lazarus, 1971).

Lazarus hypothesised that this may be due to the failure to assess key modalities and the focus of behaviour therapy on antecedent and response. Lazarus went on to develop BASIC ID as a range of modalities that could help with the understanding and assessment of problems. From this grew core Multimodal techniques such as structural profiles, tracking and firing orders, use of Multimodal Life History Inventory (MLHI) and bridging between modalities (Lazarus, 1971).

Consequently, Multimodal therapy is ideal in the treatment of substance misuse problems as from its inception it has focused on relapse assessment and prevention. The following paper looks at the assessment of problems related to cocaine use, and suggests that knowledge of how cocaine works on the nervous system can support a Multimodal assessment and can facilitate client involvement in therapy.

Key words: Multimodal therapy, modalities, substance misuse, assessment, cocaine.

Cognitive Behavioural Treatment for substance misuse has focused on the cognitions that lead to and reinforce using, and as such have tended to produce generic models of treatment (Ellis et al, 1988; Beck et al, 1993). Whilst these have had a generally favourable impact, the approaches have not taken into consideration the effect substance use has on the person across multiple modalities. In the treatment of stimulant misuse this has

1. Paper presented at the National Conference of the Association for Rational Emotive Behaviour Therapy in Association with the Association for Multimodal Therapy held in London, UK on 24 November 2006.

meant that the efficacy of Cognitive models has been not been conclusively established.

The cornerstone of the Multimodal assessment lies in the assessment across seven modalities: **B**ehaviour, **A**ffect, **S**ensation, **I**mages, **C**ognition, **I**nterpersonal and **D**rug/Biology. I would argue that an understanding of the effects of cocaine on the body and nervous system will help develop an initial assessment across **BASIC ID**.

Using this approach will promote the growth of a therapeutic alliance as well as normalising the person's experiences, encouraging continued engagement in treatment. Normalising the experiences enables the therapist and client to conceptualise the individual's problems and begin to make a distinction between mood fluctuations and disturbances directly related to use of cocaine and abstinence, and mood disturbances that may predate use. Assessment will also need to include problems that may be a result of prolonged use.

An important aspect of Multimodal theory is that people have preferred modalities. In other words some people could be described as action based, as doers, preferring to act rather than contemplate or think. Some people are sensitive to emotions, others to relationships. Traditionally, people presenting with problems related to addictions have been seen as resistant. This approach has been challenged by the work of Miller and Rollnick (1991) and the motivational interviewing approach is widely accepted as beneficial. Typically, this involves an assessment of the person's drug or alcohol use, followed by a process of eliciting motivational statements and responses in order to help the person develop motivation to alter their behaviour. In a similar vein I would suggest that assessing across modalities coupled with information on how cocaine works is a way of building up a multifaceted motivation.

Cocaine

Cocaine use has been on the increase over the last decade. This is due to the dramatic drop in price on the street. Cocaine has been seen as the 'champagne' of drugs, associated with wealth and status. This reputation continues though availability has meant that all social classes use cocaine. The association of cocaine with the media and celebrities has meant that there is a mixed social message regarding use, as compared with other drugs such as opiates.

The current consensus is that cocaine is not an addictive drug in

that it is not possible to develop a physical dependency. Consequently withdrawal from cocaine has no dangerous consequences, and takes between 24 and 48 hours following a two to three day binge (Shaw et al, 2005). It is important to understand that the use of cocaine produces intense cravings and a compulsion to continue using. This often means that people will continue using until 'the money runs out' when on a binge.

Though cocaine is not physically addictive, it is important to understand that people can become emotionally and psychologically dependent on cocaine. The actions of the drug itself often serve as a powerful re-enforcer for continued use. This is due to the effect of the drug itself upon the Central Nervous System.

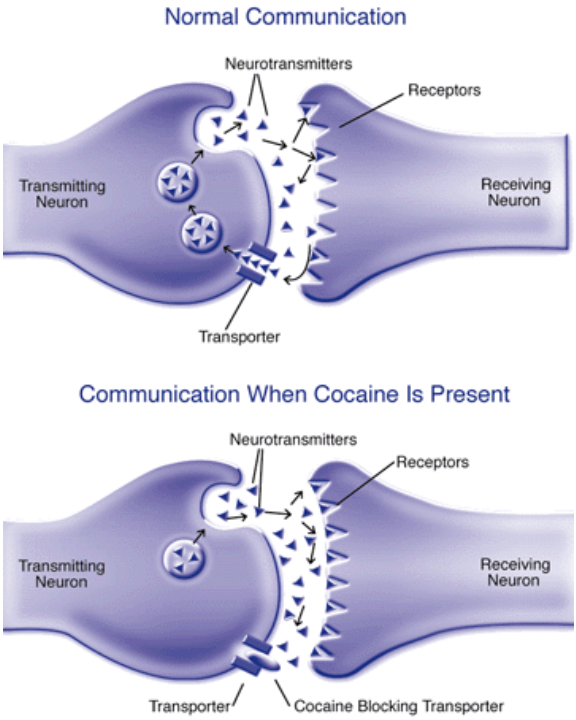
Cocaine and how it works

Cocaine is a powerful CNS stimulant affecting the Sympathetic Nervous System. Cocaine is extracted from coca leaves and is commonly available in an acid state. The acid state is in the form of a powder and chemically is known as Cocaine Hydrochloride. In this state cocaine can be sniffed or can be injected. The commonest way of taking Cocaine Hydrochloride is by sniffing or 'snorting'. This produces a slower acting and longer lasting 'high' with less intensity. Whereas crack is seen as an unacceptable drug in many circles, Cocaine Hydrochloride enjoys a higher status.

Cocaine can be turned into an alkaloid state and in this can be smoked. In its alkaloid state cocaine is commonly known as either freebase, or as crack cocaine. When smoked, cocaine has a very rapid, short lasting high as smoking takes the drug directly to the brain via freshly oxygenated blood.

Cocaine works by stimulating the release of the neurotransmitters serotonin and dopamine between transporter and receptor neurons (nerve cells) in the brain. In the normal release neurotransmitters are released across the gap between neurons and attach to receptor sites. Following this excess neurotransmitters are returned to the neuron via transporters. As well as stimulating release, cocaine also works as a blocker, restricting the re-uptake of serotonin and dopamine. This results in the flooding of serotonin and dopamine, producing a euphoric rush within 30 minutes of taking the drug.

The euphoria is replaced by an uncomfortable comedown; this compels the person to take more cocaine, chasing the original high, but



also to manage symptoms. However, repeated use depletes dopamine and serotonin as further receptors are blocked. This leads to a situation where no matter how much cocaine is taken, there comes a point where the person is unable to get high any further. It is important to note that dopamine also acts as a powerful behavioural re-enforcer as part of the brain's internal reward system. Depletion in dopamine and serotonin in transporter neurons causes a chemical depression. Prolonged cocaine use also increases the levels of adrenalin in the nervous system, resulting in sleep disturbance and physical tension. Prolonged use results in paranoid and delusional ideation and a state that regular users describe as 'Prang' (D'Augostino and Grey, 2004).

Having established an understanding of the physiological effects of cocaine, it is possible to assess problems across modalities. In this way we are performing a modality scan as opposed to focusing on cognitions or feelings. Understanding the action of cocaine, it is advisable to move with the physical and sensory aspects of using first, as this will encourage a working relationship and build a basis of empathy.

In all assessments that involve substance misuse the following need to be asked:

- What quantity is person using?
- How long since last used?
- Has the person had a recent checkup with GP?
- Is the person using other drugs as well as or in combination with cocaine?

It is important to note that there are no safe ways to take cocaine, especially if use is regular. Prolonged use increases the risk of strokes, coronary problems, and if used in conjunction with alcohol, liver damage.

Bridging modalities

Most clients will respond positively to the question, 'Would you be interested in knowing how cocaine works?' This is a useful first bridge linking how cocaine works with the biological modality, asking about any physical problems resulting from use, how the sleep pattern is, eating habits, etc. This can lay the ground for interventions around diet, ie looking at foods that are rich in amino acids which are the building blocks for neurotransmitter replacement. The amino acids that help in the production of serotonin (Tryptophan) and dopamine (Tyrosine and Phenylalanine) are found in dairy products, white and red meats, pulses and grains (D'Augostino and Grey, 2004).

Other interventions include assessing sleep patterns and looking at sleep hygiene and the reduction of drugs such as caffeine. This can also be a place to assess other drugs used in combination, or when not taking cocaine, eg it is common for people to be prescribed antidepressants, but to stop taking these when on a binge, thus undermining any effectiveness. It is important to note that many people using drugs will use other drugs to manage the side-effects and still further drugs to mange the side-effects of the side-effects. With powder cocaine users, a favourite drug is alcohol. Advice about alcohol and the recommended units and an assessment of drinking patterns will be important.

As a rule of thumb people are generally happier talking about the physical effects of use than the emotional, usually because of strong emotions such as shame and depression. It is important to ground the person's experience in the biological effects of the drug as this allows the person the opportunity to understand that current moods, ie depressions or irritability, are linked with neurotransmitter depletion.

This is helpful when bridging into Interpersonal Modalities, where

irritability in relationships can be attributed to depletions. For many clients the statement, 'It's not me, it's my neurotransmitters' has given them space to back down from arguments with partners and family members, without losing face. It is important also to discuss whether partners are using and whether cocaine forms part of their shared habits. Cocaine is a powerful aphrodisiac and can form part of a couple's sex life; for others sex and cocaine are mixed and offering sexual favours for cocaine is common. Some clients have fed back that having cocaine gave them access to partners who normally would not be interested. Cocaine causes erectile dysfunction and is commonly used in combination with Viagra. Cocaine also causes vaginal dryness so discomfort during sex, bruising and tearing is common. The impact of sex as a behavioural re-enforcer is important to be aware of as the person may be losing access to sex when giving up cocaine use.

As Martlatt and Gordon (1985; see also Wanigatne et al, 1990) pointed out, in relapse prevention awareness of the impact of peer pressure and interpersonal disputes is a major reason cited for relapse, so assessment and discussion of relationships is crucial.

Bridging into the modalities of sensation and affect is key, with a need to connect certain emotions, ie excitement and anger, with Sympathetic Nervous System arousal. Linking the experience of adrenaline release into the system and craving is important. Similarly, looking at the discomfort that accompanies inactivity and boredom, or that accompanies depression, can help the person identify emotional and sensory triggers for using. This can enable bridging into the Cognitive Modality, looking for evidence of LFT, and also looking at the interaction between LFT and using fantasies in the imagery modality. Assessing images can be fruitful, linking relapse fantasies with tension and physiological arousal. Relapse fantasies are a powerful re-enforcer and often have a strong sensory element.

In keeping with the premise that the biological mechanism behind cocaine helps build a bridge, it is helpful to discuss chemical depression (A) as a result of depletion of dopamine. If there is an acknowledgement of depression, it can be pointed out that though cocaine promises a short-term solution, long-term cocaine increases the duration of depression and enhances low motivation and feeling worn out. Bridging into the Behavioural modality can be key in helping the person understand the behaviours and rituals associated with using. Behaviour provides a powerful tool in supporting abstinence, and identifying using patterns and behavioural re-enforcers for using and not using are key.

Conclusion

Multimodal approaches provide a powerful framework in assessing substance misuse. This is further enhanced by knowledge of how a substance acts upon the Central Nervous System. Unlike other therapies, Multimodal therapy integrates assessment across modalities to enable the development of a comprehensive treatment blueprint. Whereas other Cognitive approaches focus on the person's thinking, inferences and belief systems, the Multimodal approach attempts to understand the problem from a wider range. Whilst remaining consistent within the Cognitive Behavioural tradition, this allows for a greater flexibility in assessing and treating a wide range of problems.

For substance misusers, this enables a more flexible approach and builds up a therapeutic relationship by including a wide range of factors within the assessment. This is a win-win situation as a thorough assessment underpins effective treatment, and the holistic approach can foster a strong therapeutic relationship.

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The Rational Emotive Behaviour Therapist Vol 12 No 1 (2007)
Journal of The Association for Rational Emotive Behaviour Therapy

BRIEF REPORT
A cognitive-behavioural self-help approach to stress management and prevention at work: a randomised controlled trial[1]

Stefania Grbcic and Stephen Palmer

Abstract

A stress self-help manual was developed for middle managers, based on a cognitive behavioural self-help approach. It was evaluated using a randomised controlled trial. Significant changes were obtained on the BSI ($P<0.001$) at post-treatment, as well as on the SA45 ($P<0.001$) indicating intervention effectiveness regardless of the frequency of work stressors and lack of organisational support. Measures of coping indicated that the intervention increased task, emotion, and distraction-oriented coping styles ($P<0.001$). No trainer, coach or counsellor was used to teach the self-help approach.

Key words: Stress, stress management, stress prevention, randomised controlled trial, self-help CBT manual.

Introduction

Stress and stress-related disorders have been on the increase both in the UK and worldwide (Health and Safety Executive [HSE], 2006). Guidelines for managing stress at work have been proposed by the HSE (2001). However, most of these are aimed at reducing and preventing stress in employees and not in managers.

There are a number of stress management programmes in place, including self-help, but very few have been empirically validated in a middle management population.

1. Paper presented at the National Conference of the Association for Rational Emotive Behaviour Therapy in Association with the Association for Multimodal Therapy held in London, UK on 24 November 2006. This article is a brief summary. Full paper to be published later.

Design

A novel stress self-help manual, based on a cognitive behavioural self-help approach, was developed for middle managers and evaluated in this randomised controlled trial (N=102).

Methods

The self-help manual was provided to participants, to work through the manual independently, without therapist input or assistance, for a period of six weeks. Four outcome measures were used to measure change: Brief Symptom Inventory (BSI; primary outcome measure), Symptom Assessment-45 (SA45), Coping Inventory for Stressful Situations (CISS) and the Job Stress Survey (JSS).

Results

Treatment effects were evaluated using analyses of covariance. Significant changes were obtained on the BSI ($P<0.001$) at post-treatment, as well as on the SA45 ($P<0.001$), indicating intervention effectiveness regardless of the frequency of work stressors and lack of organisational support. Measures of coping indicated that the intervention increased task, emotion, and distraction-oriented coping styles ($P<0.001$). The intervention was not found to have an effect on the avoidance-oriented and the social diversion coping styles. Further analysis indicated that discussing the manual with others during the treatment period had a significant effect on outcomes, suggesting that future interventions should encourage groups within organisations rather than individual participation, or using the manual as an adjunct to various forms of psychological therapy. Qualitative data was also collated, which revealed that the participants felt more in control and confident after working through the manual.

Conclusions

While further evaluation by independent researchers is recommended, including cost-effectiveness analysis, the self-help manual based on the cognitive behavioural and rational emotive behavioural approach has shown initial effectiveness and is considered a potentially useful tool for managing and preventing stress in a work setting.

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The Rational Emotive Behaviour Therapist Vol 12 No 1 (2007)
Journal of The Association for Rational Emotive Behaviour Therapy

Is Guilt getting off the hook? Using REBT to develop new models of shame and guilt indicates that guilt may be more pathogenic than research suggests

Katherine Wright

Abstract

This paper presents new definitions of shame and guilt, which suggest that guilt may be more pathological than some previous research has indicated. The fresh perspective was arrived at by integrating the Rational Emotive Behaviour Therapy (REBT) models of shame and guilt with those derived from an evolutionary approach.

Additionally, a way of developing new measures which could distinguish more effectively between shame and guilt is presented.

Key words: shame, guilt, REBT, definitions.

Shame and guilt in psychopathology

Shame and guilt have both been implicated in causing and maintaining psychological problems. But while guilt was identified as a possible pathogenic factor 100 years ago by Freud (eg Freud, 1905) and has been much discussed in the psychoanalytic literature (see Tangney, Burggraf and Wagner, 1995 for a review) scant attention was given to shame until 25 years ago. Many writers from Freud onward used the terms shame and guilt interchangeably when discussing guilt. They did not attempt to distinguish between the two emotions, or to consider shame as a separate emotion. For this reason, Helen Block Lewis called shame the 'sleeper' in psychopathology (Lewis, 1987).

However, the last 25 years has seen a burgeoning of work on shame in the literature, and of attempts to clarify the distinctions between shame and guilt. With this has come a pattern of identifying shame as a more pathological feature than guilt.

As noted by Harder and Greenwald (2000), shame has been linked

to 'every possible diagnosable disorder'. They have catalogued around 50 references covering alcohol and drug abuse, antisocial personality, delinquency and criminal violence, anxiety disorders, borderline personality, depression, domestic violence and marital dysfunction, eating disorders, narcissistic personality, paranoia, post-traumatic stress disorders, sexual and physical abuse, sexual disorders and suicide.

Many of these links are now supported by empirical evidence. This research has been made possible by the operationalisation of shame, with the development of measures of shame-proneness.

Links have been demonstrated with destructive anger (Tangney et al, 1996), hostility (Tangney, Wagner and Gramzow, 1992), male violence (Gilbert, 1994), bullying (Ahmed and Braithwaite, 2004), social anxiety (Gilbert, 2000; Tangney and Dearing, 2002), anxiety (Harder 1995; Ang and Nanyang, 2004), somatic problems (Allan, Gilbert and Goss, 1994), eating disorders (Andrews and Hunter, 1997; Burney and Irwin, 1999; Jamekar, Masheb and Grilo, 2003; Cook, 1993), dissociation (Talbot, Talbot and Tu, 2004), alcoholism and drug abuse (Cook, 1993), suicidality (Shreve, 1987), post-traumatic stress disorder (Cook, 1993), relationship difficulties (Gilbert, Pehl and Allan, 1994) and obsessive compulsive disorder (Tangney and Dearing, 2002; Harder, 1995).

Shame has been linked particularly strongly to depression (Gilbert, 1992; Gilbert, Pehl and Allan, 1994; Tangney, Burggraf and Wagner, 1995; Andrews, 1995, 1997; Hoblitzelle, 1987; Ang and Nanyang, 2004; Cook, 1993; Allan, Gilbert and Goss, 1994).

This recent evidence linking shame with pathology has been accompanied by a highlighting by several authors of a failure until recently to clarify distinctions between guilt and shame in the literature (Lewis, 1992; Gilbert, 2003; Tangney, Burggraf and Wagner, 1995; Tangney and Dearing, 2002). It has been argued further that some postulated links between guilt and pathology may be invalid because of this (Tangney, Burggraf and Wagner, 1995; Tangney and Dearing, 2002).

Tangney and colleagues have gone a step further, to argue that guilt is actually an *adaptive* response, and not linked to pathology at all (Tangney, Burggraf and Wagner, 1995; Tangney and Dearing, 2002). Their argument is backed by a substantial body of research, which is based on scales they have designed specifically to operationalise a meaningful distinction between shame and guilt. These are the Self-Conscious Affect and Attribution Inventory, the SCAAI (Tangney, Burggraff, Hamme and

Domingos, 1988; Tangney, 1990) and its more recent revision, the Test of Self-Conscious Affect, or TOSCA (Tangney, Wagner and Gramzow, 1989; Tangney, 1990; Tangney and Dearing, 2002).

For example, in two studies of students, while shame-proneness was positively correlated with a range of psychological symptoms, guilt-proneness was negatively or negligibly linked (Tangney, Burggraf and Wagner, 1995; Tangney, Wagner and Gramzow, 1992). Shame but not guilt has been shown to be correlated with anger and aggression (Tangney, Wagner, Fletcher and Gramzow, 1992), with OCD (Tangney and Dearing, 2002) and with drug abuse (Dearing, Stuewig and Tangney, 2005).

However, the validity of this experimental data is contingent on the accuracy of the underlying assumptions about what defines shame and guilt, and what distinguishes between them. It has been shown that even highly educated adults have problems defining and distinguishing between shame and guilt in the abstract (Tangney, 1989; Lindsay-Hartz, De Rivera and Mascolo, 1984).

Tangney and associates' definitions of shame and guilt reflect an evolutionary model of emotions which is thoroughly grounded in evolutionary theory, and has been extensively elaborated. They make intuitive sense. However, it is suggested here that they can be further refined by the integration of REBT ideas, and that the new model produced raises a question mark over some of Tangney and associates' empirical data. Before examining them in detail, it will be helpful to take a brief look at the historical development of distinctions between shame and guilt.

Distinctions between shame and guilt

One of the earliest attempts to distinguish between shame and guilt was made using an anthropological model. In this, shame was regarded as a relatively primitive emotion that is largely supplanted by guilt in more 'advanced' societies (Benedict, 1946/1974; Erikson, 1950; Piers and Singer, 1953). This model was based on the questionable assumption that 'civilisation' is an objectively arbitered moral progression from the 'primitive'.

A more recent hypothesis is that shame is dependent on public exposure, whereas guilt remains a secret (eg Gehm and Scherer, 1988). Another is that different kinds of transgression produce shame and guilt. Neither of these stands up to empirical testing (Tangney et al, 1994; Tangney et al, 1996; Tangney, 1992; Tangney et al, 1994). A major conceptual advance

came when Lewis (1971, 1987) suggested it is the individual's *appraisal* of the transgression that makes the difference, rather than its objective nature. She made the further distinction that *shame focuses on the badness of the self, whereas guilt focuses on the badness of the action.* Through Lewis's work, the *sense of the 'devalued and subordinated self'* (Gilbert, 2003) emerged as central to shame (Kaufman, 1989, 1996; Nathanson, 1994; Lewis, 1992; Beck, Emery and Greenberg, 1985).

Evolutionary models of guilt and shame

Evolutionary models (eg Gilbert 1997a, 1997b, 1998, 2003; Gilbert, Bailey and McGuire, 2000; Harder and Greenwald, 2000) moved thinking on by looking at the adaptive *function* of emotions (Ekman, 1994; Ekman and Davidson, 1994; Frijda, 1994). Guilt and shame increase fitness, that is the survival and reproductive power of the individual and the group, in different ways (Trivers, 1985; O'Connor, 2000).

Ranking versus attachment drives

In the evolutionary model, both shame and guilt increase fitness by helping people to operate in groups. For mammals, which invest heavily in rearing their young over a protracted period, group living is almost essential. But the two emotions emerged at different stages of evolutionary history, and are part of different drives.

Shame evolved at a more primitive stage in an unstable and threatening environment, and is part of a 'self preservative' or 'threat-defence' system (Wang, 2005; Gilbert,1989). Shame minimises loss through conflict by *guiding social ranking behaviours,* allowing safety and provision for all members of a group (Sloman, 2000). We fit in by accepting lowly rank by being submissive (damage limitation) or by winning superior rank by being aggressive or attractive. Feelings of shame help us monitor how well we are doing in our efforts to be socially accepted. A feeling of shame is a signal we are violating the system, not winning social acceptance. Shame is a self-focused fear of negative evaluation by others. It is characterised by defensiveness, avoidance, powerlessness and secrecy.

Guilt, on the other hand, evolved at a later stage when the environment was less threatening, and is therefore less allied to fear. It is part of a 'species-preservative' or 'safety' system (Wang, 2005; Gilbert, 1989). It helps to maintain group living by *regulating positive attachment strategies* which encourage proximity between individuals (Sloman, 2000).

It operates within a care-giving, avoiding-harming-others drive, which is the origin of 'altruistic' behaviours. Guilt is based on concern for others and the ability to feel empathy. The focus is on the other, not the self, and the concern is with reparation rather than concealment. The emotion arises as a result of conflict between selfish needs and caring for others (O'Connor, 2000).

Wang has presented strong empirical evidence that there are two distinct physiological systems underlying the self-preservative and species-preservative systems (Wang, 2005).

The evolutionary model elaborated

Gilbert has summarised guilt/shame distinctions, as shown in Table 1.

	GUILT	**SHAME**
SELF OPINION	Cause of hurt to others	Bad, weak, unattractive, flawed
ASSOCIATED EMOTIONS	Sorrow, remorse, empathy	Fear, disgust, anger at self
CAPABILITY	Capable	Powerless
BEHAVIOURS	Reparation	Concealment, avoidance, escape, submissiveness, defensiveness
FOCUS	The harmed 'victim'	The flawed self
ASSOCIATED DRIVE	Attachment	Ranking

Table 1: The key distinctions between guilt and shame in Gilbert's model (from Gilbert, 1997b, 2003).

The distinctions are clarified by the following example in which a driver accidentally runs over a cat.

	GUILT	**SHAME**
THOUGHTS	Poor cat! Poor owner!	I'm a terrible driver The owner and neighbours will hate me if they find out

BEHAVIOURS	Try to resuscitate cat, take it to vet, trace owner and offer apology, comfort and reparation	Bury the body Drink to forget

Table 2: A scenario clarifying the different kinds of thoughts and behaviours that characterise guilt and shame (developed from a private communication with Gilbert).

The evolutionary model thus supplies a detailed and evidence-based distinction between guilt and shame.

Tangney and associates' models of guilt and shame

Tangney and associates' definitions of guilt and shame reflect this evolutionary model, and Gilbert quotes their research as evidence to back it (eg Gilbert, 2003). They define shame as being characterised by a global and stable negative view of the self with a fear of revealing defects to others, which produces a desire to hide or anger (Tangney, Burggraf and Wagner, 1995). Guilt is seen as arising from a negative evaluation of a particular behaviour, and is characterised by less global and stable attributions. The focus on behaviour is said to produce feelings of 'remorse and regret'.

However, it is proposed here that the distinction can be clarified further by the examination of the kinds of *beliefs* underlying shame and guilt, as elaborated in the REBT model.

Why are beliefs important?

O'Connor (2000) cites evidence that pathogenic guilt among survivors of trauma is likely to result in psychological problems *when linked to pathogenic beliefs* (Weiss, 1983, 1986, 1993). This suggests there is a need to examine the *cognitive dynamics of guilt and shame* and how these function within the evolutionary framework. Our innate caring and ranking drives are modulated by our *learned values – our belief systems* about ourselves, the world and other people (Beck, Rush, Shaw and Emery, 1979). These beliefs are learned from the values of society, the role-modelling of childhood caregivers, and the selective reinforcement of our behaviours as children (Bandura, 1969). They interact with our innate drives to determine what makes us feel guilty or ashamed (Bierhoff, 2005).

REBT definitions

These cognitive dynamics are central to the REBT model (Ellis and Becker, 1982; Dryden and Yankura, 1993; Dryden and Yankura, 1995). Here it is the underlying beliefs of an individual which shape the distinctions between shame and guilt. A distinction is made between 'healthy' and 'unhealthy' emotions. 'Unhealthy' emotions are driven by beliefs which are inflexible, inconsistent with reality, and illogical (Dryden and Yankura, 1995).

Shame, as in Gilbert's model, is described as fear of negative judgement by others. And guilt is seen, as in O'Connor's, as a conflict between what is morally right, or selfless, and what is selfish. The difference is that the 'unhealthy' emotion of shame is paired with its 'healthy' counterpart, regret, and the 'unhealthy' emotion of guilt is paired with the healthy counterpart, remorse.

These distinctions are clarified in Tables 3 and 4.

Dryden (1997) pinpoints the difference between shame and regret as that in shame, people rank themselves below others in terms of *global* worth, whereas in regret, they just rank themselves below others on the particular 'weakness' currently under consideration. In other words, that it is a *specific* rather than *global* self/other judgement. These are concepts from Attribution Theory (Weiner, 1985).

Distinctions derived from Attribution Theory

According to Attribution Theory, the causes people assign to an event influence the type of emotional response they have. Weiner proposed these attributions fall along three different dimensions. An internal-external dimension describes whether the individual perceives the cause to be down to oneself or environmental factors. A stable-variable dimension describes whether the cause is changing or not. A controllable-uncontrollable dimension describes to what extent the individual can control the cause. A further dimension of global-specific was subsequently proposed (Abramson, Seligman and Teasdale, 1978).

Regret and Shame

	HELPFUL EMOTION	**UNHELPFUL EMOTION**
	REGRET	***SHAME***
THOUGHTS	I've revealed a personal weakness or acted badly in public, and others will notice and think badly of me.	I've revealed a personal weakness or acted badly in public, and others will notice and think badly of me.
BELIEFS	I don't like the fact that I've acted this way and that others may think badly of me, but: ...there's no reason why I *must not* have done this, ...and there's no reason why people *must not* think badly of me. It's a pity this happened, but not absolutely terrible. I choose to accept myself as a fallible human being for acting this way.	They're right – I'm worthless for revealing my weakness. I *should not* have revealed my weaknesses in public. Other people *should not* think badly of me. This is absolutely terrible. I am absolutely terrible.
BEHAVIOURS	Focus on any humorous aspect. Apologise. Make reparation. Use attempts of others to restore social equilibrium, and make self feel better.	Escape – remove self from spotlight, by avoiding eye contact, leaving, or making self small and inconspicuous, hiding. Inability to use attempts of others to restore equilibrium, and make self feel better. Avoidance of pain by using alcohol or drugs, and other self defeating activities.

Table 3: REBT distinctions between regret and shame (from Dryden and Yankura, 1995).

Remorse and guilt

	HELPFUL EMOTION	UNHELPFUL EMOTION
	REMORSE	*GUILT*
THOUGHTS	I have broken my personal code of moral values – either by doing something I consider bad, or by not doing something good.	I have broken my personal code of moral values – either by doing something I consider bad, or by not doing something good.
BELIEFS	I don't like what I did, or failed to do, but there is no reason why *I must not* have done it. I'm a fallible human being who did the wrong thing and not absolutely bad.	I absolutely *should not* have done what I did, or should have done what I failed to do. I'm absolutely bad for having done so, or not done so.
BEHAVIOURS	Communication to others about the reasons for the actions or omissions. Apologies and reparation without desperation, so that relationships are repaired. Self acceptance. Self forgiveness. Taking responsibility. Attempts to understand the reasons for the actions or omissions.	Attempts to 'put it right' by: desperately begging forgiveness from others accompanied by statements of self loathing, self punishment. Rumination on how bad the self is. Avoidance of responsibility for the act or omission, by making defensive excuses, or blaming others. The belief that the self is bad leads to adopting behaviours that make the person more likely to 'sin' in future, as a self fulfilling prophecy, eg eating disorders, and avoidance of pain by using alcohol or drugs, and other self defeating activities.

Table 4: REBT distinctions between remorse and guilt (from Dryden and Yankura, 1995).

Using an Attribution Theory analysis gives the following useful distinctions in the model presented here.

Attribution	**Shame**	**Regret**	**Guilt**	**Remorse**
Global v Specific	global	specific	global	specific
Uncontrollable v Controllable	uncontrol-lable	control-lable	uncontrol-lable	control-lable
Stable v Variable	stable	variable	stable	variable
Internal v External	internal	internal	internal	internal

Table 5: Distinctions between shame, regret, guilt and remorse using Attribution Theory (Weiner, 1985).

In other words, inflexibility of beliefs means the attributions are global, uncontrollable and stable, and in the cases of guilt and shame, also internal. Flexible beliefs are characterised by attributions which are specific, controllable and variable, and may or may not be internal.

Distinctions according to domains of perfectionism

A further useful distinction has been made by Dunkly, Zuroff and Blankstein (2003). They suggest there are two types of perfectionism – one related to striving to meet *personal standards* and the other related to *self-criticism.* This reflects the two domains of guilt and shame.

An integrated model

This analysis has taken ideas from four different models – the evolutionary, REBT, Attribution Theory, and Dunkly and associates' domains of perfectionism. It is suggested that the following are the key elements with which to build a new integrated model:

- Both extreme shame and extreme guilt are characterised by inflexible beliefs (perfectionism) bearing attributions which are global, stable, uncontrollable and internal.
- Shame is characterised by fear of negative evaluation by others, self focus, stable view of the self as bad, avoidance, concealment, escape, defensiveness and submissiveness.
- Guilt is characterised by a conflict between selfish and altruistic desires and distress at not meeting personal standards over a particular act,

and is underlain by an ability to feel concern for others, and produces unproductive attempts at reparation.

- Regret is a degree of self criticism which is helpful for the individual, in which beliefs are flexible, the attributions are specific, variable and controllable. Remorse involves a degree of criticism of the self for performing or omitting a particular act, in which the beliefs are flexible, the attributions specific, variable and controllable. The focus is more on the act than the self.

Theses features are summarised in Table 6.

Theory	**Guilt**	**Remorse**	**Shame**	**Regret**
Evolution-ary	Distress at harming others, focus on the act, reparation.		Fear of negative evaluation by others, self focus, self as bad, avoidance and concealment.	
REBT	Driven by inflexible beliefs about the badness of the act and the self. Unproductive attempts to put right, avoidance.	Acknowl-edgement of badness of the act, self-forgiveness, reparation.	Driven by inflexible beliefs about the badness of the self. Avoidance, concealment.	Acknowl-edgement of fallibility of the self, humour, reparation.
Attribution	Internal, stable, uncontrollable, global	Internal, variable, controllable, specific	Internal. stable, uncontrollable, global	Internal, variable, controllable, specific
Domain	Personal standards	Personal standards	Essential self	Essential self

Table 6: A summary of defining features of guilt, remorse, shame and regret using four different models.

The attributes of the emotions defined in the integrated model are summarised in Table 7.

	Guilt	**Remorse**	**Shame**	**Regret**
Thought	It's awful that I did that.	I wish I hadn't done it.	It's awful that I'm like that.	I wish I hadn't been like that.
Attribution	The result will be disastrous, there's nothing I can do, I always mess up like this.	But it's not the end of the world, maybe I can sort it out, and hopefully I won't do it again.	Everyone will hate me, there's nothing I can do, it's because I'm fundamentally bad.	People might not like me for it, but they'll come round, and hopefully I won't be like that in future.
Focus	I've hurt someone. I hate myself for not keeping my standards.	I'm really sorry for the person I've hurt.	I'm despicable through and through.	I am daft sometimes.
Self	Bad	Fallible	Bad	Fallible
Behaviour	Beg forgiveness.	Reparation and comfort.	Avoidance, concealment.	Make a joke, set up friendly communication.

Table 7: The attributes of guilt, remorse, shame and regret in an integrated model.

The scenario of the man running over the cat would be analysed like this:

Driver runs over cat	**Guilt**	**Remorse**	**Shame**	**Regret**
Thoughts	It's unforgivable that I wasn't paying attention. I've done something very wrong and the owner will be upset.	Poor cat! Poor owner!	I'm a terrible driver. The owner and neighbours will hate me if they find out.	That's bad. People will know I wasn't paying attention, but the important thing is to try to revive the cat and find the owner, and get my eyes tested.
Actions	Trace the owner and beg forgiveness, then get drunk.	Try to revive cat, take it to vet, trace owner and offer comfort and reparation.	Bury the body. Drink to forget.	Try to revive the cat, take it to the vet, trace the owner. Get an eye test.

Table 8: A scenario clarifying distinctions between guilt, remorse, shame and regret in a new integrated model.

The Continuum Concept

As the *degree* of shame or guilt felt will depend on the *degree* of inflexibility of the beliefs, and these will vary from mood state to mood state (Teasdale and Fogarty, 1979; Teasdale, Taylor and Fogarty, 1980), it may be more helpful to conceptualise a continuum from guilt to remorse and one from shame to regret.

In a continuum model, guilt and remorse, shame and regret are seen as the extreme poles.

EXTREME GUILT……..……..REMORSE
EXTREME SHAME……..…….. REGRET

Most situations will trigger an experience somewhere along either or both continua, rather than be categorically at either end.

Shame/guilt interactions

It would be unhelpful to oversimplify the distinctions between shame and guilt, and to ignore interactions between the two emotions. We can feel ashamed of behaving in a non-altruistic way because of fear of what others will think of us. And as Gilbert points out (Gilbert 2005), we can behave in an uncaring way if to do otherwise would appear to conflict with social approval (Milgram, 1963; Zimbardo, 1995).

Another factor is that dysphoric emotions lower the threshold for experiencing other dysphoric emotions by activating negative automatic thoughts (Teasdale and Fogarty, 1979; Teasdale, Taylor and Fogarty, 1980; Teasdale, 1988), and as guilt and shame are so closely linked cognitively, it seems likely that guilt will easily trigger shame and vice versa.

Implications for data on guilt

It appears that the evolutionary model of shame and guilt can be refined by making distinctions between shame and regret and between guilt and remorse.

Tangney and associates state clearly that in their model shame is characterised by an appraisal of the self which is internal, global and stable (Tangney et al, 1985, p.346), while guilt is characterised by internal, *specific and unstable* attributions.

In other words, the guilty person has healthy, flexible beliefs. It is not surprising, therefore, that guilt does not correlate with pathology as much as shame in their research (Tangney and Dearing, 2002). *In the model outlined by the author, this emotion would be called remorse.* Tangney and Dearing's explanation for guilt which *is* pathological is that this occurs when shame is also involved.

Thus the TOSCA scales which are said to distinguish shame from guilt rest on definitions of guilt which would more accurately be called remorse.

It follows that research based on these questionnaires appearing to show that guilt does not have pathological links may be flawed, as the scales may be failing to distinguish it from remorse. It may also be the case that shame is even more pathological than already indicated, if regret is partialled out.

Developing a new measure of guilt and shame

There have been three main approaches to measuring guilt and shame proneness. The first looks at situations which it is assumed will

induce one emotion rather than the other (eg the Anxiety Attitude Survey, Perlman, 1958). Respondents are asked how anxious they think most people would feel in this situation. The results are used to create indices against which to measure experimental subjects. The problem with this is the assumption that it is the *kind of situation* which distinguishes between shame and guilt.

The second is the 'global adjectives checklist' approach. Respondents are asked to make global ratings of how particular adjectives apply to themselves. An example is the Revised Shame-Guilt Scale (Hoblitzelle, 1987a, 1987b). One of the problems with this is that several of the questions use the *terms* 'shame' and 'guilt', and this relies on the assumption that respondents have the same understanding of these abstract terms as the questionnaire, and that the questionnaire has made meaningful distinctions in the first place.

The third, which has avoided these pitfalls, is the scenario based measure, such as the TOSCA. Respondents are presented with a series of common life situations, such as realising they have forgotten a lunch date with a friend and stood them up (TOSCA-3, Tangney and Dearing, 2002). They are presented with four possible responses, and are asked to indicate on a scale from 1 to 5 for each one how likely they would be to respond in this way. The underlying assumption is that two of the responses represent the presence of either shame or guilt. In the above example the 'shame' response is, 'You would think I'm inconsiderate'. The 'guilt' response is, 'You'd think you should make it up with your friend as soon as possible'.

It has been argued here that measures are only as valid as the underlying definitions of shame and guilt. That is, do the definitions accurately reflect what people understand by the terms? It is proposed that the validity of the model presented in this paper could be tested by drawing up a TOSCA-style questionnaire outlining four different responses to a series of scenarios, each of which is designed to reflect shame, regret, guilt or remorse according to the model's defining features. Respondents would be asked to tick which of regret, shame, remorse or guilt they feel each response most closely resembles.

A statistically significant number of matches whereby respondents identify the response as defined in the model would lend some validation to the definitions. If the definitions were validated, a TOSCA style questionnaire to measure guilt and shame proneness could be drawn up based on them.

A suggested item is outlined in Table 9.

Below are situations that people are likely to encounter in day-to-day life, followed by four different reactions to them. As you read each reaction, try to imagine which emotion best describes how the person is feeling, out of guilt, remorse, shame and regret. Then circle the one you've chosen. *A man runs over a cat.* a) He thinks 'I'm such a bad driver, the owner will hate me, and all the neighbours will be talking about me.' He buries the body, then goes home and gets drunk. GUILT, REMORSE, SHAME, REGRET. b) He thinks 'Poor cat! Poor owner! He tries to revive the cat, traces the owner to offer an apology and comfort. GUILT, REMORSE, SHAME, REGRET. c) He thinks 'That's bad. People will know I wasn't paying attention, but the important thing is to try to revive the cat and find the owner.' He tries to revive the cat, traces the owner, and has an eye test. GUILT, REMORSE, SHAME, REGRET. d) He thinks 'It's unforgivable that I wasn't paying attention. I've done something very wrong and the owner will be upset.' He traces the owner and begs forgiveness, then gets drunk. GUILT, REMORSE, SHAME, REGRET. Scoring for this item is as follows: a) shame c) regret b) remorse d) guilt

Table 9: An item on a suggested questionnaire designed to test the validity of the new definitions of guilt, remorse, shame and regret outlined in Chapter Three.

Summary and Conclusion

This paper has described the development of new definitions of shame and guilt by integrating an REBT approach with an evolutionary one. It has also drawn on Attribution Theory and the concept of domains of perfectionism.

The resulting models have identified an important distinction between shame and regret on the one hand, and guilt and remorse on the other. It appears that these distinctions have not been previously identified in current models of guilt and shame which are based on an evolutionary approach.

A result of failing to make these distinctions is that measures of guilt and shame proneness may be confusing shame with regret, and guilt with remorse. This means that research based on these questionnaires appearing to show that guilt does not have pathological links may be flawed. It may also be the case that shame is even more pathological than already indicated, if regret is partialled out.

Additionally, a way of developing a new measure which could distinguish more effectively between shame and guilt proneness is presented.

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NEWS UPDATE

During the summer of 2006 the Board members of the **Association for Rational Emotive Behavioural Therapy** attended several meetings hosted by the UKCP. These meetings took place in order to define competencies for each of the different schools of Psychotherapy currently under the UKCP.

The UKCP had already drawn up a generic list of competencies in 2001, which covered the range of skills from negotiating a contract to terminating work with a client. Our brief was to identify competencies that would define REBT as a specific Therapy. In effect the question was 'If you saw an REBT therapist in action, what would define the practice as REBT?'

The purpose of drawing up competencies is to prepare for the registration of psychotherapies. The driving force behind this is the Department of Health; at stake is the right to distinguish oneself as a registered REBT therapist as opposed to a generic psychotherapist.

Preparation – starting the therapy	Help client generate a goals list for therapy agreed with client with regard to desired outcomes. Conduct a GABCDE assessment of client problems. Explaining and defining how client's problems can be explained within REBT model, and the benefits of looking at problem through ABC model. Assess a client's problems across a range of modalities. Discuss importance of client/therapist collaboration and mutual understanding of client's goals, and how these are defined and measured throughout therapy. Discuss with client similarities and differences between REBT and other CBT models and the technical and theoretical basis for these differences. Clarify the tasks that therapist and client are responsible for throughout therapy. Agree a contract with the client; at the same time acknowledge client autonomy to end therapy at any time.

The therapeutic work and the working alliance	Help client to prioritise goals for therapy. Socialise client into problem-focused approach through setting of agreed agendas with client each session. Develop client's motivation to change in order to meet goals. During therapy demonstrate to client the difference between client presented Irrational Beliefs and Healthy Rational alternatives to deal with presented problem. Integrate client feedback into approach at beginning, during and end of each session. In particular review any resistance to change or relapse experiences for client. Monitor cognitive, emotional and behavioural change and evaluate at the beginning and end of each session both from a client and therapist perspective. With agenda setting reviewed on a regular basis. Attend regular Supervision to discuss effective or ineffective client practices in order to develop new or enhanced approach for therapy or assess the new for onward referral. Develop a flexible working relationship based on: client focused approach, matching styles, ie formal, informal, to client preference. Teach client how REBT is relevant to their presenting problems. Teach the benefits of adopting a philosophy of self-acceptance. Teach the benefits of adopting a philosophy of accepting others as fallible human beings and accepting life as it is. Teach client to use REBT self help forms in order to facilitate the development of the client's skills outside of the therapy sessions. Educate client about use of and benefits of homework in therapy. Help define and negotiate appropriate homework goals that are challenging but not overwhelming to client, taking into consideration their age, level of distress.

Ending the therapy	Through monitoring, client feedback and discussion ascertain client movement towards their chosen goals and endings of therapy. Ensure ending session discusses relapse prevention using already learned and practised life changes. Offer follow-up review session (3 months hence). If appropriate ensure that route to referral to another therapist or therapy is clearly defined.
Evaluation	Ongoing evaluation (case notes) of therapeutic alliance; boundaries; personal competence, client movement and effective therapy stratagems within and after a session; with a supervisor; and from attaining client written feedback (evaluation form - client anonymous).

The following is the result of this task, and it represents several months' work, and a degree of discussion with board members. These competencies have been sent to Albert Ellis for comment.

- Must know the key concepts of the biological, physical, social, psychological and clinical sciences, which are relevant to their profession-specific practice.
- They must also know how professional principles are expressed and translated into action through a number of different assessment, treatment and management approaches to practice, and how to select or modify approaches to meet the needs of an individual.
- Has read core REBT texts, and is familiar with the development of REBT as a psychotherapeutic model.
- Be familiar with the philosophical basis of REBT, and its place alongside other Cognitive Behavioural and Constructivist therapeutic approaches.
- Has understanding of REBT's distinction between ego based problems and problems caused by Low Frustration tolerance.
- Has understanding of REBT's stance regarding Unconditional Self Acceptance and its preference over self-esteem.
- Has understanding of REBT's philosophy of Unconditional Acceptance of others as fallible human beings.
- Has understanding of benefits of REBT's philosophy of unconditional

acceptance of life conditions as they are.

- Has understanding of the difference between emotional and meta-emotional problems.
- Demonstrate within practice an understanding of similarities and differences between REBT and other CBT models and the technical and theoretical basis for these differences.
- Demonstrate an understanding of challenges in delivering REBT in clinical practice. This would include an ability to assess who is suitable for REBT. Also demonstrates an understanding of difficulties encountered during therapy, and how this relates to presenting problems and habits.
- Demonstrate an understanding of research results in REBT and the history of REBT research. Ability to critique REBT research as well as evidence research that supports REBT's effectiveness.
- Understands REBT treatment rationale/philosophy.
- Understands REBT treatment structure and importance of pacing and planning sessions to facilitate process.
- Able to assess treatment standards as well as monitoring within the session, client feedback and homework tasks.
- Integrates client feedback into approach.
- Able to use inference chaining to assess Irrational Beliefs.
- Assess and distinguish between ego based problems and problems arising from Low Frustration Tolerance.
- Teach the difference between ego based problems and Low Frustration Tolerance problems.
- Teach the benefits of adopting a philosophy of High Frustration Tolerance.
- Teach REBT model of disturbance, that emotional distress is caused and maintained by rigid patterns of thinking that arise when a wish is elevated to a demand.
- Teach difference between Rational and Irrational Beliefs and their role in disturbance and in the maintenance of physiological and psychological ill-health.
- Teach REBT model of healthy and unhealthy negative emotions, for example the difference between the healthy negative emotion of sadness and the unhealthy negative emotion of depression. Teach that REBT psychology states that unhealthy negative beliefs are underpinned by Irrational Beliefs.

- Teach client how REBT is relevant to their presenting problems.
- Assess whether preferential REBT or non-preferential REBT (CBT) is appropriate to client.
- Help client generate a goals list and develop client's motivation to change in order to meet goals. Help client to prioritise goals for therapy. Socialise client into problem-focused approach through setting of agreed agendas with client each session.
- Teach the benefits of adopting a philosophy of self-acceptance.
- REBT's stance regarding Unconditional Self Acceptance and its preference over self-esteem.
- Teach the benefits of adopting a philosophy of accepting others as fallible human beings.
- Teach the benefits of adopting a philosophy that accepts life as it is.
- Teach client to use REBT self help forms in order to facilitate the development of the client's skills in disputing Irrational Beliefs and in reinforcing Rational Beliefs.
- Educate client about use of homework in therapy.
- Help define and negotiate appropriate homework goals that are challenging but not overwhelming to client, taking into consideration their age, level of distress.

Make use of theoretical model(s) to develop own practice

- Personal experience of using REBT. An effective practitioner will have learnt and practised how to apply the theoretical and practical elements of REBT on their own problems.
- Using the REBT theoretical and assessment model to establish client problems across a range of modalities.

The planning and progress of the treatment are consistent with the theoretical model

- Demonstrate an understanding of REBT treatment Sequence Assessment session for both client and therapist to review each other and, once established, the agenda issues to be reviewed and in what sequential order. This has also been answered before above.
- Once the above is determined, to continually monitor, assess and evaluate where client is within agreed agenda sequence and support the client's movement through the processes to a level of manageable self-change.

- Understand range of REBT specific techniques and when to use them in REBT treatment sequence.
- Understand behavioural techniques and how to employ them within therapy, ensuring client is fully aware that cognitions can inhibit or enhance effective behavioural practices which encourage well-being.
- Understand rationale and use of Vivid Techniques within REBT such as Imagery to elicit physical and emotional understanding of presented problem and to supplement with alternative or reconstructed images that act as inner healers.
- Build upon client's developed self-help processes by teaching relapse prevention strategies before end of therapy.

Application of the model is relevant and appropriate to the client by ensuring that theoretical concepts are delivered in a manner that maximises the age and level of understanding of the client

- Understand the limitations of REBT in clinical practice.
- Acknowledge limitations of knowledge and ability of client to work with REBT processes. Ensure that effective referral strategies are in place.

INFORMATION FOR CONTRIBUTORS

The Co-Editors welcome research findings, REBT practice demonstrated through descriptions of case studies, or group sessions, etc., theoretical studies, considered responses to published articles or current issues, reports of experiments, any news, views, ideas, letters and information about new publications or activities, research needs, and training.

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All articles/correspondence are to be sent to: Prof. Stephen Palmer, Co-Editor, 'The Rational Emotive Behaviour Therapist', The Centre for Rational Emotive Behaviour Therapy, Broadway House, 3 High Street, Bromley BR1 1LF.

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

The Association is a company limited by guarantee and not having a share capital.
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