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Editorial

Welcome to this issue of *The Rational Emotive Behaviour Therapist*, which includes three articles on topics such as Substance abusing adolescents, Depression and cognitive-vulnerability and a new Training and Education section featuring a contribution from Professor Windy Dryden.

We are currently also working on our next issue, which will be available in early 2011 covering the application and research of Rational Emotive Behavioural Therapy (REBT) into areas such as Anger, Resilience and Dog behavioural problems.

For future issues case studies, book reviews, research, and papers focusing on REBT and Cognitive Behaviour Therapy are welcome.

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Rational Emotive Behaviour Therapy with Substance Abusing Adolescents

Philip James

Substance abuse among adolescents is a growing concern in both the UK and Ireland. Both countries consistently report high rates of substance misuse among their teenagers when compared to their European neighbours. As a result many adolescents presenting for therapy may have substance abuse problems making it vital that REBT therapists working with this age group are able to provide appropriate interventions. This article examines adolescent substance misuse and covers many areas including rates of substance abuse, the REBT perspective and research on substance abuse as well as many practical considerations. Finally it makes some suggestions for the development of REBT in this area.

Key words: Adolescents, substance misuse, alcohol, review article, REBT

Introduction

Substance abuse among adolescents is a hot topic. In the UK and Ireland it would appear that we have a greater problem with this issue than our continental neighbours. The European School Survey Project on Alcohol and other Drugs (ESPAD) project surveys the pattern of use of a variety of substances by 15 and 16 year old children across Europe. Their most recent survey was completed in 2007 and found that 56% of Irish and 70% of British teenagers had drunk alcohol in the previous thirty days while 26% and 33% of Irish and British teenagers (respectively) had been drunk in the same period. By contrast, the percentage of teenagers reporting being drunk in the last 30 days in Portugal Sweden (11%), Italy (12%) and Greece (12%) are considerably lower. A similar picture emerges when cannabis smoking is examined – 9% of Irish teenagers and 11% of British teenagers have smoked cannabis in the preceding thirty days compared to only 1% of Swedish and 3% of Greek teenagers (Hibell et al. 2009).

As a result a considerable amount of research and discussion has gone into developing CBT interventions for this population. In Ireland the latest mental health policy document, “A Vision for Change” has called for the development of four specialist teams to deal with adolescents with “dual-diagnosis”, and specifically recommends the employment of counsellors with expertise in motivational enhancement therapy and / or CBT (Department of Health & Children 2006). In 2005 a Government report was published in Ireland which outlined how substance abuse services for adolescents should be developed (Department of Health & Children 2005). Many leading REBT theorists have also published books about the use of their techniques with those with substance abuse problems (Ellis et al. 1988, Ellis & Velten 1992, Dryden & Matweychuk 2000, Bishop 2001) but there has been little attention given to applying REBT with adolescents who abuse substances. It is generally accepted that applying REBT with children and adolescents requires a different approach than when working with adults (DiGiuseppe & Bernard 2006). It is hoped that this article will provide some information for those who are attempting to use REBT with adolescents who are presenting with substance abuse issues.

The Evidence for CBT and REBT with Substance Abusing Adolescents

Since the 1970's many studies have been completed which have demonstrated the effectiveness of general CBT interventions with adults presenting with substance abuse problems. It is important to note that these studies vary greatly in the type of interventions being applied and the format. For example, many studies on CBT with substance abuse appear to be skewed towards the behavioural end of the spectrum and almost totally ignore the cognitive end. Likewise the delivery of the intervention varies considerably such as the use of individual or group therapy. More recently studies have demonstrated the effectiveness of CBT interventions with adolescents but these studies are plagued by numerous methodological flaws including small samples, inadequate control or comparison groups and even no description of the intervention provided (Kaminer & Waldron 2006).

There has been some research carried out on the effectiveness of REBT with substance abuse. For example, Mas-Baga (2000) reported on a programme where REBT was used as the treatment of choice in a therapeutic community. While he reports some good results, the study again has considerable methodological limitations. In a review of the research into the effectiveness of REBT for alcohol problems, Terjesen et al. (2000) concluded that there was not strong evidence for REBT's effectiveness. While REBT frequently results in changes in irrational thinking this only resulted in limited behavioural change. It would appear that REBT requires more research into its use with substance abusing clients and this should also include its use with adolescents. Meanwhile the numerous books have been published for professionals and outline the REBT theory of addiction do not contain chapters on applying REBT with adolescents presenting with substance abuse problems (Ellis et al. 1988, Bishop 2001). Likewise, the most recent book on REBT with children does not contain a chapter related to substance abuse (Ellis & Bernard 2006). However, Gonzalez et al. (2004) completed a meta-analysis of 19 studies on the effectiveness of REBT with children and adolescents. They concluded that REBT had a significant positive effect on a number of outcomes, in particular disruptive behaviours. This would provide some hope that REBT is likely to be effective with children and adolescents who have substance abuse problems.

The REBT theory of addiction

Ellis and colleagues (1988) have described four patterns of alcohol or substance abuse. They are:

- The abstinence and LFT pattern
- The intoxication as coping pattern
- The intoxication equals worthlessness pattern
- The demand for excitement pattern

In the abstinence and Low Frustration Tolerance (LFT) pattern the client has LFT in relation to postponing drug use – i.e. “I can't stand being deprived of drugs / alcohol”. This irrational belief leads the client to experience discomfort anxiety which is alleviated when they use the desired substance and thus a vicious circle has begun. The intoxication as coping pattern is similar to the LFT pattern outlined above except here the LFT is a secondary or meta-emotional problem related to dealing with a primary problem. For example, a client who is depressed about a relationship break-up may then have LFT in relation to dealing with the depression and alcohol is used to alleviate the frustration about dealing with the depression. In the intoxication equals worthless pattern clients sometimes conclude that their drinking or drug use and the effects of it, such as rows, over spending etc, are evidence that they are worthless. This irrational belief leads to guilt and depression, the client in turn

uses drugs or alcohol to alleviate these feelings, leading to more depression and guilt and therefore more drinking. Finally, Ellis et al. (1988) hypothesise that some clients may have a strong sensation seeking personality and use substances to create a “party” to rid themselves of boredom which they termed the demand for excitement pattern.

Ellis et al. (1988) point out that one of the difficulties in getting clients to work on their substance abuse problem is the fact that alcohol and other drugs frequently work as effective measures in reducing negative emotions such as anxiety – at least in the short term. Substances definitely work more quickly than psychotherapy (and with less effort) and so their use can be negatively reinforcing resulting in a spiral effect of increasing use. Unfortunately they are not long term solutions to the client’s difficulties and usually create more problems than they solve but clients acting on irrational beliefs rarely act in their long term interest.

Some important points when working with adolescents

It is important to adapt your REBT techniques to take into account the age of your clients. DiGiuseppe and Bernard (2006) suggest that children under the age of 12 years approximately are not sufficiently cognitively developed so as to enable them to understand the type of abstract disputes typically used when working with adults. Therefore, particularly when working with younger children concrete examples should be examined and the therapy should be active to encourage involvement. Wilde (1992) recommends that therapists bear numerous things in mind when working with adolescents – for example they tend to have considerable insecurities and often work hard to hide them, they can be very sensitive to perceived criticism and they often define themselves through their group associations as they tend to have a poor sense of self. A further and enlightening discussion on the principles of working with adolescents can be found in Young (1989).

Based upon the literature and the 'author's' experiences there are some further points to bear in mind when working with adolescents who are abusing substances. One of the most important issues is when do you treat a teenager who is using drugs. Adolescence is a time of experiment and self discovery. Consequently it is also a time when many teenagers experiment with drugs or alcohol and it is not possible to treat every child who drinks alcohol or uses drugs. Many teenagers who present (or are presented) for treatment in relation to drugs or alcohol do not meet the usual criteria in relation to substance dependence. The most pragmatic solution is to focus on the client’s trajectory in the assessment. For example, is the substance use causing harm in the various aspects of functioning such as relationships, hobbies and school work? Where is this young person likely to be in six months time? A 16 year old who has admitted to smoking cannabis weekly but who is getting on well in school and maintains a strong interest in extra curricular activities may not need intervention. On the other hand a 16 year old who drinks alcohol monthly but when drinking usually gets into physical fights and trouble with the police may be a good candidate for treatment. In essence the aim is to foster a system where those who are presenting are assessed to see how much harm they are experiencing – if there appears to be little or no harm a brief educational intervention is often enough to encourage the teenager to examine their drug use. Full therapeutic interventions are best reserved for clients who have definite harm as a result of their drug use.

It is important also to think about how treatments will be delivered. Poulin et al. (2001) found that teenagers who participated in a CBT group got worse in relation to smoking and teacher rated delinquency. Based upon this article many people now believe that group interventions are contra-indicated with teenagers with substance abuse problems. However, recent reviews of the evidence for CBT with adolescents with substance abuse problems have concluded that group CBT is effective, (Waldron and Kaminer 2004, Kaminer and Waldron 2006). In fact, as most teenagers use substances while in the company with their peers,

groups could in fact have an added benefit in preparing teenager for dealing with such situations, (Waldron & Kaminer 2004). The contradictory findings of Poulin et al. (2001) and Kaminer and Waldron (2006) have been explained by the different focuses of the two groups: Poulin was providing a preventative intervention while Kaminer and Waldron examined the literature on interventions with those with identified substance abuse problems. Therefore group REBT interventions for those with substance abuse problems are likely to be effective.

In addition many young people presenting with addiction problems also have co-morbid mental health problems. Many mental health services take the view that clients need to deal with their substance abuse problem prior to obtaining treatment for their mental health problem. International research indicates that best outcomes are achieved when both problem are addressed together (Whitmore & Riggs 2006). Therefore the use of a multi-disciplinary approach is advisable, including Psychiatrists, Psychologists and Social Workers among others. Closely related to this is the issue of parental involvement. The parents of substance abusing teenagers may suffer considerable distress and disturbance in relation to their child's substance abuse (Usher et al. 2007) and parents are likely to have considerable impact on a client's progress in treatment. As a result some form of parent or family intervention is warranted and this may be delivered as either traditional family therapy (Schmidt et al. 1996, Hogue et al. 2006) or as an REBT style intervention (Ellis 2001, Joyce 2006).

Closely related to this is the issue of consent. In the UK, children aged 16 and 17 can legally consent to treatment and in some cases children younger than this can be deemed competent to consent if they are intelligent enough to comprehend their situation and treatments involved. This process is referred to as 'Gillick Consent', (Christian & Gilvarry 2002). However, this is based in case law and so far has yet to be applied to substance abuse treatment. In Ireland, under 18's are legally regarded as children according to various Acts. However, the '*Non-Fatal Offences against the Person Act*' (Government of Ireland 1997) reduced the age of consent to 16 for surgical, medical and dental treatments but did not address psychological treatments directly. Therefore, regardless of the jurisdiction someone is working in, attempts should be made to have parental or guardian consent when working with anyone aged below 18. If for some reason this is not possible the attempts made to do so should be documented and treatment be provided so long as the teenager is 16 or over and the clinician is satisfied that the individual is competent to provide the consent. I would caution against providing treatment to those aged under 16 years without consent from a parent or guardian. Regardless of the situation all decisions and the rationale for arriving at that decision should be clearly documented and ideally not taken by an individual. The decision can be discussed with a supervisor, manager or colleague and this discussion should also be documented.

One final consideration when working with teenagers is the notion of therapeutic goals. Within substance abuse treatment there are two broad goals: abstinence and reduction. Most of the REBT books proffer abstinence as the goal of therapy (Ellis et al. 1988, Ellis & Velten 1992, Tate 1997) and this is also the goal suggested in Cognitive Therapy (Beck et al. 1993). However, Bishop (2001) provides an interesting discussion on this topic and concludes that while abstinence is usually the ideal result for those with substance abuse problems the reality is that many people are likely to have some relapses in the future. He therefore suggests a pragmatic approach where the goal is set as whichever is likely to encourage the client into treatment as any reduction is likely to be an improvement. I believe that this is a very useful approach with teenagers. Many teenagers find it difficult to contemplate the idea of never using again and such a goal may scare them away from therapy. The goal is therefore set in line with the client's goal and can always be revisited later. It is also important to bear in mind the fact that many teenagers who present for treatment will be abusing a variety of substances with alcohol and cannabis being the most common. Different goals will need to be set with each substance the client is using, for example to stop using cannabis and to reduce the use of alcohol.

Developing the use of REBT with substance abuse

As mentioned earlier there is little empirical evidence at present to support the use of REBT with addictions. The author, like many other REBT therapists believe that REBT is likely to prove effective with substance abusing clients regardless of age. In this final section two suggestions are made regarding possible ways for developing REBT by incorporating ideas which have been developed within other therapies. Dryden (1991) has argued for some time that REBT can be improved by using ideas and techniques from other forms of therapy in a theoretically consistent manner.

The first issue I would like to discuss is the difficulty in trying to get clients to commit to therapy. Many clients with substance abuse problems do not see themselves as having a problem and are “sent” to therapy by a third party such as police, courts or parents. Bishop (2001) provides a useful framework for considering clients with substance abuse problems. He postulates that clients tend to fall into three categories. Type 1 clients do not believe or recognise they have a problem and are often in therapy because they were sent. Type 2 clients can recognise that they have a problem but are not sure if they want to do anything about it or if anything can be done. Finally, Type 3 clients are not ambivalent and know exactly what they want to change. Bishop also points out that clients are unlikely to be at the same point with each problem or substance. They may be a Type 3 client in relation to their cocaine use and a Type 1 client in relation to their alcohol use. The purpose of conceptualising clients in this way is that it gives the therapist some guidance as to how to work with a particular client or client problem. A Type 1 client who does not recognise that he has a problem is unlikely to work at changing their behaviour until they decide that there is something which they want to change. Motivational interviewing (MI) is an active directive approach to counselling which was developed initially as a means of developing substance abusing clients’ motivation for change and has considerable evidence for its effectiveness (Miller & Rollnick 2002). MI theory suggested that one of the frequent mistakes made by therapists working with clients with substance abuse problems is focusing prematurely on a problem before the client accepts there is a problem. As a result the clients becomes resistant and therapy more difficult as a result. A traditional REBT problem solving approach may result in a Type 1 client concluding that the therapist is not listening to him (he does not believe he has a problem) and is therefore more likely to drop out of therapy. Conversely, a Type 3 client who is highly motivated to work on a problem is likely to respond well to a traditional REBT problem solving approach and become frustrated with a slower paced MI approach. Therefore the style and pace of therapy needs to take the client’s view of their problem into account and spending a number of sessions exploring the client’s view of their problem may speed up therapy in the long run by engaging the client. MI aims to resolve a clients ambivalence to change by eliciting statements from clients which endorse change as research has shown that such statements (termed “*change talk*” in MI) are positively correlated with actual behaviour change.

The second idea I would like to suggest is the teaching of other practical skills and ideas outside of the traditional REBT model. As mentioned earlier research has shown that although REBT is effective at cognitive changes in clients with substance abuse this does not always translate to actual behaviour change. When reading the literature on CBT which has been proved effective with substance abuse it is apparent that a very wide variety of skills and techniques are taught. Substance abuse can have serious negative impact on many aspects of an individual’s life such as relationships, occupational and educational functioning. Much of the individual’s time is spent engaged in activities related to substance misuse and particularly with teenagers, much of their identity is also related to substance abuse. For example, among teenagers who smoke cannabis they can frequently use the drug every day and often

when with their peers. In addition they may listen to music or relate to a famous star who endorses cannabis use, wear t-shirts which promote cannabis and even attend rallies seeking its legalisation. Even if such a teen decides that they wish to stop cannabis use most of their life revolves around its use, providing constant reminders and therefore increasing risk of relapse. Most of the REBT books on substance abuse focus on the irrational beliefs and unhealthy emotions related to substance abuse with little attention paid to the other aspects which may influence substance misuse. No matter how rational a client becomes they will always be human and so not perfectly rational – therefore relapses are always possible. The more potential stressors and triggers which are dealt with will reduce the risk further. With this in mind the Community Reinforcement Approach (CRA) suggests a number of extra interventions that may be provided to a client in addition to cognitive-behavioural techniques to reduce the likelihood of relapse (Meyers & Miller 2006). These include relationship counselling, communication, problem solving, drink refusal and job seeking skills training. Similarly, certain medications may also be useful in helping the client avoid relapses and access to them may be useful to a client and again emphasises the importance of access to a multi-disciplinary team. For example, disulfiram (Antabuse) helps a client avoid drinking as the ingestion of alcohol will result in aversive reactions such as vomiting and sickness.

Summary

This article has described the current state of REBT research and theory with substance abusing adolescents. While numerous articles and books have been published which outline the REBT theory of substance abuse little empirical research has been completed and what research has been done does not support the effectiveness of REBT. In particular, there is almost no published work on the use of REBT with substance abusing adolescents. A number of specific points for working with adolescents have been offered along with some ideas which might improve the effectiveness of REBT with substance abuse. If REBT is to maintain its position as a leading cognitive-behavioural therapy in an increasingly more evidenced-based society much work is needed to develop the research and theory behind it.

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Depression & Cognitive-Vulnerability: The Role of Dysfunctional Attitudes & Negative Attributional Styles

Despina M Rothi

This paper presents an evidence-based discussion of two cognitive approaches to understanding the onset, maintenance and treatment of depression: Abramson, Seligman, & Teasdale's (1978) hopelessness, attribution-based theory, and Beck's (1967) schema-based theory¹. More specifically, it compares and contrasts the pathways to depression proposed by the two models. The discussion focuses mainly on one particular aspect: 'cognitive-vulnerability'. This concept can be found in most cognitive theories of depression, although the manner with which it is conceptualised may differ. The discussion commences by considering the effectiveness of cognitive therapy for depression, both in terms of facilitating remission and preventing relapse. The discussion then explores how the two models differ in their proposed pathways. This includes an examination of the hypothesised developmental origins of cognitive-vulnerability, and the evidence for the correlational and causal status of cognitive-vulnerability mechanisms proposed by the two theories. The paper concludes with an evaluation of the potential utility of greater information in this area to cognitive-therapeutic practice and preventative psychological well-being strategies.

Key words: *Depression, cognitive-vulnerability, attributional styles, cognitive therapy.*

The Problem and its Significance

Effectiveness reviews generally conclude that cognitive therapy is effective in the treatment for depression (Department of Health, 2001; Hollon, Stewart, & Strunk, 2006; Paykel et al., 1995). However, the problem of relapse is a significant one. Left untreated, up to 80% of people experiencing one major episode will experience additional episodes (Kessler, 2002).

Moore & Garland (2003) argue that approximately 30% of treated individuals experience relapse within 1-2 years from recovery, although cognitive therapy has been found to decrease relapse risk, e.g. from 47% when drug treatment is used alone, to 29% when combined with extended cognitive therapy that includes a relapse prevention component (Paykel, Scott, Teasdale, & et al, 1999).

Relapse increases the risk of depressive chronicity (Moore & Garland, 2003; Paykel et al., 1995), and chronically depressed individuals are at greater risk for relapse and treatment-resistance (Hamilton & Dobson, 2002; Scott, 1988), so much so that Post (1992) terms this effect the 'kindling hypothesis' (see also Monroe & Harkness, 2005). Given the evidence, it seems timely now to reconsider our current understandings of the cognitive pathways to depression, paying particular attention to components that may contribute to relapse.

Negative Life-Events & Negative Affect

Depression often follows negative/stressful life-events (Monroe & Hadjiyannakis, 2002), yet depression does not inevitably follow for all who experience such events. Beck's (1967) and Abramson et al's (1978) models assume that affect, associated with a life-event, is based on how an individual interprets and deliberates about that situation (A. T. Beck, 1964; Ellis,

¹ Although there are a variety of models that may be called 'attribution-based' or 'schema-based', for the purposes of exposition these terms will be used in this paper to refer to Abramson et al's (1978) and Beck's (1967) models respectively.

1962). For example, when negative events occur, people vary in terms of the intensity of their negative affective responses, for some these are severe enough to warrant classification of clinical depression (Ingram & Luxton, 2005).

Major depressive episodes are characterised by intense low mood that is consistently present for two or more weeks, and occurs together with an assortment of associated disruptions that can be motivational, cognitive, physiological, social or behavioural in nature (see APA, 2000, p.320-327).

Beck's and Abramson et al's models contain the thesis that depression susceptibility is influenced by *proximal and distal* negatively biased cognitive mechanisms, i.e. those temporally close to or distant from depression onset respectively. As such these models conceptualise depression as a cognitively mediated emotional disorder (Abramson & Alloy, 1990). Both models propose the following:

- a) Depressed mood and symptoms are a function of negatively biased *distal* cognitive mechanisms (the cognitive-diatheses), and the occurrence of negative life-events (stress).
- b) That there are two main intervening *proximal* cognitive mechanisms that may mediate between the onset of depression, and cognitive-diatheses and stress.

However, the models differ in two main ways: firstly, how the core *distal* cognitive mechanism is conceptualised; and secondly, in the nature of the intervening *proximal* cognitive mechanisms².

The Development of Cognitive-Vulnerability Mechanisms

Cognitive-vulnerability is thought to be a 'trait-like' quality, a relatively stable characteristic which may be change-resistant but is however mutable (Ingram, Miranda, & Segal, 2006). Beck's (1967) conceptualisation revolves around the concept of schemas, which can be thought of as a set of 'cognitive templates', that contain *dysfunctional attitudes* acquired mainly in childhood (A. T. Beck, Rush, Shaw, & Emery, 1979, p.12-13). These lead to the formation of cognitive distortions which are then accessed to aid cognitive information-processing, resulting in a generalised tendency to negatively distort available information when similar situations arise.

Alternatively, Abramson and colleagues argue that childhood experiences lead to the development of generalised tendencies in attributional styles (Alloy et al., 1999). As the child attempts to find meaning for his/her experiences, he/she attempts to identify causes for negative life-events (Mezulis, Hyde, & Abramson, 2006; Rose & Abramson, 1992). These cognitive 'tendencies' then serve as interpretive aids. "These [negative] events undermine the child's positive self-image as well as his/her optimism about future positive events" (Ingram, 2003, p.78). Thus, development of these *negative cognitive styles* undermine the developing child's conception of their own self-efficacy in influencing the outcome of future life-events, as well as their capacity to think positively about him/herself, thereby accentuating the likelihood that they will become hopeless³.

In summary, while Beck's schema-based approach focuses on attitude acquisition and the information-processing aspects of development, Abramson's attribution-based approach puts

² Both models include other variables in their conceptualisations that may interact with vulnerability variables to make an individual more resilient to depression onset, e.g. social support, social skills, adaptive coping strategies (Ingram & Luxton, 2005; Ingram, Miranda, & Segal, 1998; Ivanova & Israel, 2005; e.g. see: Kwon, Lee, Lee, & Bifulco, 2006).

³ The strength of this motivational drive for a positive self-image has very strong and reliable empirical support in the social psychological literature (Abrams & Hogg, 1988; Greenberg et al., 1992; Higgins, 1987; e.g. see: Sedikides, 1993; Tajfel, 1981; Taylor & Brown, 1988).

the search for meaning/explanation, and the motivation for positive self-image at the centre of the child's strivings.

Proximal Mechanisms: Cognitive Distortions & Negative Inferences

Cognitive models propose that different forms of negative cognitive mechanisms observed in depressed individuals may not simply be depressive symptoms/concomitants, but rather *causal antecedents* (Ingram et al., 1998). They propose intervening cognitive concepts (proximal mechanisms) *mediate* the relationship between negative life-events and the onset of depression.

In Beck et al's (1979) formulation, emotional distress is preceded by dysfunctional cognitions (see figure on p.5), *automatic negative thinking* that has been 'filtered' through an information processing system that contains *cognitive distortions* (J. S. Beck, 1995). Beck (1987) however, does not claim automatic negative thoughts involving the 'cognitive triad' cause depression (see also Spangler, Simons, Monroe, & Thase, 1997).

For Abramson et al (1989) *negative inferences* about the causes, consequences and self-implications of negative life-events make individuals more likely to become *hopeless* (see figure). However, there are conflicting opinions on the causal status of these proximal mechanisms. Some maintain they are causal (e.g. Ingram et al., 1998, p.113), while others claim such negative thinking does not cause depression but is part of it (e.g. Fennell, 1989). Further clarification is required to distinguish between the relatively 'automatic' *process* of cognitively distorting information about the self, world and future, or negatively inferring causes, consequences and self-implications, *from* the resulting *content*, such as 'I am worthless', 'things will never change' or 'this happens because I'm stupid' (see also Fennell, Bennett Levy, & Westbrook, 2004). Furthermore, there is no reason why process and content cannot be both cause and effect, thereby contributing to the negative feedback loop that is so often seen in depression.

Distal Mechanisms: Conceptualising Cognitive-Vulnerability

In the schema-based approach the core distal cognitive-vulnerability component implied refers to *dysfunctional attitudes* contained within schemas (e.g. "I am worthless if I do not pass all my exams"), while in the attribution-based approach the focus is on *negative attributions* contained within negative cognitive styles (e.g. "I perform badly in exams because I'm stupid"). The first is a conditional, attitude-based bias, the second a global, stable, inference-based bias.

Factor analytic research examining both dysfunctional attitudes and negative attributional styles has shown that these form discrete though correlated entities (Gotlib, Lewinsohn, Seeley, Rohde, & et al., 1993; Joiner & Rudd, 1996; Spangler et al., 1997). Furthermore, these are not merely depression symptoms, rather symptoms form an additional though correlated factor (Spangler et al., 1997).

These models overlap somewhat; both acknowledge that negatively biased self-efficacy (helplessness) can contribute to cognitive-vulnerability (Abramson et al., 1989; A. T. Beck, 1999; J. S. Beck, 1995), and both include dysfunctional attitudes *and* negative attributions as potential depression concomitants. The difference is in: a) the causal emphasis given to each of these components, and b) the nature of the effects from both *negative life-events* and each model's version of the *distal cognitive-vulnerability mechanism*.

Diathesis & Stress or Diathesis-Stress?

The distal, cognitive-vulnerability mechanism (the cognitive ‘diathesis’) and negative life-events, (the associated ‘stress’ reaction), are considered to be the main ‘causal’ components that lead to either cognitive distortions (A. T. Beck et al., 1979) or negative inferences (Abramson et al., 1989).

In the schema-based approach, stress is treated as a *mediator* between cognitive-diathesis (dysfunctional attitudes) and cognitive distortions; it is an *intervening* variable that ‘transmits’ the effects from the first cognitive mechanism to the next. Its presence is required in order for cognitive distortions to commence, as such the stress is considered to be the ‘critical incident’ (Fennell, 1989; also see figure).

In the attribution-based approach, diathesis-stress (Metalsky, Abramson, Seligman, Semmel, & Peterson, 1982) is conceptualised as an *interaction* between cognitive-diathesis (negative attributional style) and stress (again see figure). Each of these variables is thought to have, not only independent effects, but also a combined effect, where each variable can *moderate* the effect of the other. In this way an extremely negative event (e.g. losing all one’s family in the Holocaust) can result in depression even in the absence of negative attributional style, as can highly negative attributional styles even in the absence of negative events (Abramson et al., 1989). However, reliable data to support/refute these hypotheses is currently lacking (see also Alloy, Abramson, Safford, & Gibb, 2006). An additional confound relates to the possibility that these variables may be intertwined in numerous ways, such as the influence of childhood stresses on the development of cognitive-diatheses in the first place (Traill & Gotlib, 2006).

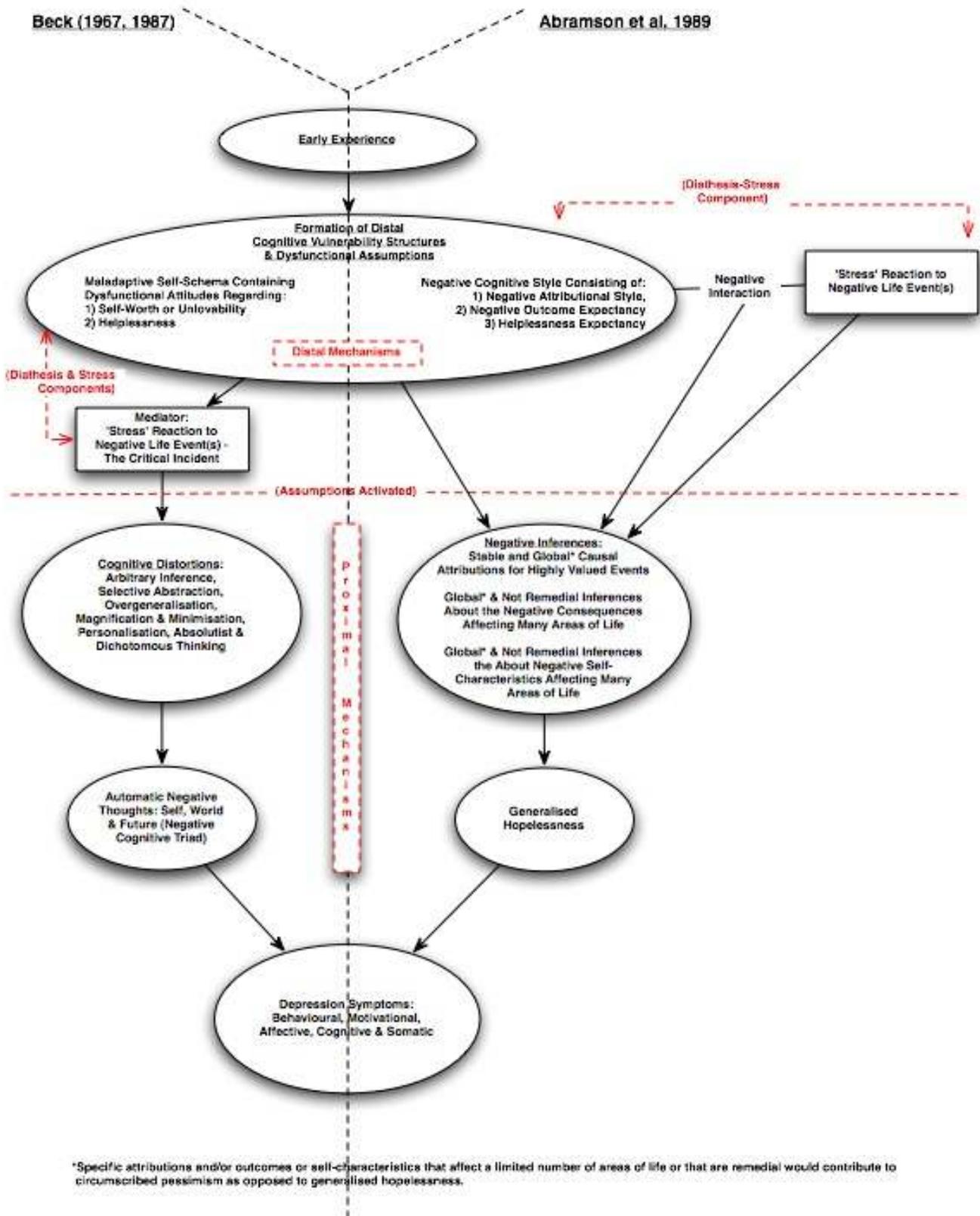
Dysfunctional Attitudes, Negative Attributional Styles & Depression

Reviewing the extant literature reveals much evidence for the co-occurrence of depression and both dysfunctional attitudes and negative attributional styles (Dohr, Rush, & Bernstein, 1989; Persons & Miranda, 1992; Segal, Williams, & Teasdale, 2002). Some studies reveal the intensification of both of these in remitted depressives under conditions of naturally occurring/induced low mood (Abela, Brozina, & Seligman, 2004; Scher, Ingram, & Segal, 2005), or cognitive load (Wenzlaff, Meier, & Salas, 2002). Alternatively, Rude, Covich, Jarrold, et al. (2001) report neither of these conditions are required if implicit measures are used (for a discussion on methodological issues see Riskind & Alloy, 2006). However, much research conducted in this area is retrospective, occurring either during or following a depressive episode. Evidence during an episode may simply indicate concomitant status, and evidence for persistence following an episode may simply reflect “inert ‘scars’ of the disorder, persisting effects that have no functional role in vulnerability” (Rude, Wenzlaff, Gibbs, Vane, & Whitney, 2002, p.425).

It has been surprisingly difficult to find reliable evidence for *latent* cognitive-vulnerability components (i.e. pre-depressive-episode occurrence) that may predispose one to depression (Ingram et al., 1998). Evidence for the *casual* nature of these constructs is very limited. Given that cognitive models give these constructs causal status, these findings are problematic for such conceptualisations.

More recently, researchers have used *prospective* data, some derived from the longitudinal ‘Temple-Wisconsin Cognitive Vulnerability to Depression’ (CVD) Project, to examine causality. This well designed project provides some interesting findings, which, considered in conjunction with other research, provide more convincing evidence.

Figure: Cognitive Models of Depression



Issues & Controversies in Cognitive-Vulnerability: Research Evidence

Attempts to investigate the role of cognitive-vulnerability provide interesting results. Spangler et al. (1997) for example, report depressed participants exhibited either dysfunctional attitudes or negative attributional styles but not both, potentially indicating distinct pathways to depression and depression subtypes. Abramson, Alloy, & Metalsky (1988) have argued for such subtypes: 'negative-cognitive-triad' and 'hopelessness' depressions (for the criteria of hopelessness depression see Alloy, Abramson, Safford et al., 2006). Indeed, studies examining residual symptoms following cognitive therapy report that, although reduced, worthlessness and hopelessness symptoms are still present (Scott, Teasdale, Paykel, & et al, 2000) potentially contributing to future susceptibility, possibly negative-cognitive-triad and hopelessness depression respectively.

In the CVD project researchers classified participants using their scores on both dysfunctional attitudes and negative attributional styles measures; those scoring in the top quartile on both measures (high-risk) were compared to those in the bottom quartile (low-risk). Retrospective data indicated high-risk participants were significantly more likely to have a history of both major (using DSM criteria) and hopelessness depression (Alloy et al., 2000). Prospective data (2½ year follow-up) indicated participants' high-risk status predicted first onset and recurrence of major and hopelessness depression as well as minor episodes (see also prospective data from studies of depression in children and adolescents, e.g.: Abela & Hankin, 2008). Moreover, risk-status also predicted depression comorbid with anxiety but not anxiety alone, suggesting cognitive-vulnerability, as defined by these two models, is depression-specific (Alloy, Abramson, Walshaw, & Neeren, 2006; Alloy & Riskind, 2006). Relatedly, high-risk participants had higher historical and future suicidality (Alloy & Riskind, 2006).

Given the manner with which participants were classified, the CVD findings do not clarify which, if any, form of cognitive-vulnerability dominates. In a separate study however, Haefel, Abramson, Voelz *et al.* (2003) report that although both forms were associated with depression, negative attributional styles showed consistently stronger associations with both major and hopelessness depression than did dysfunctional attitudes. Additionally, comparisons between remitted and never depressed individuals indicated remitted individuals had significantly higher negative attributional styles; no significant differences were observed in levels of dysfunctional attitudes.

An additional important point that may help explain these findings is highlighted by Gibb, Alloy, Abramson, Beevers & Miller (2004). These authors suggest caution when interpreting findings from continuous data that has been dichotomised to form subgroups for comparison (as in the CVD project). They argue *quantitative* dichotomisation does not necessarily indicate *qualitative* differences in negative cognitive styles and that it may also obscure the presence of non-linear relationships. Their research indicates cognitive vulnerability is present in all individuals to lesser or greater degree and that the important factor may not be a matter of type of negative cognitive style but rather the strength of its influence when in interaction with other factors (such as negative life events).

Conclusions & Practice Implications

This paper has reviewed evidence and current understandings of cognitive-vulnerability to depression. It has highlighted differences apparent in the extant literature that seeks to elucidate the influence of various cognitive mechanisms considered relevant to depression onset, maintenance and relapse. The mixed evidence indicates negative attributional styles *and* dysfunctional attitudes are correlated with cognitive-vulnerability; it also *suggests* causal relationships, however the strength of the causal arguments requires further investigation and evidence. As such whether the different forms of cognitive vulnerability lead to different de-

pression subtypes is also currently unclear. Although some commentators suggest instead that both forms may “co-occur [to] make depression more likely still” (Joiner & Rudd, 1996, p.65).

A clarification of the casual components of cognitive-vulnerability may provide a means for determining where the focus of cognitive therapy should be both for preventing relapse and for early intervention in those presenting with depression, thereby potentially reducing the incidence of relapse. For example, therapy could focus on attenuating clients’ dysfunctional attitudes, negative attributional styles or both, depending on the clients’ particular presentation. Many strategies already exist to tackle both these cognitive-vulnerabilities, such as: activity monitoring and scheduling, Socratic questioning, behavioural experiments, rational-emotional role-play, decentering, attentional control training and attributional retraining, to name a few (Abramson et al., 1978; J. S. Beck, 1995; Bennett Levy et al., 2004; Forsterling, 1985, 2001; Hilt, 2004; Segal et al., 2002). The more precise application of these can only serve to augment the effectiveness of cognitive therapy.

Further clarifying the role of different cognitive-vulnerabilities can better inform pro-active psychological well-being strategies, potentially preventing initial depression-onset, e.g. in schools as part of the government’s ‘Healthy Schools’ emotional well-being initiative (Department of Education and Skills, 2003; Department of Health, 2005). Evidence exists that teaching children to make more positive attributions for negative life-events provides some protection against future depression (Gillham, Reivich, Jaycox, & Seligman, 1995; Jaycox, Reivich, Gillham, & Seligman, 1994). Additionally, informed pro-active strategies can also be included in national parenting schemes (Home Office, 2006) that aim to teach parents about harmful/protective parenting styles.

In conclusion, the schema-based approach that informs much of our cognitive therapeutic practice has served us well, both as practitioners and clients. However, the incidence of depression-relapse, as argued at the beginning of this paper, continues to be a problem. It now seems timely both to reconsider our approach and energise our endeavours to better understand the differences between those individuals who show life-time and short-term remission. This is particularly important in the current NHS climate, which is veering more towards short/time-limited, solution-focused therapy. Finally, in the opinion of this author, given what we now know about the course and recurrence of depression, cognitive therapy, without due consideration to client’s particular cognitive-vulnerabilities, and without a relapse prevention component after remission, represents a false economy. The cost of our current approach is indeed high and multifarious: it impacts our depressed clients’ lives and those of their families; it allows the perpetuation, from one generation to the next, of a treatable difficulty; it damages the economy through lost workdays; and, because relapsed clients require multiple treatment cycles, it increases national economic health costs.

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Training & Education Section:

What is Rational Emotive Behaviour Therapy (REBT)?: Outlining the Approach by Considering the Four Elements of its Name

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Introduction

There have been many approaches to outline the defining features of Rational Emotive Behaviour Therapy (e.g. Dryden, 2009, Ellis, 1994) but none have done so just by detailing the four elements that comprise the name of the therapy: i) rational; ii) emotive iii) behaviour and iv) therapy. In this article I will show how you can teach trainees about REBT by using this four element approach. As you read the article, please note that I am addressing trainees and students who do not know about the approach or are relatively new to it.

Rational

When Albert Ellis established the therapy in the 1950s, he called it “Rational Therapy” (Ellis, 1958). He did so because he wanted to stress that emotional problems are based on irrational thinking and that if we are to address these problems effectively, we need to change such thinking to its rational equivalent. It is interesting to note that while REBT has had two previous names, the term “rational” is common to all three names. It is the constant feature that spans REBT’s 50+ year old history. So what do REBT therapists currently mean by the term “rational”? I can best answer this question if I contrast it with the term “irrational”.

The terms “rational” and “irrational” in current REBT theory are most commonly used as adjectives in front of the noun “beliefs”. Such beliefs can also be thought of as attitudes in that they describe a person’s stance or position towards something.

Let me consider the major characteristics of rational beliefs and contrast these with the major characteristics of irrational beliefs. In what follows, I will consider the rational belief in the left hand column and the irrational belief in the right hand column to facilitate the comparison.

A Rational Belief is Flexible or Non-extreme

1. A rational belief is flexible

Here is an example of a rational belief that is flexible.

"I want my colleague to like me, but she does not have to do so"

Imagine that you hold such a belief. As you do so you will see that this belief is flexible because while you assert what you want (i.e. *"I want my colleague to like me..."*), you also acknowledge that you do not have to get what you want (i.e. *"...but she does not have to do so"*).

2. A rational belief is non-extreme

Here is an example of a rational belief that is non-extreme.

"It is bad if my colleague does not like me, but not the end of the world"

Again imagine that you hold this belief. As you do so you will see that this belief is non-extreme because while you assert that you find the event negative (i.e. *"It is bad if my colleague does not like me..."*), you also acknowledge that such an evaluation is not extreme because it could always be worse (i.e. *"...but not the end of the world"*).

An Irrational Belief is Rigid or Extreme

1. An irrational belief is rigid

Here is an example of an irrational belief that is rigid.

"My colleague has to like me"

To compare this belief with the flexible version in the left-hand column, we need to state it in its full form

"I want my colleague to like me, therefore she has to do so"

Again imagine that you hold this belief. As you do so you will see that this belief is rigid because while you not only assert what you want (i.e. *"I want my colleague to like me..."*), you also demand that you have to get it (i.e. *"...therefore she has to do so"*)

2. An irrational belief is extreme

Here is an example of an irrational belief that is extreme.

"It is the end of the world if my colleague does not like me"

To compare it to the non-extreme version in the left-hand column we need to state it in its full form

"It is bad if my colleague does not like me, and therefore it is the end of the world"

Again imagine that you hold this belief. As you do so you will see that this belief is extreme because you not only assert that you find the event negative (i.e. *"It is bad if my colleague does not like me..."*), you also claim that it could not be worse (i.e. *"...and therefore it is the end of the world"*).

A Rational Belief is True

Imagine that you hold the following rational belief that I introduced above: *“I want my colleague to like me, but she does not have to do so”*. You will note that this belief is made up of two parts:

“I want my colleague to like me...”
“... but she does not have to do so”

Let’s take one part at a time. First, you can prove that you would like your colleague to like you; after you this is your desire. Also, you can probably cite reasons why you want your colleague to like you (e.g. it makes for a good working relationship where you can help each other). So, the first part of your belief is true.

Now let’s look at the second part of the rational belief. You can also prove that the other person does not have to like you. To state otherwise would be to deny that person free choice.

So if both parts of this rational belief then we can say that the belief taken as a whole is true.

An Irrational Belief is False

Now imagine that you hold the following irrational belief that I introduced above: *“My colleague has to like me”*. Again this belief is made up of two parts:

“I want my colleague to like me...”
“... and therefore she has to do so”

Let’s take one part at a time. First, you can again prove that you would like the other person to like you for reasons discussed opposite. So, the first part of your belief is true.

Now let’s look at the second part of the irrational belief. You cannot prove that your colleague has to like you. If that were true, she would have no choice but to like you. This demanding component of your irrational belief in effects robs your colleague of free choice, which she retains in the face of your demand. Thus, this second part is false.

As both parts of a belief have to be true for the belief to be true then we can say that the irrational belief is false.

Also, when we consider this irrational belief in its short form (i.e. *“My colleague has to like me”*) then it is clear that it is false since it again attempts to rob your colleague of the freedom not to like you which she does in reality have.

A Rational Belief is Sensible

Taking the rational belief: *“I want my colleague to like me, but she does not have to do so”* we can ask the question: does this belief make sense? We can answer that it does since you are explicitly acknowledging that there is no connection between what you want and what you have to get.

An Irrational Belief is Not Sensible

Taking the full form of your irrational belief: *“I want my colleague to like me, and therefore she has to do so”* we can again ask the question: does this belief makes sense? Here our answer is that it does not because it asserts that there is a connection between what you want and what you have to get. The idea that because you want something you have to get it is, in fact, childish nonsense when coming from an adult.

A Rational Belief is Largely Constructive

When you hold a rational belief the consequences of doing so will be largely constructive. For example let's suppose that you hold the following rational belief: *"I want my colleague to like me, but she does not have to do so"* and you bring this belief to a situation where your colleague snaps at you for no good reason. In this situation you will experience three different, but related consequences which I will now illustrate:

Emotional consequence

Here you will tend to be concerned about your colleague's response, but not anxious about it

Behavioural consequence

Here you will be likely to enquire of your colleague in an open way if there is anything wrong

Thinking consequence

Here you will tend to think that your colleague is upset with someone or something which could be to do with you, but may well be nothing to do with you

An Irrational Belief is Largely Unconstructive

When you hold an irrational belief the consequences of doing so will be largely unconstructive. For example let's suppose that you hold the following irrational belief: *"My colleague must like me"* and you bring this belief to the situation where your colleague snaps at you for no good reason. In this situation you will experience three different, but related consequences which I will now illustrate. As I do so, compare these consequences to those that stem from your belief if it were rational (see opposite)

Emotional consequence

Here you will tend to be anxious, rather than concerned about your colleague's response

Behavioural consequence

Here you will tend not to avoid your colleague or try desperately to get her to like you

Thinking consequence

Here you will tend to think that your colleague is upset with you rather with someone or something that had nothing to do with you

Emotive

The term "emotive" in REBT means that which is relevant to your emotions. Like every other approach to therapy REBT is based on a model of emotions. Since REBT is a therapeutic approach it is primarily concerned with relieving people's emotional disturbance. However, it also acknowledges that people are bound to have negative emotions when faced with negative life events (henceforth called adversities in this book). To accommodate these two positions REBT distinguishes between emotions that are negative in tone and have largely unconstructive consequences and emotions that are negative in tone and have largely constructive consequences. The former are known as unhealthy negative emotions (UNEs) and the latter healthy negative emotions (HNEs).

The REBT Model of Emotions

The REBT model of emotion states that the emotions that we experience are based largely on the beliefs that we hold about ourselves, others and the world. More specifically it states that our unhealthy negative emotions about life’s adversities are based largely on the irrational beliefs that we hold about these adversities and that if we want to experience healthy negative emotions about the adversities in question we need to change our irrational beliefs to rational beliefs.

This is shown in the following figure in which “A” stands for adversity, “B” for beliefs and “C” for the consequences of these beliefs (in this case the emotional consequences). This is REBT’s famous ABC model which you can find outlined in any REBT textbook (e.g. Dryden & Branch, 2008).

A	B	C
Adversity	Irrational Beliefs	Unhealthy Negative Emotions
Adversity	Rational Beliefs	Healthy Negative Emotions

Let me illustrate this model by referring to the example that I introduced earlier in this chapter.

A	B	C
<u>Adversity</u> My colleague may not like me	<u>Irrational Belief</u> My colleague must like me	<u>Unhealthy Negative Emotion</u> Anxiety
<u>Adversity</u> My colleague may not like me	<u>Rational Belief</u> I want my colleague to like me, but she does not have to do so	<u>Healthy Negative Emotion</u> Concern

Because life’s adversities are negative, it is not appropriate for you to feel good about them or even neutral about them. It is healthy to experience negative emotions, but not problematic ones about such life events. These problematic emotions in REBT are known as unhealthy negative emotions (UNEs) and these are listed in the following table and contrasted with their healthy negative equivalents.

Unhealthy Negative Emotions	Healthy Negative Emotions
------------------------------------	----------------------------------

Anxiety	Concern
Depression	Sadness
Guilt	Remorse
Shame	Disappointment
Unhealthy Anger	Healthy Anger
Hurt	Sorrow
Unhealthy Jealousy	Healthy Jealousy
Unhealthy Envy	Healthy Envy

I want to make two points here;

As detailed above, unhealthy negative emotions (UNEs) largely stem from irrational beliefs about life's adversities while healthy negative emotions stem largely from rational beliefs about these same adversities.

We do not have commonly agreed words in the English language to describe healthy negative emotions. The terms that I have used in the right hand column of the above table are my own. Feel free to use alternative terms that are more meaningful to you.

Intellectual vs. Emotive Understanding

The other major area where the term "emotive" comes up in REBT is in distinguishing between two different types of understanding: intellectual understanding and emotive understanding (Ellis, 1963). These are particularly important when a person is trying to change an irrational belief to its rational belief alternative.

Let me illustrate this distinction by using the above example where you currently hold the irrational belief (i.e. "My colleague must like me") and your colleague has snapped at you. Let's suppose that you acknowledge that your irrational belief is irrational (meaning that it is rigid, false, not sensible and largely unconstructive – see above). And let's assume, furthermore, that you acknowledge that your rational alternative belief (i.e. I want my colleague to like me, but she does not have to do so") is rational (meaning that it is flexible, true, sensible and largely constructive). When your understanding of these two points is intellectual in nature, you say things like "Well, I can understand this in my head, but not in my heart" and "I understand it, but I don't feel it". Here, you will still feel anxious about the prospect of your colleague not liking you, you will act in ways that are consistent with your irrational belief (i.e. you will either avoid your colleague or desperately try to get her to like you) and you will tend to think in highly distorted ways about your colleague (e.g. "She is definitely upset with me" and "If I don't win her over immediately, she will never like me again"). In other words, while you understand intellectually the reason why your irrational belief is irrational belief and why your rational belief is rational, this understanding has little or no impact on your emotions, behaviour and subsequent thinking. You still think, act and feel in ways consistent with your irrational belief even though you know it is irrational.

However, when your understanding of these points is emotive in nature, you not only grasp the points intellectually, but you also feel, think and act in ways that are consistent with the rational belief and that are inconsistent with the irrational belief. Thus, you will feel concerned, but not anxious about the prospect of your colleague not liking you, you will act in ways that are consistent with your rational belief (i.e. you will check out with her why she snapped at you) and you will tend to think in realistic ways about your colleague (e.g. "She may or may not be upset with me" and "If she is upset with me, we can talk it through and resolve the issue"). In other words, you understand the reason why your irrational belief is irrational belief and why your rational belief is rational and this understanding has a decided constructive impact on your emotions, behaviour and subsequent thinking. You think, act and feel in ways consistent with your rational belief.

In REBT, we argue that intellectual understanding is a necessary, but insufficient ingredient for constructive psychological change and many of the chapters in this book are devoted to helping you to move from such intellectual understanding to the emotive understanding necessary for such change to occur.

Behaviour

The term “behaviour” in REBT refers to both overt behaviour and to an urge to act that is not translated into overt behaviour. The latter is known as an action tendency. REBT’s model of behaviour parallels its model of emotions in arguing that irrational beliefs tend to lead to behaviour that is largely unconstructive in effect and that rational beliefs lead to behaviour that is largely constructive in effect. The former is associated with unhealthy negative emotions (UNEs) and the latter and the latter with healthy negative emotions (HNEs).

This is shown in the following figure in which “A” stands for adversity, “B” for beliefs and “C” for the consequences of these beliefs (in this case the behavioural consequences).

A	B	C
Adversity	Irrational Beliefs	Unconstructive Behaviour
Adversity	Rational Beliefs	Constructive Behaviour

Let me illustrate this model by referring again to the example that I introduced earlier in this chapter.

A	B	C
<u>Adversity</u> My colleague may not like me	<u>Irrational Belief</u> My colleague must like me	<u>Unconstructive Behaviour</u> Avoidance of colleague Desperate attempts to get colleague to like me
<u>Adversity</u> My colleague may not like me	<u>Rational Belief</u> I want my colleague to like me, but she does not have to do so	<u>Constructive Behaviour</u> Asking colleague directly if there is anything wrong

In the table below, I outline the major behaviours associated with the eight unhealthy and healthy negative emotions listed above.

<p>Unhealthy Negative Emotion with Associated Unconstructive Behaviours and Action Tendencies</p>	<p>Healthy Negative Emotion with Associated Constructive Behaviours and Action Tendencies</p>
<p style="text-align: center;"><u>Anxiety</u></p> <p style="text-align: center;">Withdrawing from threat Avoiding threat Seeking reassurance even though not re-assurable Seeking safety from threat</p>	<p style="text-align: center;"><u>Concern</u></p> <p style="text-align: center;">Confronting threat Seeking reassurance when reassurable</p>
<p style="text-align: center;"><u>Depression</u></p> <p style="text-align: center;">Prolonged withdrawal from enjoyable activities</p>	<p style="text-align: center;"><u>Sadness</u></p> <p style="text-align: center;">Engaging with enjoyable activities after a period of mourning or adjustment to the loss</p>
<p style="text-align: center;"><u>Guilt</u></p> <p style="text-align: center;">Begging for forgiveness</p>	<p style="text-align: center;"><u>Remorse</u></p> <p style="text-align: center;">Asking, not begging, for forgiveness</p>
<p style="text-align: center;"><u>Shame</u></p> <p style="text-align: center;">Withdrawing from others Avoiding eye contact with others</p>	<p style="text-align: center;"><u>Disappointment</u></p> <p style="text-align: center;">Keeping in contact with others Maintaining eye contact with others</p>
<p style="text-align: center;"><u>Hurt</u></p> <p style="text-align: center;">Sulking</p>	<p style="text-align: center;"><u>Sorrow</u></p> <p style="text-align: center;">Assertion and communicating with others</p>
<p style="text-align: center;"><u>Unhealthy anger</u></p> <p style="text-align: center;">Aggression (direct and indirect)</p>	<p style="text-align: center;"><u>Healthy anger</u></p> <p style="text-align: center;">Assertion</p>

<p><u>Unhealthy jealousy</u></p> <p>Prolonged suspicious questioning of the other person</p> <p>Checking on the other</p> <p>Restricting the other</p>	<p><u>Healthy jealousy</u></p> <p>Brief, open-minded questioning of the other person</p> <p>Not checking on the other</p> <p>Not restricting the other</p>
<p><u>Unhealthy envy</u></p> <p>Spoiling the other's enjoyment of the desired possession</p>	<p><u>Healthy envy</u></p> <p>Striving to gain a similar possession for oneself if it is truly what you want</p>

The behaviours listed are above are what a person does or tends to do when her irrational or rational belief about an adversity has been fully activated. However, the impact of belief on behaviour can be seen in other ways.

Short-term Self-protective Behaviour

In the ABC model that I have presented in this article, an adversity occurs or is deemed to occur at “A”, the person holds a belief about this adversity at “B” and experiences emotional, behavioural and thinking consequences of holding this belief at “C”. In this model the person’s belief (e.g. “My colleague must like me”) is specific to the specific adversity that she encounters.

However, beliefs can be held at a more general level (e.g. “People with whom I work must like me”) and when a belief is more general in nature, the person has a tendency to bring such a belief with them, as it were, to situations where a relevant adversity may occur. Thus, in our example, if a person holds a general irrational belief (e.g. “People with whom I work must like me”), then the person will be hypersensitive to the possibility of not being liked by a colleague and act to prevent this adversity actually occurring (e.g. by being extra nice to a person whom she thinks may, but has not yet shown her some disapproval). In this way the person is acting to protect herself in the short-term, but the longer-term effect of this behaviour is unconstructive in a number of ways:

- She does not get to test out her hunch that the person will disapprove of her
- She does not get to deal constructively with such disapproval should it occur and
- She tends to maintain her irrational belief since she is acting in a way that is consistent with it

Over-compensatory Behaviour

When a person holds an irrational belief and particularly one that is general in nature, then she may try to deal with actual or potential adversities by behaving in a manner that is over-compensatory. By using over-compensatory behaviour the person is trying to prove to herself the opposite of what she actually thinks is the truth about her, the other person or the world.

A common example of this occurs when a person privately considers that he would be weak if he can't deal with a challenge, but tries to prove to himself that he is strong by facing an even greater challenge.

Therapy

The word "therapy" comes from the Greek "therapeia" meaning "a service, an attendance" which, in turn, is related to the Greek verb "therapeuo" meaning "I wait upon."

REBT therapists, therefore, can be seen to offer a "service" to people who have problems in a number of areas: i) emotional problems; ii) practical, dissatisfaction problems and iii) personal development problems (Bard, 1980, Grieger & Boyd, 1980 ; Wessler & Wessler, 1980). A distinctive feature of REBT is that it outlines a logical order for dealing with these problems.

Disturbance before Dissatisfaction

REBT argues that unless there are good reasons to the contrary, it is best for us to address our emotional problems before our dissatisfaction problems (Dryden, 1985). The reasoning is as follows. If we try and deal with our dissatisfaction before we deal with our emotional disturbance, then our disturbed feelings will get in the way of our efforts to change directly the adversities about which we are dissatisfied.

For example, let's take the example of Paul who is dissatisfied about his wife's spending habits. However, he is also unhealthily angry about her behaviour and every time he talks to her about it he makes himself angry about it, raises his voice to his wife and makes pejorative remarks about her and her spending behaviour. Now what is the likely impact of Paul's expression of unhealthy anger on his wife? Does it encourage her to stand back and look objectively at her own behaviour? Of course, it doesn't. Paul's angry behaviour is more likely to lead his wife to become unhealthily angry herself and/or to become defensive. In Paul's case, his anger had, in fact, both effects on his wife. Now, let's suppose that Paul first addressed his unhealthy anger and then discussed his dissatisfaction with his wife. His annoyance at her behaviour, but his acceptance of her as a person would help him to view her own behaviour perhaps as a sign of emotional disturbance and his compassion for her would have very different effects on her. She would probably be less defensive and because Paul would not be unhealthily angry, then his wife would also be less likely to be unhealthily angry. With anger out of the picture, the stage would be set for Paul to address the reasons for his dissatisfaction more effectively.

Disturbance before Development

In the late 1960s and early 1970s, I used to go to a number of encounter groups. This was the era of personal growth or development. However, there were a number of casualties of these groups and when these occurred it was because attendees were preoccupied with issues of emotional disturbance and they were being pushed too very hard to go into areas of development that warranted greater resilience.

In general then, it is very difficult for us to develop ourselves when we are emotionally disturbed. To focus on areas of development when someone is emotionally disturbed is akin to encourage that person to climb a very steep hill with very heavy weights attached to their ankles. First, help the person to remove their ankle weights (i.e. address their emotional disturbance) before discussing the best way of climbing the hill!

Dissatisfaction before Development

Abraham Maslow (1968) is perhaps best known for his work on self-actualisation. The rele-

vance of this concept for our present discussion is this. It is very difficult for humans to focus on higher order “needs” when we are preoccupied with issues with respect to lower-order needs. Thus, if a person is faced with a general dissatisfying life experience which cannot be compartmentalised and also wants to explore his writing ambitions, he should address the former first unless this life dissatisfaction will help him write a better book!

While I have outlined REBT’s preferred order in dealing with problems, it also values flexibility. Thus, if a person wants to deal with his problems in a different order, he should do so and observe the results. If it works, that is fine. If not then REBT’s preferred position may prove to yield better results. The proof of the pudding is in the eating!

Conclusion

While outlining REBT by considering the four elements that comprise its name is not comprehensive, it does introduce trainees and other students relatively unfamiliar with REBT with some of its key elements.

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