Association of Rational Emotive Behaviour Therapists
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Rational Emotive Behaviour Therapist

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Editorial

Welcome to the latest 'new look' issue of *The Rational Emotive Behaviour Therapist*, which includes a range of interesting articles covering topics such as 'Irrational beliefs and postnatal depression', 'An REBT conceptualisation of Iraqi refugee exile-related stressors' and 'Mindfulness, MBCT, & REBT: Disciplinary demarcation and integration potential'.

You will also find a message from the AREBT Chair, David Baker, reflecting on his first year in post and looking forward to future developments.

There is also an update on Accreditation Matters from Meir Stolear on p75 and a comment about REBT and IAPT from Edelweiss Collings on p74.

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

Thank you to each of the contributors.

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Message from the Chair

These thoughts are mine and not AREBT policy, however after being in office for a year I hope they do, at some level, reflect themes and ideas prevalent within the association.

We have just finished a most successful conference held in London. The feedback from registrants was very positive, with some commenting that the standard of presentations was the highest they had experienced at conference. This success is, in large part, due to our conference sub-committee – Fay Kalapoda, Avy Joseph and Dennis Bury. My thanks to them all and also to the staff at Faraday House, Syracuse University – an excellent venue and a warm welcome. I trust we shall build on this success and I know that Dennis is already analysing the feedback data to make sure future events are even more worthwhile, exciting and relevant.

A central theme that emerged from the presentations was the continuing relevance of REBT as the jewel in the CBT crown. Of particular relevance to this theme was the key note address from Dr Jason Jones, stressing the idea that the dominance of Beckian CTs has led to a situation where REBT has been misunderstood or ignored. I share Jason's views that this neglect demonstrates poor scholarship, since in a 'society' obsessed with its empirical credentials the myopia about REBT is paradoxical because REBT has significant theoretical strengths over other cognitive therapies under the CBT umbrella.

The message, in respect of the use of REBT within IAPT is very mixed, too. Some providers encourage the use of REBT, while services in other areas specifically discourage its use, apparently predicated on the basis that it's not CBT! At the same time, here at AREBT, we see a continued interest in the use of REBT from Asian countries and Australia, all of whom espouse the elegance, flexibility and efficaciousness of REBT.

I hope that commissioners and providers of mental health care in the NHS will promote the use of REBT, recognising its continuing potential for scientific development and therapeutic effectiveness, and I would remind such readers that REBT is not significantly different from CT either.

Concerns about economy of scale is ever present in a modest-sized organisation such as AREBT, which punches far above its weight. Our memorandum of understanding with BABCP, which acknowledges joint accreditation, will help us to proclaim the REBT message, as both organisations seek excellence of care for mental health. In addition, I was particularly pleased to welcome Professor Peter Trower, founder of the centre for REBT at the University of Birmingham, whose work as a clinical psychologist in the NHS infers

much eminence, and Dr Jason Jones, course director of that organisation, to our conference. I hope their willingness to give up their time and present at conference, will herald the start of a good working relationship. I shall personally do all I can to encourage such a move.

AREBT and REBT face some interesting challenges in the very near future. There was a general feeling at the AGM that we should spend some of our very modest resources to ensure the continuing facility for REBT to be taught to master level. This is something your committee is very much aware of and will be top of the agenda at our next committee meeting, which is likely to be held in January next year.

I would like to make a special mention of thanks to Toby Chelms, who spearheaded the introduction of our new website. Regrettably, Toby has had to stand down from the role due to professional pressures. Toby has offered to help any volunteer who will come forward to 'manage' the website, for us. This is an increasingly important role. So please, if you have an interest in this role, contact me or any member of the committee – we need your help.

I welcome Desi Shortt, who has taken over the important role of treasurer. Peter Ruddell has stood down, again, for professional reasons. AREBT owes a real debt of gratitude to Peter, who has been its treasurer since inception. The organisation could not have functioned without Peter's guiding hand on the financial tiller – thank you Peter for all the years of dedicated service, always conducted in your diplomatic and gentle style.

Your committee has developed special areas of interest in the form of research [academic], scientific, fellowship, conference and supervision sub-committees. We are all working hard to foster the impact of REBT. This is also a suitable place to thank our Journal editor, Dr Siobhain O'Riordan, and honorary editor, Professor Stephen Palmer, for their work in raising the standard of this publication over many years. As with all the committee, they give of their time freely and with enthusiasm.

We shall shortly announce a new form of membership for researchers and academics to join AREBT, so that we can encourage research into the use of REBT. The association is very keen to encourage further research into the use of REBT, reminding readers that Ellis was adamant REBT was a multi-model therapy – an idea not missed by some of our presenters at conference who outlined the use of REBT in mindfulness (Debbie Malki); coaching (Gladeana McMahon); self-acceptance groups (Ian Martin); the treatment of psychopathological perfectionism (Dr David Baker), and the use of humour in therapy (Daniel Fryer).

I would like to encourage any member of AREBT who feels they can make a contribution, but does not necessarily wish to engage in committee work, to come forward – we need all the help we can get.

I wish all members a peaceful, enjoyable and safe Christmas, and a successful New Year.

Dr David Baker, Chair, AREBT

Irrational beliefs and postnatal depression: a correlational study

Denise Christy

This study investigated the existence of irrational beliefs in women with young babies. Women with and without postnatal depression, with babies aged 4 weeks to 6 months, were recruited via the Netmums website, as well as from non-National Health Service run postnatal depression groups. Self-report scores on the Edinburgh Postnatal Depression Scale, Beck's Depression Inventory and Beck's Anxiety Inventory were compared to scores on the Shortened General Attitude and Belief Scale.

The hypotheses were firstly, that there is a relationship between irrational beliefs and postnatal depression, and secondly that women with postnatal depression hold more irrational beliefs than women without postnatal depression. The correlation between the ranking of scores on the Edinburgh Postnatal Depression Scale, Beck's Depression Inventory, Beck's Anxiety Inventory and the Shortened General Attitude and Belief Scale was examined, and a positive correlation was seen between scores on the Shortened General Attitude and Belief Scale and scores on the three measures of depression and anxiety.

High scores on the following subscales of the Shortened General Attitude and Belief Scale: self-downing, need for comfort and need for approval, predicted high scores on the Edinburgh Postnatal Depression Scale. High scores on the self-downing and demand for fairness subscales predicted high scores on the Beck's Depression Inventory.

Key Words: *Postnatal Depression, Anxiety, Irrational Beliefs, Correlation, REBT*

1. Introduction – Postnatal Depression – Definition and risk factors identified in research

The history of research into postnatal depression has been one of a movement from seeing postnatal depression as a biologically or hormonally based distinct form of depression, to a mood state that incorporates many of the symptoms of both depression and anxiety as classified under the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) (Kammerer et al, 2008).

Postnatal depression normally begins in the first 4-6 weeks following the birth. The existing classifications for postnatal depression have their limitations (Cox, 2004). The International Classification of Diseases (ICD-10) requires depression or any other mental disorder to be classified as postnatal, if they begin within six weeks of birth and if they do not fit under another classification. The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), refers to depression or other illness as postnatal only if it begins within four weeks of the birth.

The expression 'postnatal depression' was first used by psychiatrist Brice Pitt (Pitt, 1968 cited in Lee, 2006). There is some debate amongst researchers (Lee, 2006: Jones et al, 2010) as to whether postnatal depression represents a distinct disorder or is depression occurring in the postnatal period. However, its detrimental effect on mother and child has led psychologists, sociologists and other medical professionals to concentrate on a broad range of psychosocial and medical factors present at this time, in an effort to inform the treatment of postnatal depression.

Previous research with regard to postnatal depression has looked at a wide range of psychosocial factors relevant in the development of postnatal depression. However, much of the research reviewed in meta-analysis (O'Hara 1996, 2009; Beck 2001) has concentrated on extending the range of identifiable demographic and psychosocial factors rather than focusing on the cognitive style or irrational beliefs held by the mother.

The key psychosocial factors already identified in research are the past history of psychopathology in the mother, antenatal depression, the state of a woman's marital relationship during pregnancy, the absence or presence of social and emotional support to the mother, being from a lower social class, experiencing 'stressful' life events during pregnancy, having a difficult (self-perceived) pregnancy or delivery, and low self-esteem (O'Hara 1996, 2009; Beck 2001; Milgrom, Martin & Negri 1999).

In a recent review of the risk factors for postnatal depression in Australian populations, Boyce (2003) included additional factors from the body of research, including the age of the mother (being younger or older than average first-time mothers) and early experiences (with particular interest in the quality of parenting they received). In addition, a genetic or 'culturally impacted' family history of a tendency to depression and biological functioning with regard to sensitivity to oestrogen were considered (Boyce, 2003). In a re-analysis of data collected during two previous longitudinal studies, Boyce and Hickey (2005) identified three key factors which did not significantly vary across studies: the impact of past psychopathology, interpersonal stresses and a vulnerable personality. The relationship with socio demographic factors was seen inconsistently in research and Boyce and Hickey (2005) suggested that this may have been related to the different populations studied and that therefore these factors did not present as robust risk factors.

Research has focused increasingly on individual psychology and personality style as factors in postnatal depression. Dudley, Roy, Kelk and Bernard (2001) used structured interview and questionnaires (The Edinburgh Postnatal Depression Scale (Cox, Holden & Sagovsky, 1987), The General Health Questionnaire (Goldberg et al., 1976), the Eysenck Personality Inventory (Eysenck & Eysenck, 1980), Defence Style Questionnaire (Andrews et al., 1989, Andrews et al., 1993), Parental Bonding Instrument (Parker, 1979, 1983), the Spanier Dyadic Adjustment Scale (Spanier, 1976)) and the Carey Scale (Carey, 1970) to look at psychological correlates of depression in fathers and mothers in the first postnatal year. The most significant at-risk factor for postnatal depression in mothers and fathers was found to be neuroticism, although it was not necessary or sufficient for postnatal depression.

Leigh and Milgrom (2008) looked at risk factors for antenatal depression, postnatal depression and parenting stress, recruiting women antenatally from two major hospitals

in Melbourne, Australia. Using regression analysis, it was found that antenatal depression and a history of depression were the strongest predictors of postnatal depression. The predictors for antenatal depression were: low self-esteem, antenatal anxiety, low social support, negative cognitive style, major life events, low income and a history of abuse. Antenatal depression, history of depression and parenting stress was said to account for 66 per cent of the variance with regard to postnatal depression.

Although irrational beliefs have rarely been examined, core beliefs have been studied in the ante and postnatal period, in the context of Young's Schema theory (Blissett and Farrow 2007). Eighty-seven women completed the Young Schema Questionnaire (Young, 1998, as cited in Blissett and Farrow, 2007) during pregnancy and at 6 and 12 months post partum. Although the focus of this research was on the stability of core beliefs over a major life event, the subscales did include items of interest with regard to irrational beliefs. For example, one core belief identified was 'unrelenting standards', described as 'exceptionally high-internal standards of performance, usually to avoid criticism'. Indeed, Blissett and Farrow found the most commonly reported unhealthy beliefs were associated with (p. 595) 'self sacrifice' and 'unrelenting standards'. These core beliefs were said to increase between pregnancy and 6 months after the birth.

Much of the research in the area of cognitive style and vulnerability has not made use of existing measures of irrational beliefs but rather focused on the development of new scales for identifying cognitive vulnerability in mothers. Boyce, Hickey, Gilchrist and Talley (2001) developed a personality scale to measure vulnerability to postnatal depression. This scale, the Vulnerable Personality Style Questionnaire (VPSQ), was designed as a self report 9-item questionnaire, to measure vulnerability and to a lesser extent, resilience. In an earlier review of risk factors Boyce (1994, cited in Boyce et al, 2001) identified personality style and in particular neuroticism, interpersonal sensitivity, obsessionality and dysfunctional cognitive style as factors in developing postnatal depression. In the development of this new measure, the VPSQ, he aimed to combine a number of personality traits in one brief scale, for clinical and research use.

Boyce et al (2001) observed that depressed women scored significantly higher on the Vulnerable Personality Style Questionnaire when baseline depression was controlled for, and it was found to have some predictive qualities in logistic regression analysis. An increased score on the vulnerability scale was said to increase the risk of postnatal depression. In further psychometric testing, Dennis and Boyce (2004) used the VPSQ as part of a longitudinal study with Canadian women. With regard to interreliability, in this study the Cronbach's alpha coefficient for the VSPQ was moderately good at 0.67, and it was also able to predict depression at the rate of 1:1.3.

Church, Brechman-Toussaint and Hine (2005) also used this measure (the VPSQ) alongside the Dysfunctional Attitude Scale (DAS: Weissman, 1980; Weissman & Beck, 1978, as cited in Church et al, 2005), the Maternal Attitudes Questionnaire (MAQ: (Theut, 1990, as cited in Church et al, 2005)) and Edinburgh Postnatal Depression Scale (EPDS: Cox, Holden & Sagovsky, 1987) in their research. They used path analysis to look at dysfunctional cognitions as a mediator between non cognitive risk factors and postnatal depression. In this correlational study, they found the relationship between having a

difficult baby and postnatal depression to be mediated by maternal-specific dysfunctional cognitions (MAQ) scores. The relationship between a vulnerable personality (VPSQ scores) and depressive symptomatology was mediated by DAS and MAQ scores.

1.2. REBT Theory and postnatal depression

However, although Church et al's study was useful in helping to identify the existence of cognitive mediators in postnatal depression, it did not directly measure those irrational beliefs, which according to the theory of Rational Emotive Behaviour Therapy mediate between stressors and depression.

Rational Emotive Behaviour Therapy (REBT), is a form of cognitive behavioural therapy. It differs from other cognitive behaviour therapies, such as Beck's (1976) because it emphasises the holding of demanding, inflexible beliefs, as the prime source of emotional distress. Although, CBT acknowledges the role of demanding beliefs and unrelenting standards as one type of cognitive distortion, REBT gives them a central driving role in psychological disturbance. REBT therapists are particularly interested in working with their clients to understand the inflexible and demanding beliefs the clients hold, and helping them to work towards changing them into flexible preferences (Bernard, 1991; Dryden 1994a, 1995b, 1995c; Ellis, 1962, 1985c, 1994; Ellis & Becker 1982; Ellis & Harper 1975; Grieger & Woods, 1993; Phadke, 1982; Walen, DiGiuseppe, & Dryden 1992, as cited in Ellis and Dryden, 1997). These inflexible, demanding beliefs are defined in REBT theory as irrational beliefs, because as demanding beliefs, they are generally not useful, do not help people to reach their goals and are illogical and unrealistic. When these beliefs are triggered, they lead to unhealthy negative emotions, such as depression and anxiety, and to a tendency to dysfunctional behaviour.

REBT makes use of an ABC(DE) model to describe and work with emotional problems (Ellis, 1994; David & Szentagotai 2006a, as cited in Ellis, David & Lynn, 2010). According to the model, people hold demanding beliefs (B) about activating events (A) and it is these demanding beliefs that are considered to be the primary cause of emotional distress. Of course, events contribute to distress, especially when they are extremely negative events, and it could be said that we all hold irrational beliefs at times. However, as we cannot change some events, it is more useful to change our beliefs about those events, and REBT encourages people to accept themselves, while working towards change. This is why clients are encouraged to dispute (D) their irrational demanding beliefs, in order to take on more healthy rational beliefs (E), to modify their behaviour and to experience healthy emotions.

Rational-Emotive Behaviour Therapy proposes that the holding of these inflexible demanding beliefs about ourself, others and the world will not necessarily lead to emotional problems without a trigger. It is when the demand is not met, that emotional problems such as depression occur. This can lead to catastrophising (believing something is so bad, that nothing could be worse) and a belief that the person cannot cope with the situation. It also frequently leads to self or other damning. In the context of postnatal depression, inflexible demanding beliefs may make adjustment to her new circumstances very difficult for the mother. Although the birth of a child is seen as a positive event, it does involve some loss. The mother may find her career disrupted and put on hold

temporarily or permanently. She may become isolated from her old social contacts. Existing high standards in many areas of her life may be challenged by a demanding baby. Irrational beliefs which have originated in childhood (for example, a belief that one absolutely must not be rejected) may be triggered by a seemingly dissatisfied child. In the absence of social support, a mother may struggle to deal with her conflicting beliefs: that she must not fail as a mother, that she absolutely must be able to cope and that she must not feel depressed when she has a new baby.

Rational beliefs are flexible beliefs. Expressed as preferences rather than demands, they lead to healthy emotions, both negative and positive. They are adaptable, and come from an acceptance of oneself, others and the world around us. They enable us to adapt and to cope with challenging life events as they inevitably occur.

Looking at the Vulnerable Personality Style Questionnaire (VPSQ), in the light of REBT theory and research, the VPSQ has items pertaining to affect as well as cognition. In the questionnaire each personality tendency is assessed according to a statement which begins, 'In general, I….' which does not distinguish between preference and demand: the two types of belief that are clearly differentiated in REBT. The Dysfunctional Attitude Scale Questionnaire used in Church et al (2005) tested dysfunctional attitudes according to Beck's Cognitive Model, rather than Ellis's Rational Emotive Behavioural Therapy Model.

The Dysfunctional Attitude Scale Questionnaire was again used recently in research into cognitive style and personality and vulnerability to postnatal depression (Jones et al, 2010). It was used alongside the Eysenck Personality Questionnaire (Eysenck & Eysenck, 1975, as cited in Jones et al, 2010), and the Rosenberg Self-esteem Questionnaire (Rosenberg, 1965, as cited in Jones et al, 2010). However, this time the researchers worked with two groups of remitted depressives: women who had experienced postnatal depression in the past, and women who had experienced depression but not after childbirth. These women were compared with a healthy female control group on the above measures.

Cognitive vulnerability (i.e. higher levels of neuroticism, dysfunctional beliefs and lower self-esteem) was seen in women who had experienced both postnatal depression and depression, but not in the control group. This suggests that cognitive vulnerability (however assessed) is present in all depressed women. However, some women with cognitive vulnerability may not suffer from postnatal depression, even though they may be depressed at other times. If irrational beliefs are a more accurate measure of cognitive vulnerability, then vulnerability could be more effectively assessed using one brief scale such as the Shortened General Attitude and Belief Scale, which takes approximately 4 minutes to complete.

If, as the Jones et al (2010) research appears to indicate, depression and anxiety during the postnatal period do not differ in terms of cognitive vulnerability or symptomology from these emotional problems in relation to other triggers, then this conclusion is supported by REBT theory. According to REBT theory and previous research linking irrational beliefs to clinical and non-clinical depression (McDermut, Haaga and Bilek 1997; Macavei, 2005) it is the irrational beliefs held by women with postnatal depression that may contribute to unhealthy negative emotions. Irrational beliefs could mediate between the negative event (such as an unsettled baby or perceived lack of social support)

and the subsequent depressed or anxious state. Women with irrational beliefs would not always have postnatal depression; but those with postnatal depression would probably have a higher level of irrational beliefs.

There is currently little research in the area of REBT and postnatal depression. However, in a rare study, Milgrom and Beatrice (2003) used the General Attitude and Belief Scale (GABS: Bernard, 1998) to identify the existence of irrational beliefs in a sample of women diagnosed with postnatal depression. Looking at the subscales of the GABS, higher rates of self-downing, higher needs for achievement and approval, more demanding of fairness and more need for comfort were found in women with postnatal depression. These irrational beliefs persisted, even at 24 months, once depressive status was controlled for.

In Milgrom and Beatrice's study (2003) the researchers looked at irrational beliefs and defence and attachment styles in mothers. Forty one depressed women and 47 non-depressed women were compared. The depressed mothers were all inpatients at psychiatric mother-baby units in Melbourne. They all had scores more than or equal to 12 on the Edinburgh Postnatal Depression Scale (EPDS), in addition to diagnosis of major depression by a psychiatrist. A control group of non-depressed women (with EPDS scores less than 12) was recruited from health centres in the same geographical area.

Milgrom and Beatrice (2003) compared the scores of depressed and non-depressed women on a number of measures: the Edinburgh Postnatal Depression Scale , the Beck Depression Inventory (BDI: Beck, Ward, Mendelson, Mock, & Erbaugh, 1961), the Hamilton Depression Rating Scale (HDRS: Hamilton, 1960), The Defence Style Questionnaire (DSQ: Andrews, Singh & Bond, 1993), the General Attitude and Belief Scale and the Levenson's Locus of Control Scale (Levenson, 1973).

The EPDS, HDRS, DSQ, GABS and Levenson's Locus of Control Scale, were completed twice: 3 months after giving birth, and 24 months after giving birth. The BDI was also completed at 24 months.

Depressed mothers were found to have higher HDRS scores than non-depressed mothers at 3 and 24 months. At the 24 month stage of assessment, depression levels were seen to go down and were then classified as moderate rather than severe. Therefore Milgrom and Beatrice controlled for the effects of ongoing depression in their analysis. Milgrom and Beatrice (2003) found that these irrational beliefs persisted, even at 24 months, once depressive status was controlled for.

Milgrom and Beatrice (p286) concluded that this evidence suggests that "women with PND (postnatal depression) possess cognitive styles that could be considered 'depressogenic', in that systematic errors in thinking are linked with "irrational" beliefs". They also stated (p286) that "irrational beliefs are likely to make it more difficult to care for an infant who makes constant demands such as frequent night waking, does not respect 'fairness', demands rather than gives comfort and makes it hard to be the perfect mother or fulfil the need to achieve."

These irrational beliefs then were hypothesised to exist as a 'trait', which differentiated depressed and non-depressed women, even when those irrational beliefs had not been activated by a challenging event: such as childbirth and/or coping with a demanding young baby.

Looking at general attitudes and beliefs, Milgrom and Beatrice found that depressed women had more irrational beliefs and scored higher on each subscale: self-downing,

need for achievement and approval, demanding of fairness, and need for comfort.

However, the Milgrom and Beatrice (2003) study was carried out using a depressed sample, who were inpatients at mother-baby units in Melbourne, Australia, receiving treatment for severe depression. Those with puerperal psychosis do not appear to have been excluded from the study. The results from their research cannot be generalised to non clinical samples or women from other geographical areas.

1.3. The present study

It was considered of interest to look at irrational beliefs in a non-clinical sample in the United Kingdom, as the participants in Milgrom and Beatrice's earlier study were in a psychiatric hospital in Australia. The aim of the current research was to partially replicate the Milgrom and Beatrice (2003) study using a different population, and to examine the following hypotheses: firstly, that there is a relationship between irrational beliefs and postnatal depression, and secondly, that women with postnatal depression hold more irrational beliefs than women without postnatal depression. It was also considered of interest to examine which irrational beliefs, on the subscales of the Shortened General Attitude and Belief Scale, might predict postnatal depression.

Research into the types of irrational beliefs held by such women could help elucidate a particular model for this disorder, and inform treatments for postnatal depression and preventative psycho education.

In the following study, women were recruited with babies in the age range 1-6 months, with the aim of looking at the correlation of scores on the Shortened General Attitude and Belief Scale with scores on a number of measures: the Edinburgh Postnatal Depression Scale, Beck's Depression Inventory and the Beck's Anxiety Inventory. In the original Milgrom and Beatrice research, mothers completed the range of measures when their babies were 3 months old and later at 24 months. However, it was decided that limiting the respondents to women with babies at 3 months would have made recruitment of participants overly complicated, and would have had a detrimental affect on the sample size. Additionally, it was not possible due to time constraints to carry out a 24 month follow-up.

In addition, due to the conceptualisation of postnatal depression as a mixture of symptoms pertaining to both depression and anxiety, in the current study it was considered of interest to examine scores for anxiety, alongside those for postnatal depression.

As stated earlier, Milgrom and Beatrice (2003) also examined the subscales of the General Attitude and Belief Scale to identify some of the irrational beliefs that might correlate with postnatal depression. In other research, Ciarrochi (2004) correlated the subscales of the Common Beliefs Survey III (another measure of irrational beliefs) with measures of well-being. He found different subscales to be predictors of different emotions: he discovered self-downing to predict depression, but not anxiety, and 'need for approval' to predict anxiety but not depression. Ciarrochi suggested that REBT interventions should focus on different types of irrational belief, according to the client's problem. Identifying the appropriate beliefs to target could be helpful to therapists working with women with postnatal depression. This research therefore, follows the Milgrom and Beatrice research in examining the subscales of a

measure of irrational beliefs, in this research, the Shortened General Attitude and Belief scale (SGABS: Lindner et al, 1999) with regard to postnatal depression.

The current research was an initial investigation into the correlation of irrational beliefs with self-reported postnatal depression, and therefore did not look into cause and effect.

2. Method

2.1. Ethical issues

The research was reviewed and approved by the Goldsmiths University of London Ethics Committee, due to the vulnerability of the participants. Taking into account any distress participants may experience while completing the measures, the research was designed to include detailed information about sources of support for postnatal depression. The researcher (a qualified counsellor) also made herself available to participants on a designated telephone number, if they needed to discuss any aspects of the research or if they experienced any distress. In addition to this, where women appeared to be experiencing symptoms of severe postnatal depression (from their responses on the BDI or EPDS), the researcher made contact with those women to ensure that they were getting support from their health visitor or General Practitioner. Although the questionnaires were coded to ensure confidentiality, the participants were aware that the researcher had records of the address and contact details for each coded response. These records were kept securely by the researcher.

2.2. Design

The participants in the current research completed a package of self-report scales, and the correlation between scores on the Edinburgh Postnatal Depression Scale, Beck's Depression Inventory II (Beck & Steer, 1996), Beck's Anxiety Inventory (Beck & Steer, 1993) and the Shortened General Attitude and Belief Scale were examined. The Hamilton Depression Rating Scale used by Milgrom and Beatrice (2003) was not used in the current research, as it was not designed for self-report and therefore unsuitable for postal survey. The shortened 26-item version of the General Attitude and Belief Scale was used as it was a valid measure of irrational beliefs, but was more concise than the 55-item full version of the General Attitude and Belief Scale. The Defence Style Questionnaire and the Levenson's Locus of Control Scale used by Milgrom and Beatrice (2003) were not used in the current research, as the researcher was not interested in investigating defence style or locus of control.

To recruit participants, an advertisement was placed on the 'Netmums' website, a national United Kingdom website for mothers, with 840,000 members (**www.netmums.com**) under the pages for 'Help and Support' and specifically postnatal depression (PND) for a period of one month, and for a further two weeks under the page entitled 'Baby' under the heading 'Bump to Teens'. (A free prize draw for £100, £50 and £25 retail vouchers was offered as an incentive to participate in the study, and to thank respondents for their participation.)

In addition, a search was made under internet search engines yahoo (**http://uk.yahoo.com**) and google (**www.google.com**) for 'Postnatal Depression Support Groups'. Groups run by the National Health Service were not approached. Ten groups were identified and

approached with regard to participating in the research. Three groups responded and agreed to publicise the research. One group declined, due to no women fitting the criteria in their group (that is, babies aged 6 months or younger). The National Childbirth Trust (the United Kingdom's largest charity for parents) was also approached, but declined to participate.

The advert asked for women with babies between the ages of 4 weeks and 6 months, both with and without postnatal depression. Women with babies under the age of 4 weeks were not included in the research, in order to control for 'baby blues' (a common temporary psychological state right after childbirth). In the screening questions, those women under 18, or with puerperal psychosis, were excluded from taking part in the study. No translation materials were available and therefore women needed to have English as a first language or be fluent in English.

The advert contained an email link, so that women interested in participating could contact the researcher easily. Women who responded to the advert by emailing the researcher, were then asked to provide their postal address, so that an information pack, giving more details about the study, and a consent form could be sent to them. They were then asked to give written informed consent after reading the information pack, which also contained additional sources of help and support with regard to postnatal depression.

Although the information pack contained a section summarising the aims of the study, advising that it would look at "general attitudes and beliefs and how they may impress or reflect their mood", CBT theory and REBT theory in particular were not explained, nor were irrational beliefs mentioned. This does not mean that 'demand characteristics', where participants guessed the purpose of the study and responded to that, could not be ruled out, but it was considered a reasonable balanced statement, that accommodated informed consent, without revealing the researcher's hypothesis.

Those who gave their written consent to take part in the study were asked to complete the package of questionnaires and return them in a stamped addressed envelope. Consent forms were sent back under separate cover in a stamped addressed envelope. The questionnaires did not contain the names of the respondents or their contact information and were coded to ensure confidentiality under the terms and conditions of the research. If the questionnaires were not returned within 3 weeks, a reminder was sent out.

Of the 56 sets of questionnaires sent out to respondents, 52 were returned. The data from one respondent was not included due to a substantial number of missing responses on the Shortened General Attitudes and Belief Scale. A second package of questionnaires was returned without being completed, due to the mother no longer fitting the criteria; her baby being 7 months old.

The data from the 50 completed sets of questionnaires was then analysed, looking at correlations between scores on the measures given below, with regard to postnatal depression, anxiety and irrational beliefs. Additional demographic data given on a general questionnaire was also looked at. Information requested on this form included age of mother, age of baby in months, ethnicity, previous experience of depression and anxiety, previous experience of depression and anxiety in pregnancy, the experience of a subjectively traumatic birth, and a recent bereavement.

2.3. Participants

Participants were 50 women with babies aged from one to six months. The mean age of 48 women was 31.69 years (SD=4.80), with a median age of 32. They ranged in age from 23 to 44. Two women did not give their age. Ninety per cent (45) of the participants were recruited via the Netmums website and 10 per cent (5) from PND groups. Ninety-six percent (48) of the sample were White British. Four per cent of the sample (2) was Asian British.

Of the 50 women, 52 per cent (26) had not suffered from depression before. Twenty-six per cent (13) had on one occasion, and 22 per cent (11) had experienced depression on more than one occasion. Forty-six per cent (23) had not suffered from anxiety before. Twenty-four per cent (12) had suffered from anxiety on one occasion, while 30 per cent (15) had suffered anxiety on more than one occasion. Eight per cent (4) had been depressed during their recent pregnancy and 2 per cent (1) had been depressed in more than one pregnancy. These were subjective responses and no information was requested regarding diagnosis, medication or severity of the depression or anxiety previously experienced.

Thirty-six per cent (18) had a subjectively traumatic birth, and 12 per cent (6) had suffered bereavement in the past year. These two questions were asked to differentiate postnatal depression from bereavement or post-traumatic stress disorder.

Thirty-five women scored less than 12 on the Edinburgh Postnatal Depression Scale (EPDS). Thirty-four women scored less than 17 on the Beck's Depression Inventory (BDI-II). These women were considered to be below the threshold set by the researcher for possible postnatal depression, and formed the control groups with regard to both measures.

The threshold for EPDS was set at 12 or above. Although possible depression is indicated at 10 or above, a higher threshold was set in this study, replicating the cut-off score on the EPDS in the original study by Milgrom and Beatrice (2003). Matthey, Henshaw, Elliott and Barnett (2006), reviewing cut-off scores for the EPDS, recommended the conservative score of 13 or more for probable major depression and 10 or more for at least probable minor depression. However, in this study, although mothers scored 11 or 13 (either side of the study cut-off score for probable major depression), no scores of 12 were recorded. Therefore a change in the threshold to the higher figure of 13 would not affect the outcome of the study.

The BDI-II score for depression was set at 17 or above, as this, according to the Beck Depression Inventory Manual (pg 11) "yielded a 93 per cent true-positive rate and an 18 per cent false-positive rate for the presence of major depression in the University of Pennsylvania clinical sample (n=127)". The cut-off score of 17 or above was recommended for use in research studies by the authors.

2.4. Materials

The Edinburgh Postnatal Depression Scale

10-item self report questionnaire for postnatal depression Each item consists of a statement, with four possible responses regarding levels of agreement with the statement. The 'normal' response scores 0 and the 'severe' response scores 3. Three items are reverse scored. The maximum score is 30. The cut-off score recommended by the authors

(Cox and Holden, 2003) is 12 or 13 for research purposes. The Edinburgh Postnatal Depression Scale, unlike the Beck's Depression Inventory, avoids somatic symptoms of depression, referring only to sleep difficulties on one item. According to Cox and Holden (2003), the split-half reliability of the Edinburgh Postnatal Depression Scale was 0.88 and the Cronbach's alpha 0.87. (Cronbach's alpha for the Edinburgh Postnatal Depression Scale for this current study was 0.91).

The Beck Depression Inventory-II

21-item self report questionnaire for depression The questionnaire consists of 21 headed items covering aspects of depression (for example: pessimism). Within each item, there are 4 statements (scored 0-3), with a total possible score of 63. The manual suggests cut score guidelines of 0-13 for minimal depression, 14-19 for mild depression, 20-28 for moderate depression, and scores of 29-63 as severe depression.

The BDI-II extends the BDI-1A's symptom reporting time from the previous one week to the previous two weeks, which brings it in line with American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders – 4th Edition* (DSM-IV; 1994) criteria. In addition to this, in order to bring the BDI-1A in line with the assessment of symptoms for depression outlined in the DSM-IV , the authors of the BDI-II dropped four items (Weight Loss, Body Image Change, Somatic Preoccupation and Work Difficulty) and replaced them with four new items (Agitation, Worthlessness, Concentration Difficulty and Loss of Energy). The authors, Beck, Steer and Brown (1996) in the BDI-II manual (p13), claimed Cronbach alphas higher than those for the BDI-1A, when the measure was tested on both Pennsylvania/New Jersey hospital outpatient samples and college students, at .92 and .93, respectively. (Cronbach's alpha for the Beck's Depression Inventory II for this study was 0.94.)

The Beck Anxiety Inventory-II

21-item self report questionnaire, which measures symptoms for anxiety, for use alongside the BDI Each symptom is accompanied by a 4-point Likert scale, with responses ranging from 'not at all' to 'severely'. The range of scores is from 0-3, and the maximum score is 63. A score of 0-7 reflects a minimal level of anxiety; scores of 8-15 mild anxiety, 16-25 moderate anxiety and 26-63 indicate severe anxiety. Beck, Epstein et al (1988, cited in Beck & Steer, 1993) found that the BAI had high internal consistency reliability, with Cronbach coefficient alpha of .92 in use with 160 outpatients of mixed diagnosis. Reliability varies at between .92 and .94, according to Beck and Steer (1993). (Cronbach's alpha for the Beck's Anxiety Inventory for this study was 0.90).

The Shortened General Attitude and Belief Scale

26-item self report questionnaire, consisting of two subscales, rationality and irrationality, looking at six factors: need for achievement, need for approval, need for comfort, demands for fairness, self-downing and other downing The maximum score is 110 for irrationality (22 items), and 20 for rationality (4 items). Each subscale consists of statements and a Likert scale ranging from 1 (strongly disagree) to 5 (strongly agree).

The Rationality Subscale has 4 statements (e.g. 'I have worth as a person even if I do not perform well at tasks that are important to me'). The Self-downing Subscale has 4 statements (e.g. 'If important people dislike me, it is because I am an unlikeable, bad person'). The Need for Achievement Subscale has 4 statements (e.g. 'It's unbearable to fail at important things, and I can't stand not succeeding at them'). The Need for Approval Subscale has 3 statements (e.g. 'It's awful to be disliked by people who are important to me and it is a catastrophe if they don't like me'). The Need for Comfort Subscale has 4 statements (e.g. 'It's unbearable being uncomfortable, tense or nervous and I can't stand it when I am'). The Demand for Fairness Subscale has 4 statements (e.g. 'I can't stand a lack of consideration from other people, and I can't bear the possibility of their unfairness'). The Other-downing Subscale has 3 statements (e.g. 'When I am treated inconsiderately, I think it shows what kind of bad and hopeless people there are in the world'). *(See Appendix 1 for the full version of the SGABS).*

This is the shortened version of the 55-item General Attitude and Belief Scale. Lindner et al's (1999) study found a test-retest correlation for total irrationality of r =.91 and a Cronbach's alpha of .65–.87. Lindner et al (1999) found a moderate but significant correlation of r =.41 between the SGABS and the Beck's Depression Inventory, but a higher correlation of r=.77 between SGABS and the Irrational Belief Scale.

MacInnes (2003) found the measure to have good internal reliability, with Cronbach's alpha for each subscale varying between 0.62 and 0.87, in line with Lindner's (1999) research. (Cronbach's alpha for the Shortened General Attitude and Belief Scale for this study was 0.89.) The Shortened General Attitude Belief Scale, made no mention of Irrational Beliefs in its title, which was also considered by the researcher to be useful, as it was less likely to reveal the researcher's hypothesis to the participants.

The Edinburgh Postnatal Depression Scale and other measures, are not diagnostic tools in themselves without a supplementary interview, and therefore provide an indication of a tendency to be depressed or anxious, rather than an absolute diagnosis, and this is taken into account in the analysis.

2.5. Statistics

In a preliminary examination of the data prior to commencing detailed analysis, it was discovered that in many cases the data was not of normal distribution and therefore did not conform to the criteria for parametric tests, and therefore a number of non-parametric tests were conducted: Spearman's Correlation and the Mann Whitney U test. Multiple regression was also carried out with regard to examining the subscales of the SGABS. Data was analysed using PASW (SPSS) 17 for Windows XP.

3. Results

The participants' questionnaires were reviewed for missing data, and then total scores on each measure and subscale were calculated for the completed questionnaires.

3.1. The relationship between irrational beliefs and postnatal depression

The data was taken as a whole (without splitting the women into groups) to examine the correlation between the scores on all the measures. First, it was predicted that there would be a relationship between irrational beliefs and postnatal depression (hypothesis one). Secondly, if women with postnatal depression held more irrational beliefs than women without postnatal depression (hypothesis two), there would be a positive correlation between irrational belief s and postnatal depression.

As the data did not conform to the criteria for a parametric test, Spearman's correlation, a non-parametric measure of correlation, was conducted on the variables: scores on the Shortened General Attitude and Belief Scale (the measure of irrational beliefs), Edinburgh Postnatal Depression, Beck's Depression Inventory and Beck's Anxiety Inventory (*see Table 1*). It was predicted that the differences between ranks would be small if there were a high correlation between them, and that women scoring high on the depression and/or anxiety scales, would similarly score high on the irrational beliefs scale.

Table 1: Spearman's Correlations: Irrational Beliefs (Shortened General Attitude and Belief Scale), Edinburgh Postnatal Depression Scale, Beck's Depression Inventory and Beck's Anxiety Inventory

		EPDS	SGABS	BAI
EPDS	Correlation Coefficient	.58**		
	Sig. (2-tailed)	.00		
BAI	Correlation Coefficient	.48**	.80**	
	Sig. (2-tailed)	.00	.00	
BDI	Correlation Coefficient	.62**	.81**	.75**
	Sig. (2-tailed)	.00	.00	.00

***Correlation is significant at the 0.01 level (2-tailed). N=50*
EPDS=Edinburgh Postnatal Depression Scale; BAI=Beck's Anxiety Inventory;
BDI=Beck's Depression Inventory II; SGABS=Shortened General Attitude and Belief Scale

The Spearman Correlation (*Table 1*) on the scores on the Shortened General Attitude and Belief Scale (irrationality), and the Edinburgh Postnatal Depression scale, Beck's Depression Inventory and the Beck's Anxiety Inventory showed a significant relationship between the (ranking of the) scores, $p < .01$.* Again, women who scored higher on the irrational beliefs scale tended to score higher on the depression and anxiety measures, with significance at the 1 per cent level.

** Pearson's Correlation also found a positive correlation between irrational beliefs and depression (EPDS and BDI scores) at the p <.01 level (2-tailed test)*

3.2. Comparisons between women with and without postnatal depression

In order to evaluate further the hypothesis that 'women with postnatal depression hold more irrational beliefs than women without postnatal depression', the women were split into two groups: depressed and non-depressed, according to their scores on the Edinburgh Postnatal Depression Scale and the Beck's Depression Inventory.

The mean scores on the Shortened General Attitude and Belief Scale (the measure of irrationality) were then calculated for the two groups classified as depressed and not depressed, according to the Edinburgh Postnatal Depression Scale (*see Table 2*).

A Mann-Whitney U test was then performed to test for significance (*see Table 3*).

Table 2: Mean scores on the Shortened General Attitude and Belief Scale for women with and without postnatal depression (Edinburgh Postnatal Depression Scale)

EPDS	Mean	Std. Deviation	N
Not depressed EPDS*	59.34	12.62	35
Depressed EPDS	77.07	14.19	15
Total	64.66	15.34	50

**EPDS=Edinburgh Postnatal Depression Scale*

Table 3: Mann-Whitney Test regarding significance of difference in mean scores on Shortened General Attitude and Belief Scale for Depressed and Non Depressed women (on EPDS)

Ranks				
	EPDS	N	Mean Rank	Sum of Ranks
Total irrationality SGABS	Not depressed EPDS	35	20.46	716.00
	Depressed EPDS	15	37.27	559.00
	Total	50		

EPDS=Edinburgh Postnatal Depression Scale;
SGABS=Shortened General Attitude and Belief Scale

The mean score on the Shortened General Attitude and Belief Scale for the women with postnatal depression (Edinburgh Postnatal Depression Scale) (M= 77.07; SD=14.19) was higher than the mean score for the women without postnatal depression (M=59.34: SD=12.62). The Mann Whitney U test showed this difference to be significant: U=86.0; exact p <.01 (two-tailed)*. This indicates that women with postnatal depression tend to have higher average scores for irrational beliefs.

**Also ran t test and t was significant at the p < .01 level.*

Then average scores on the Shortened General Attitude and Belief Scale were looked at with regard to women depressed and not depressed, according to the Beck's Depression Inventory (*see Table 4*). Again, the Mann-Whitney U test was performed to test for significance (*see Table 5*).

Table 4: Mean scores on the Shortened General Attitude and Belief Scale for women with and without postnatal depression (Beck's Depression Inventory-II)

BDI	Mean	Std. Deviation	N
Not depressed BDI	58.26	12.70	34
Depressed BDI	78.25	11.16	16
Total	64.66	15.34	50

BDI=Beck's Depression Inventory II

Table 5: Mann-Whitney Test regarding significance of difference in mean scores on Shortened General Attitude and Belief Scale for depressed and non depressed women (on BDI)

Ranks				
	BDI	N	Mean Rank	Sum of Ranks
Total irrationality SGABS	Not depressed EPDS	35	20.46	716.00
	Not depressed BDI	34	19.49	662.50
	Depressed BDI	16	38.28	612.50
	Total	50		

BDI=Beck's Depression Inventory-II; SGABS=Shortened General Attitude and Belief Scale

The mean score on the Shortened General Attitude and Belief Scale for the women with postnatal depression (Beck's Depression Inventory-II) was greater (M=78.25; SD=11.16) than the mean score for the women without postnatal depression (M=58.26; SD=12.70). A Mann Whitney U test showed this difference to be significant: U=67.50; exact $p < .01$ (two-tailed)*. This again indicates that women with postnatal depression tend to have higher average scores for irrational beliefs.

As postnatal depression is often co-morbid with anxiety, it was considered of interest to examine the mean scores for irrationality, as assessed by the Shortened General Attitude and Belief Scale, for women with and without anxiety, as measured by the

Beck's Anxiety Inventory (*see Table 6*). A Mann-Whitney U test was then performed to test for significance (*see Table 7*).

**Also ran t test and t was significant at the p < .01 level.*

Table 6: Mean scores on the Shortened General Attitude and Belief Scale for women with and without anxiety (Beck's Anxiety Inventory)

BAI	Mean	N	Std. Deviation
Not anxious BAI	60.72	36	14.93
Anxious BAI	74.79	14	11.58
Total	64.66	50	15.34

BAI=Beck's Anxiety Inventory

Table 7: Mann-Whitney Test regarding significance of difference in mean scores on Shortened General Attitude and Belief Scale for anxious and not anxious women (on Beck's Anxiety Inventory)

Ranks				
	BAI	N	Mean Rank	Sum of Ranks
Total irrationality SGABS	Not anxious BAI	36	21.69	781.00
	Anxious BAI	14	35.29	494.00
	Total	50		

BAI=Beck's Anxiety Inventory
SGABS=Shortened General Attitude and Belief Scale

The mean Shortened General Attitude and Belief Score for women suffering from anxiety as assessed by the Beck's Anxiety Inventory was higher (M=74.79, SD=11.58) than the mean score for women who were not suffering from anxiety (M=60.72, SD=14.93). A Mann Whitney U test showed this difference to be significant: U=115.00; exact $p < .05$ (two-tailed)*. This indicates that women with postnatal anxiety tend to have higher average scores for irrational beliefs.

Mann Whitney U tests showed that on all three measures (EPDS, BDI-II and the BAI) women with depression or anxiety tended to score higher on the SGABS (the irrational belief scale).

3.3. Predicting postnatal depression from the Shortened General Attitude and Belief Scale and its relevant subscales

The third research question of interest was which subscales of the Shortened General Attitude and Belief Scale (representing different types of irrational beliefs) would predict postnatal depression?

**Also ran t test and t was significant at p<.01 level*

Firstly, Spearman's correlation was performed with regard to each subscale of the Shortened General Attitude and Belief Scale and postnatal depression and anxiety (as assessed by the Edinburgh Postnatal Depression Scale and the Beck's Depression Inventory) (*see Table 8*).

Table 8: Spearman's Correlation with regard to each subscale of the Shortened General Attitude and Belief Scale, and the Edinburgh Postnatal Depression Scale, the Beck's Depression Inventory II and the Beck's Anxiety Inventory

		BAI	BDI	EPDS
Self-downing scale	Correlation Coefficient	.44**	.60**	.52**
	Sig. (2-tailed)	.00	.00	.00
Need for achievement	Correlation Coefficient	.41**	.52**	.45**
	Sig. (2-tailed)	.00	.00	.00
Need for approval	Correlation Coefficient	.48**	.67**	.52**
	Sig. (2-tailed)	.00	.00	.00
Need for comfort	Correlation Coefficient	.46**	.61**	.62**
	Sig. (2-tailed)	.00	.00	.00
Demand for fairness	Correlation Coefficient	.25	.26	.31*
	Sig. (2-tailed)	.08	.07	.03
Other downing	Correlation Coefficient	.21	.27	.28*
	Sig. (2-tailed)	.14	.06	.05

** significant at p <.05 level. ** significant at p <.01 level.*
BAI=Beck's Anxiety Inventory
BDI=Beck's Depression Inventory II
EPDS=Edinburgh Postnatal Depression Scale

A significant correlation at the 1 per cent level was seen between self downing, need for approval, need for achievement and need for comfort with postnatal depression and anxiety as measured by all three measures. A significant correlation at the 5 per cent level was seen between demand for fairness and other downing with regard to just the EPDS.

In checking the full correlation matrix (not shown) no correlation coefficient between the subscales on the SGABS was higher than .74 (between self-downing and need for approval). No tolerance values in the coefficients table for multiple regression were below .2. No heteroscedasticity was observed in the scattergram. Therefore, it was considered appropriate to perform a multiple regression analysis.

In order to look at the predictive values of each of the subscales of the Shortened General Attitude and Belief Scale, a standard multiple regression (*see Table 9*) was performed between the Edinburgh Postnatal Depression Scale as the dependent variable and the six irrational subscales as independent variables.

Table 9: Multiple regression analysis regarding the subscales of the Shortened General Attitude and Belief Scale and their correlation with the Edinburgh Postnatal Depression Scale

Model	Unstandardised Coefficients		Standardised Coefficients	t
	B	Std. Error	Beta	
(Constant)	-3.76	3.74		-1.01
Self-downing scale	.66	.21	.45	3.17**
Need for achievement	.04	.25	.03	.16
Need for approval	.10	.05	.23	2.10*
Need for comfort	.71	.30	.37	2.38*
Demand for fairness	-.31	.35	-.14	-.91
Other downing	.07	.33	.03	.21

*** significant at p<.01. * significant at p<.05.*

Three independent variables contributed significantly to prediction of EPDS score: self-downing (sig.=0.00, p <.01), need for comfort (sig.=0.02, p <.05) and need for approval (sig.=0.04, p<.05.).

The model summary (not shown) gives R as .74, R squared as .54 and adjusted R squared as 0.48. R was significantly different from zero, F=8.51, p < .01.

R squared at .54, indicates that 54 per cent of the variance in Edinburgh Postnatal Depression Scale Scores can be explained by variation in Shortened General Attitude and Belief Scale scores. The multiple regression analysis was then repeated with the Beck's Depression Inventory II as the dependent variable and the following sub-scales on the Shortened General Attitude and Belief Scale. Similarly, the six irrational subscales were also entered as independent variables, to predict postnatal depression (*see Table 10*).

Table 10: Multiple regression analysis regarding the subscales of the Shortened General Attitude and Belief Scale and their correlation with the Beck's Depression Inventory.

Model	Unstandardised Coefficients		Standardised Coefficients	t
	B	Std. Error	Beta	
(Constant)	-.28	5.89		-.05
Self-downing scale	1.61	.33	.63	4.91**
Need for achievement	.38	.39	.13	.98
Need for approval	.05	.08	.06	.60
Need for comfort	.90	.47	.27	1.92
Demand for fairness	-1.18	.54	-.30	-2.18*
Other downing	.16	.52	.04	.31

*** significant at p< .01; * significant at p < .05*

Two independent variables contributed significantly to prediction of BDI score: self-downing (sig.=0.00, p<.01) and demand for fairness (sig.=0.04, p<.05). (Need for comfort contributed, at just outside the 0.05 level, at sig.=0.06.)

The model summary (not shown) gives R as .80, R squared as .64 and adjusted R squared as 0.58. R was significantly different from zero, F=12.46, p <.01. R squared at 0.64 indicates that 64 per cent of the variance in Beck's Depression Inventory scores can be explained by variation in Shortened General Attitude and Belief Scale scores.

A further standard multiple regression was performed between the Beck's Anxiety Inventory as the dependent variable and the sub-scales on the Shortened General Attitude and Belief Scale as independent variables to predict postnatal anxiety (*see Table 11*).

Table 11: Multiple regression analysis regarding the subscales of the Shortened General Attitude and Belief Scale and their correlation with the Beck's Anxiety Inventory.

Model	Unstandardised Coefficients		Standardised Coefficients	t
	B	Std. Error	Beta	
(Constant)	-3.18	6.22		-.51
Self-downing scale	61	.35	.31	1.75
Need for achievement	27	.41	.12	.65
Need for approval	.07	.08	.11	.81
Need for comfort	.65	.50	.25	1.30
Demand for fairness	-.41	.57	-.14	-.72
Other downing	.14	.55	.04	.26

No single independent variable contributed significantly to prediction of BAI score, although self-downing contributed at the 0.08 level of significance, just outside the 5 per cent level of significance.

The model summary (not shown) gives R as .55, R squared as .30 and adjusted R squared as .20. R was significantly different from zero, F=3.09, $p \leq .013$. R squared at .30, indicates that 30 per cent of the variance in Beck's Anxiety Inventory scores can be explained by variation in Shortened Attitude and Belief Scale scores.

4. Discussion

The findings from this study do indicate that women with postnatal depression tend to have higher rates of irrational beliefs, generally scoring higher than their non-depressed counterparts. This research is the first on a UK population of mothers with postnatal depression, using the Shortened General Attitude and Belief Scale to assess irrational beliefs.

The findings from this study also indicate a correlation between irrational beliefs, as measured by the Shortened General Attitude and Belief Scale, and postnatal depression as

measured by the Edinburgh Postnatal Depression Scale, and Beck's Depression Inventory II, and give support to the researcher's hypothesis. Those with high scores on the SGABS will score high on the EPDS, BDI and BAI. Conversely, those with low scores on the SGABS will score low on the EPDS, BDI and BAI. However, although a relationship was discovered, the direction of the relationship could not be determined.

These findings support the earlier study (Milgrom and Beatrice 2003), which identified the existence of irrational beliefs, as measured by the full version of the General Attitude and Belief Scale, in women with diagnosed postnatal depression in an Australian population.

The current research also identified that high scores on the following subscales of the Shortened General Attitude and Belief Scale: self-downing, need for comfort and need for approval tended to predict high scores on the Edinburgh Postnatal Depression Scale. Similarly, high scores on the self-downing and demand for fairness subscales predicted high scores on the Beck's Depression Inventory II. (Need for comfort contributed but just outside the level of significance required to give confidence in this result.)

Women who scored highly on the Beck's Anxiety Inventory, tended to score highly on the following subscale of the Shortened General Attitude and Belief Scale: need for comfort. However this result was again just outside the level of significance required.

Milgrom and Beatrice also discovered higher rates of self-downing, need for achievement, need for approval, demanding of fairness and need for comfort in women with postnatal depression. Both studies therefore recognise that self-downing tends to be associated with postnatal depression, as measured by the Beck's Depression Inventory and the Edinburgh Postnatal Depression Scale in the current research and as measured by the Hamilton Depression Rating Scale in Milgrom and Beatrice. This is also in line with Rational Emotive Behaviour Therapy research (Ciarrochi 2004) that correlates depression with the self-downing subscale of irrational belief measures.

The current research and Milgrom and Beatrice (2003) both recognise the importance of scores on the following subscales: self-downing, need for approval, need for fairness and need for comfort. However, there was some variation with regard to the two depression measures in the current research. Other downing was not seen as a significant factor in the Milgrom and Beatrice study or the current study. The Milgrom and Beatrice study however did identify need for achievement as a factor and this did not feature in the current study to any degree of significance.

By way of explanation, there are some differences to be noted between the Milgrom and Beatrice study (2003) and the current research. The Milgrom and Beatrice study compared mean scores on the subscales of the General Attitude and Belief Scale for depressed women and the control group, rather than using multiple regression analysis and correlation to look at the relationship between depression measures and the subscales of the Shortened General Attitude and Belief Scale. The women in the Milgrom and Beatrice study were inpatients in psychiatric units in Melbourne, Australia, whereas although many of the women in this study were self-reporting postnatal depression, they were not psychiatric inpatients and were from a UK population. Also, in the current research, postnatal depression was measured using the Edinburgh Postnatal Depression Scale, Beck's Depression Inventory II (BDI-II) and the Beck's Anxiety Inventory, whereas the Milgrom and Beatrice study used the Hamilton Depression

Rating Scale (HDRS) at 3 months postnatally, and the HDRS and BDI at 24 months postnatally. In the current study, women only completed the measures at one point in time, at between 1 to 6 months after the birth of their child.

4.1. Limitations/and suggestions for future research

There are inherent limitations in the correlational design of the research. Correlational design highlights a possible relationship between the scores on the measures. However, it does not show the direction of the relationship or definitively that one causes the other; i.e. that irrational beliefs lead to postnatal depression or that holding irrational beliefs is a symptom of postnatal depression. It also does not exclude the possibility that some other third variable or combination of variables is responsible for the high scores on both measures. As it was a correlational design, rather than experimental or outcome research, it was not possible to experiment with changing one variable and observe the outcome on the other.

However, further research using experimental designs would be useful in building a body of research using multiple methods. In order to manipulate one variable, experiments could be designed where mothers either rated their beliefs on the SGABS or were primed with irrational or rational beliefs and were then exposed to a trigger situation (for example, a written scenario or recording of their own or another baby crying) and asked to rate their response. However, as referred to earlier, any experimental work with this vulnerable group would need to be designed carefully taking ethical issues into account.

Further research that could be more acceptable would be to conduct outcome studies using specially designed REBT protocols and materials for guided self-help and group or individual therapy with this client group (women with postnatal depression). Any useful outcome research would need a comparable CBT intervention. However, a control group of no treatment or waiting list control group of over 3 months for women with postnatal depression would be difficult to achieve, and not ethical as NICE guidelines recommend that this group receive talking therapy at the earliest possible opportunity (within 3 months). Also, differentiating the CBT treatment from the REBT treatment and determining the efficacious component may be difficult for researchers, as CBT group protocols for postnatal depression such as Milgrom et al's (1999) emphasize and challenge 'unrealistic expectations', and may also work on demanding beliefs.

An additional difficulty with this correlational design, using a scale to measure irrational beliefs, is the difficulty of understanding the participants' beliefs in this type of hypothetical deductive research. REBT therapists working to understand their clients' beliefs, work with the individual's emotional and behavioural response, as well as known situational and specific triggers to elucidate the individual client's beliefs. Whether or not a belief expressed linguistically as a 'must' is a true demanding belief or a strong preference is deduced from the consequences described by the client and with socratic questioning. Scales such as the SGABS attempt to reproduce this process by using language that typically describes irrational beliefs, and by asking clients to rate their agreement or disagreement on a Likert scale. The emotional consequences are assumed to be the ratings on the measures of distress. In this correlational design, the general

situational trigger is assumed to be the birth of the child, but as well as being able to only approximate beliefs, we cannot be certain of the trigger. Further qualitative research with mothers of young babies, would be able to assess irrational beliefs more accurately. However, the assessment of irrational beliefs in REBT does require some teaching by the interviewer or researcher, which may lead to contamination of the results.

Although the SGABS may not perfectly measure irrational beliefs, there is some evidence of its validity in measuring this construct. MacInnes (2003) looked at the correlation between the subscales, and further examined the criterion and construct validity and internal consistency of the SGABS. To see if the SGABS measured the criteria of irrational beliefs, MacInnes compared the SGABS to another measure of irrational beliefs, Malouff and Shutte's Irrational Belief Scale (1986, as cited in MacInnes, 2003). He also correlated the scores on both these measures with scores on the Hospital Anxiety and Depression Scale (Sigmond and Snaith 1983, as cited in MacInnes, 2003), the General Health Questionnaire 28 –GHQ (Goldberg, 1972, as cited in MacInnes, 2003)), and the Beck Depression Inventory. In conclusion, he found that the SGABS showed good criterion validity and construct validity. Concurrent validity was seen in the measure distinguishing between those with high or low psychological distress. Also convergent validity was seen in that the SGABS was significantly correlated with the IBS. Discriminant validity was seen in that the SGABS and IBS were more strongly correlated than with any measure of psychological distress. Also the subscales of the SGABS showed good internal consistency. It may further enhance future research if a second measure of irrational beliefs is used alongside the SGABS, to further demonstrate discriminant validity.

Further research may also help to deal with the more fundamental difficulty of demonstrating the REBT claim that demanding beliefs are central to dysfunctional emotions, such as depression and anxiety. The interactive nature between emotions, behaviour and cognitions has been brought forward as an objection to the attempt to distinguish beliefs and emotions, and to assume that cognitions and beliefs determine emotions, rather than that they are an intrinsic part of emotions (as is behaviour). Ellis's ABC paradigm is fundamentally a 'mediational' model, inferring that beliefs explain the relationship between the event and the consequences. Bond and Dryden (1996) purported that this central REBT hypotheses is not capable of being tested in any meaningful way because of the interdependence of cognition, emotion and behaviour, meaning they cannot be isolated. Ellis (1996) (p107) responded to this critique by agreeing with the difficulty observed in achieving this through 'common paper and pencil tests of irrational beliefs' and also acknowledged that irrational beliefs could be a symptom of psychological disturbance rather than a cause. However, he purports that if we could show that people with irrational beliefs become less disturbed after changing them to preferences, although it would not be proof, this would still be valuable and worth investigating. Therefore, this suggests that further research in the clinical field, which includes outcome studies, using both quantitative and qualitative assessment of irrational beliefs in women (both antenatally and postnatally) would be useful, even while acknowledging the difficulty of the empirical study of the complexities of REBT, and indeed other psychological theories (including CBT).

Another question of interest is that could the research have been affected by demand

characteristics? The mothers may have become aware of what was expected from them in the research and responded in line with this. Certainly, the mothers were given an information sheet which stated that the researcher was examining beliefs and their relationship with postnatal depression. However, one of the benefits of the scale chosen by the researcher, the SGABS, was that its title did not refer directly to 'irrational beliefs'. None of the information given to the mothers referred to or explained CBT or REBT theory. However, we cannot know conclusively what role demand characteristics may or may not have played.

There are some limitations in generalising these findings to the broader population of new mothers. Firstly, the sample is almost exclusively (98%) white. Secondly, the number of women in each group is relatively small. Thirdly, the majority of mothers participating in the research were recruited via Netmums, and this group of mothers may differ from the general population of new mothers.

The sample did not include mothers with babies over 6 months old, which excluded some members of postnatal depression groups. A larger sample of depressed women may have been achieved with a widening of the inclusion criteria to mothers with babies up to a year in age or by contracting for a longer period of advertising for the research with Netmums, as the rate of response to the advert remained steady at approximately 1-2 enquiries per day.

The Beck's Depression Inventory II was used in conjunction with the Edinburgh Postnatal Depression Scale to help differentiate depressed women. However, although widely used to assess depression, Coyne et al (2000, cited in Boyd, Le and Somberg, 2005) criticised its use with postpartum women. They stated that its inclusion of physical symptoms, such as loss of energy, changes in sleeping pattern, tiredness and loss of interest in sex, could lead to false positive diagnosis of depression in new mothers. As a measure of emotional state, the Edinburgh Postnatal Depression Scale is also confounded by its measure of cognitive symptoms of postnatal depression as well as emotional items. Further studies may be needed to differentiate The Shortened General Attitude and Belief Scale from the Edinburgh Postnatal Depression Scale. However in the current research the Edinburgh Postnatal Depression Scale was found to be more strongly correlated with the Beck's Depression Inventory and the Beck's Anxiety Inventory than the Shortened General Attitude and Belief Scale.

How do we explain the two women in the current research who held a high level of irrational beliefs, but who did not appear to have postnatal depression? Social desirability may have impacted upon the respondents' willingness to report some postnatal depression symptoms. Postnatal depression is generally underreported. It is difficult to produce substantive research evidence for this being the case, due to the nature of the problem.

In a qualitative study, Woodhouse, Brown, Krastev, Perien and Gunn (2009) investigated women's opinions about seeking help for postnatal emotional problems in structured telephone interviews with 1,385 women at 9 months postpartum. In their study 14.7 per cent of these women reported emotional problems: anxiety, depression or both. Forty-one per cent of those women who reported emotional problems said they had not spoken to a health professional. The three most commonly reported reasons for not seeking help were that they felt they could deal with it on their own, that they were too busy or too embarrassed. Chew-Graham, Sharp, Chamberlain, Folkes and Turner (2009) conducted in-depth interviews with 28 women who expressed a number of reservations about

disclosing postnatal depression, including a perception that the GP would be unsympathetic and not willing to listen, and a fear that the health visitor may think of them as a 'bad mum'. This may explain why a few respondents with high scores on the General Attitude and Belief Scale did not score highly on any of the three measures: Beck's Depression Inventory, Beck's Anxiety Inventory or Edinburgh Postnatal Depression Survey. Although there is little quantitative research evidence for reluctance to self-disclose, a Netmums online survey in 2005 found that two-thirds of the 1,250 mothers surveyed had completed the screening test for postnatal depression. Of the women who stated that they felt unwell (percentage not given), 44 per cent stated that they lied to cover up their illness (feeling either unable or unwilling to acknowledge their difficulties).

Also, according to Rational-Emotive Behaviour Theory, irrational beliefs do not lead automatically to depression in the absence of a trigger. Those women with irrational beliefs, without depression or anxiety may have been in positive situations: with settled babies and/or good support systems.

In the current research only one woman was found with postnatal depression that did not appear to hold a high level of irrational beliefs (compared to the other women with postnatal depression). Further research is needed to examine cases where depression and irrational beliefs do not appear to coincide.

Could the variation in postnatal depression be attributed to another independent variable? This research did not look at all the variables implicated in postnatal depression, but the general questionnaire did ask about prior depression, depression in pregnancy, prior anxiety, anxiety in pregnancy, traumatic birth and bereavement. Of those 18 women who experienced traumatic births, just under half (8) had postnatal depression. Of those, 6 women who experienced bereavement, two-thirds (4) were depressed.

In the light of these initial studies indicating a strong link between irrational beliefs and postnatal depression, it would be interesting to conduct a more wide-ranging study, looking at the interaction of life events (pre and postnatally) with irrational beliefs, and their relative weighting with regard to predicting postnatal depression. A cohort study following women through pregnancy, again within the 6 months postnatally and with a follow-up in 24 months, would help to clarify the relative values and interaction of all observed correlational factors present in postnatal depression. It could also help to demonstrate whether irrational beliefs mediate between negative events and postnatal depression.

Jones et al (2010) (p203) suggested that any study comparing the cognitive vulnerability of women with postnatal depression with a control group should consider including a second control group of remitted depressives, so that any differences or similarities between vulnerability to depression and postnatal depression could be observed. A study looking at irrational beliefs in remitted depressives, who have suffered from postnatal depression, would help to indicate whether irrational beliefs are a trait in women who have experienced postnatal depression.

Future research could also use the Shortened General Attitude and Belief Scale alongside other measures of cognitive vulnerability being developed for use with postnatal depression, such as the Vulnerability Personality Style Questionnaire. A

correlational study, comparing scores on these two measures with the Edinburgh Postnatal Depression Scale, Beck's Depression Scale II and the Beck's Anxiety Inventory could help to clarify their relative predictive qualities with regard to postnatal depression.

4.2. Conclusion

Despite the impact that postnatal depression has on the mother and child, a unified approach to treatment has remained elusive. A comprehensive review of treatment studies (Boath and Henshaw, 2001) showed that the diverse range of theories about its cause has led to a wide range of drug and psychological treatments. However, the methodological limitations in many studies reviewed by Boath and Henshaw meant that it was hard for them to reach a conclusion as to which were the most effective treatments.

Many intervention programmes in development (Rowe and Fisher 2010) have a broad focus, working on changing the social support systems of women as well as psychological interventions. However with the findings from Milgrom and Beatrice (2003) and the current study indicating the existence of irrational beliefs in women with postnatal depression, this could mean that a more targeted and effective approach may be achieved if women with postnatal depression are offered REBT.

Stevenson et al (2010), in their review of group CBT for postnatal depression, were mainly interested in the clinical effectiveness and cost-effectiveness of group CBT in contrast to routine primary care. Only six studies met their inclusion criteria for quantitative review and two for qualitative review. They found no adequate evidence on which to assess group CBT with other treatments for PND. This suggests that more outcome research is needed in this area to draw any conclusions about the effectiveness of CBT or indeed REBT in this area.

Further studies looking at the particular irrational beliefs that are important in postnatal depression will be of interest in developing a protocol for treating postnatal depression. If women with postnatal depression have more irrational beliefs than women without postnatal depression, as indicated in the research, then an outcome study looking at specific REBT interventions and their effectiveness in working with postnatal depression would be useful. REBT emphasises the mother's collaborative role in her own therapy. It recognises all human beings as fallible, and helps people to deal effectively with their feelings of guilt. REBT's particular emphasis on self-acceptance and flexibility of beliefs could be particularly therapeutic in helping mothers to deal with the challenges of early parenthood and postnatal depression.

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Biography

Denise Christy holds a BACP accredited Diploma in Integrative Counselling and an MSc in RECBT. She is provisionally accredited with the BABCP and AREBT. She has been working within the NHS for 5 years, firstly as a counsellor in a GP surgery, in a service run by Bromley Community Counselling Service for the NHS, and more recently as a CBT Psychotherapist within an IAPT service, run by Mind in Bexley for the NHS. She also has a private practice. She has a particular interest in working with women (and their partners) in the perinatal period, and in finding ways to increase their access to psychotherapy at an early stage.

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APPENDIX 1

Shortened General Attitude and Belief Scale (SGABS)

Lindner, Kirkby, Wertheim, & Birch (1999)
(The GABS was developed through a series of investigations by Burgess, 1986; DiGiuseppe et al., 1988; & Bernard, 1990)

Name: _____

Here are a set of statements which describe what some people think and believe. Read each statement carefully and decide how much you agree or disagree with it.

If you STRONGLY AGREE with the statement circle number 5
If you AGREE 4
If you are NEUTRAL 3
If you DISAGREE 2
If you STRONGLY DISAGREE 1

There are no right or wrong answers. Only you can tell what you really believe so please mark the way you really think. Circle the number which shows your agreement or disagreement with each statement. Please try to answer each question.

Example:	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
People should never break a promise	1	2	3	4	5

The person has shown that he/she agrees with the statement by circling number 4. If the person had strongly agreed with the statement he/she would have circled number 5.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1. It's unbearable to fail at important things, and I can't stand not succeeding at them.	1	2	3	4	5
2. I can't stand a lack of consideration from other people, and I can't bear the possibility of their unfairness.	1	2	3	4	5

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
3. It's unbearable being uncomfortable, tense or nervous and I can't stand it when I am.	1	2	3	4	5
4. I have worth as a person even if I do not perform well at tasks that are important to me.	1	2	3	4	5
5. I can't stand being tense or nervous and I think tension is unbearable.	1	2	3	4	5
6. It's awful to be disliked by people who are important to me, and it is a catastrophe if they don't like me.	1	2	3	4	5
7. If important people dislike me, it is because I am an unlikable bad person.	1	2	3	4	5
8. When I am treated inconsiderately, I think it shows what kind of bad and hopeless people there are in the world.	1	2	3	4	5
9. If I am rejected by someone I like, I can accept myself and still recognize my worth as a human being.	1	2	3	4	5
10. If I do not perform well at tasks that are so important to me, it is because I am a worthless bad person.	1	2	3	4	5
11. It's awful to do poorly at some important things, and I think it is a catastrophe if I do poorly.	1	2	3	4	5
12. I think it is terribly bad when people treat me with disrespect.	1	2	3	4	5

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
13. When people I like reject me or dislike me, it is because I am a bad or worthless person.	1	2	3	4	5
14. I cannot stand being treated unfairly, and I think unfairness is unbearable.	1	2	3	4	5
15. I believe that if a person treats me very unfairly they are bad and worthless.	1	2	3	4	5
16. I can't stand hassles in my life.	1	2	3	4	5
17. It's awful to have hassles in one's life and it is a catastrophe to be hassled.	1	2	3	4	5
18. I cannot tolerate not doing well at important tasks and it is unbearable to fail.	1	2	3	4	5
19. It is important that people treat me fairly most of the time, however I realize I do not have to be treated fairly just because I want to be.	1	2	3	4	5
20. If I do not perform well at things which are important, it will be a catastrophe.	1	2	3	4	5
21. It is unbearable to not have respect from people, and I can't stand their disrespect.	1	2	3	4	5
22. If important people dislike me, it goes to show what a worthless person I am.	1	2	3	4	5

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
23. I must be liked and accepted by people I want to like me, and I will not accept their not liking me.	1	2	3	4	5
24. I want to be liked and accepted by people whom I like, but I realize they don't have to like me just because I want them to.	1	2	3	4	5
25. When people who I want to like me, disapprove of me or reject me, I can't bear their disliking me.	1	2	3	4	5
26. If people treat me without respect, it goes to show how bad they really are.	1	2	3	4	5

PLEASE CHECK THAT ALL QUESTIONS HAVE BEEN ANSWERED

SHORTENED GENERAL ATTITUDE AND BELIEF SCALE SCORING OF THE SGABS

Subscales	**sum of questions**
1. Rationality	4, 9, 19, 24
2. Self-downing	7, 10, 13, 22
3. Need for achievement	1, 11, 18, 20
4. Need for approval	6, 23, 25
5. Need for comfort	3, 5, 17, 16
6. Demand for fairness	2, 12, 14, 21
7. Other downing	8, 15, 26
Total Irrationality	**sum of subscales 2-7**

An REBT conceptualisation of Iraqi refugee exile-related stressors

Najwan Saaed Al-Roubaiy

REBT has been marginalised in the scientific literature for years. Part of the reason for this marginalisation is REBT's perceived lack of multicultural attentiveness and applicability. In this article REBT's potential to be applied as a multicultural and diversity sensitive approach is demonstrated through the author's own experience of applying REBT to counselling Iraqi refugees; specifically for exile-related stressors. REBT's applicability to such a culturally diverse client group, and with such a complex range of exile-related psychosocial problems, is used to emphasise REBT's potential as a multicultural and diversity sensitive approach.

Key Words: *Iraqi, refugees, exile, stressors, multicultural, diversity, REBT*

Introduction

Counselling and psychotherapy have long been criticised for being too Western and Eurocentric (e.g. Bhugra & Bhui, 2006; Moodley, 2007; Moodley & Lubin, 2008) and REBT is no different. REBT cannot afford further marginalisation in the literature (e.g. Ellis, 2003; Khan & Khan, 2001; Malkinson, 2011) due to this perceived lack of multicultural applicability. Weinrach (2006), for example, discusses, amongst other things, the perception that REBT does not adequately address cultural diversity and goes on to argue why REBT can address diversity adequately and even references studies that demonstrate this (e.g. Chen, 1995). However, Weinrach (2006) also acknowledges the obvious scarcity of such studies in the REBT literature. Similarly, Khan & Khan (2001) also explore REBT's marginalisation in the literature as being partly due to its perceived lack of diversity and multicultural attentiveness.

Many therapeutic approaches have come to emphasise the issue of multiculturalism and sensitivity to diversity (e.g. Jun, 2010; Williams, 2005; Wheeler, 2006) and REBT should be doing the same. Attempts at applying REBT to different cultural (e.g. Chen, 1995) and religious (e.g. Ali, 2007) contexts are highly welcome because they have the potential to eventually situate REBT in a more favorable position within the current scientific literature. This article aims to demonstrate REBT's potential applicability as a multicultural, and diversity sensitive, approach through a detailed exploration of the author's own experience of using REBT with Iraqi refugee clients; specifically in addressing a range of exile-related psychosocial problems. In sharing the author's REBT conceptualisation of Iraqi refugee exile-related stressors, and the reasoning and theorising behind it, it is hoped that other REBT theorists, researchers, and practitioners

will be encouraged to further explore REBT's potential applications to similar psychosocial problems and with other culturally diverse client groups.

Personal and professional background

I came to Sweden as a fifteen year old boy with my parents and brother in 1993 as refugees from Iraq. The next six years were very difficult for me. During that time, I was burdened with trying to learn the Swedish language, adapt to the culture, deal with traumatic experiences from Iraq, tackle normal adolescent development, and create a social identity that could fit well with both my Iraqi cultural background and Swedish social atmosphere at the time. During these first six years in Sweden, I came to understand some major differences between Iraqi and Swedish culture, and tried to adapt accordingly. But this process was very problematic and psychologically taxing for me because of several psychosocial problems that I was experiencing in interacting with Swedish society. I later came to understand these psychosocial problems as exile-related stressors.

After becoming a Swedish citizen I moved to England and did a BSc in psychology, an MSc in counselling psychology, and then moved back to Sweden and further trained towards becoming a licensed psychologist; which I did in December 2007. Since then I have worked as a licensed psychologist in a heavily refugee populated district in the city of Malmo. Part of my work for the past four years has been dedicated to counselling Iraqi refugees. During that time I came to observe certain patterns and recurrent themes in my work with this client group. The recurrent themes, in my work with this client group, which are most relevant to the issue of exile-related stressors, will be discussed later in this article under the heading of 'professional observations'. But before I explore my own observations I would like to present an introduction to some of the literature on counselling refugees and addressing exile-related stressors.

Counselling refugees and addressing exile-related stressors

Research in counselling and psychotherapy with refugees generally addresses trauma and cross-cultural issues in detail and provides specific suggestions on how to tackle these difficulties (e.g. Basoglu, 1998; Drozdek & Wilson, 2004; Papadopoulos, 2002, 2004; Regel & Berliner, 2007). On the other hand exile-related stressors such as lack of social support, acculturative stress, and experiences of racial discrimination in the host country are often simply referred to as areas of importance to be addressed without actual suggestions on how these issues might be addressed through actual counselling and psychotherapeutic interventions (e.g. Harris, 2007; Gorst-Unsworth & Goldenberg, 1998; Griffiths, 2001; Miller et al., 2002). Some authors have even gone on to suggest that although exile-related stressors have a major role in refugee distress, they are beyond the scope of psychotherapy (e.g. Miller, 1999).

Refugees in the early stages of exile usually experience a 'honeymoon' period in the host country that often does not last (Griffiths, 2001; Tribe, 1999). Griffiths (2001) suggests that the relationship of refugees to the host community can worsen the pre-

migration trauma of refugees, especially in later stages of exile. In the early stages of exile, the basic human needs (e.g. food and shelter) take precedence over more sophisticated ones (e.g. need for social acceptance and recognition). The need to tell one's story and have one's experience understood by an outsider is also present early on in the early stages of exile (Griffiths, 2001).

However, as time passes and refugees move towards the later stages of exile, disappointments in both the country of origin and the host country mount up and cause much distress and disillusionment (Griffiths, 2001; Harris, 2007). Lack of social support (e.g. Gorst-Unsworth & Goldenberg, 1998), acculturative stress (e.g. Berry et al., 1987), and experiences of societal racial discrimination (e.g. Alleyne, 2009) are among some of the major causes of distress for refugees in exile. In Sweden, racist attitudes towards refugees and immigrants have been documented in several studies (e.g. Hällgren, 2005; Kamali, 2009; Pred, 2000), and so have acculturation problems (Hübinette & Lundström, 2011; Kamali, 1997).

Racial discrimination towards immigrants and refugees has also been documented in other European countries including England (e.g. Kamali, 2009) and so have the associated problems in acculturation (e.g. Dhillon & Ubhi, 2003); therefore the reasoning that will be presented leading up to the consequent REBT conceptualisation of Iraqi refugee exile-related stressors, should theoretically be as relevant and applicable to the UK context as it is to the Swedish context. However, before exploring the REBT conceptualisation and how it was arrived at, a brief review will be presented on some of the most relevant literature on each of the three major exile related stressors: lack of social support, societal racial discrimination, and acculturative stress.

Lack of social support

Social support is an important factor in the lives of refugees living in exile. Gorst-Unsworth & Goldenberg (1998), for example, found that affective social support in a sample of Iraqi refugees in Britain was important in determining the severity of both post-traumatic stress disorder (PTSD) and depressive reactions; particularly when combined with a severe level of trauma and torture. They also found social support to be a stronger predictor of depressive morbidity than trauma factors. Social support is also especially important for traumatised individuals as research has shown that lack of social support among trauma-exposed adults predicts continuation of PTSD symptoms (Brewin, Andrews, & Valentine, 2000).

Social support is associated with better immune system functioning and lower levels of stress hormones (Uchino, Cacioppo, & Kiecolt-Glazer, 1996). On the other hand, lack of social support such as the case in being ostracised by another social group, has been shown to impair cognitive functioning in sufferers (Williams, 2001). The role of social support in adaption to acculturation has also been studied. For some, links to one's heritage culture (i.e. with co-nationals) are associated with lower stress (e.g. Ward & Kennedy, 1993); for others, links to members of the society of settlement are more helpful, particularly if relationships match one's own expectations (e.g. Berry & Kostovcik, 1990); but most studies

seem to suggest that socially supportive relationships with both cultures are the most predictive of successful adaption to the host societies (Berry et al., 1987; Kealey, 1989).

Societal racial discrimination

Experiences of discrimination and racism have been associated with high levels of distress and poor self-reported health in two separate studies on Kurdish migrants in Sweden (Taloyan et al., 2006; Taloyan et al., 2008). Similarly, Noh et al. (1999) found high levels of depression and decreased adaption in south Asian refugees in Canada to be associated with experiences of perceived racial discrimination. Alleyne (2009) discusses, among other things, the difficulty in addressing subtle and institutional racism. The nature of racist attacks has also been explored by Sue et al. (2007, p273) who describe such attacks as "racial microaggressions" and define them as "brief, everyday exchanges that send denigrating messages to people of color because they belong to a racial minority group".

Alleyne (2009) discusses some of the major damaging effects of racism on sufferers such as "the grinding down experience", "racism as undermining identity", and "cultural shame". Particularly disturbing is the concept of 'cultural shame' which leads sufferers of racism to be ashamed of their own culture; thereby taking on the racist attitudes of the oppressors. Cultural shame, as conceptualised by Alleyne (2009), can be seen as a sub-type of 'internalised racism'. Internalised racism is the internalisation of the oppressor's racism by the victim (Fanon, 1952). Experiences of racism can be so psychologically distressing for sufferers that several authors have suggested the conceptualisation of racism as a form of trauma (e.g. Carter, 2007; Helms, Nicolas, & Green, 2010; Spanierman & Poteat, 2005).

Acculturative stress

Iraqi refugees living in Sweden or other similar western countries can struggle with adapting psychologically and economically to the host country (e.g. Söndergaard, Ekblad, & Theorell, 2001; Takeda, 2000). 'Acculturation' is the general term used by most researchers to describe the processes associated with adapting to new cultures in host countries (Sam & Berry, 2006). However, the term 'acculturation' is far from straightforward and is often mistakenly used interchangeably with the term 'integration' (Snauwaert, Soenens, & Boen, 2003). Integration is one of four main acculturation strategies (assimilation, integration, separation and marginalisation) and is considered to be the most adaptive (Sam & Berry, 2006). Acculturation theorists generally do not believe the process of acculturation to be generally negative or stressful, rather that different strategies are more adaptive than others.

To deal with the problematic and distressing aspects of acculturation, the concept of 'acculturative stress' was proposed (Berry, 1970). Acculturative stress is the response by people to negative psychosocial events that are rooted in intercultural contact. According to Sam and Berry (2006) acculturative stress reactions include heightened levels of depression (linked to the experience of culture loss) and of anxiety (linked to uncertainty about how one should live in the new society). Recent research on the relationship between exile-related

stressors (e.g. discrimination and acculturative stress), cultural resources (e.g. perceived social support), and psychological distress, indicates a strong positive relationship between socio-cultural adversities (or exile-related stressors) and psychological distress (Ahmed, Kia-Keating, & Tsai, 2011; Jibeen, 2011).

Professional observations

In the four years of counselling this client group, I came to see all three major exile-related stressors in the clients' accounts of refugee life in Sweden. In line with the findings of Griffiths (2001) and Tribe (1999), I came to observe that: 1) refugees in the early stages of exile usually experience a 'honeymoon' period with the host country that often does not last, 2) in the early stages of exile, the basic human needs (e.g. food and shelter) take precedence over more sophisticated ones (e.g. need for social acceptance and recognition), and 3) as time passes and refugees move towards the later stages of exile, the more sophisticated human needs become more pressing and can give much rise to emotional distress when met with neglect and rejection by the host society.

In looking specifically at Iraqi refugee clients in later stages of exile, the three major exile-related stressors, discussed in this article, seemed to be prominent features of their emotional distress. However, it is important to consider the impact of my own Iraqi refugee background on the process of counselling Iraqi refugees, before drawing conclusions from this article.

What I have come to observe in my Iraqi refugee clients, and the subsequent work done on the basis of these observations, may not be as accessible to, or applicable by, other practitioners working with this client group. Therefore it should be emphasised that the counselling work that will be presented and discussed should only serve to demonstrate REBT's potential as a multicultural and diversity sensitive approach.

Limitations in addressing exile-related stressors using general CBT

Having been trained mainly in general CBT, my initial approach to trying to address exile-related stressors with my Iraqi refugee clients, was to try to collaboratively arrive at CBT formulations that could capture my clients' problems using the terminology of general or mainstream CBT (e.g. Westbrook, Kennerly, & Kirk, 2007), so as to set the stage for the CBT interventions to come. However, many of my clients did not benefit from these CBT formulations, nor did they see positive results from the consequent work based on these formulations. There were two major limitations to my general CBT approach with this client group.

The first limitation regarded the complexity of the CBT formulations. Although clients understood and acknowledged their active roles in arriving at these formulations, many of them found the end result, with all the diagrams of vicious circles and feedback loops, to be too complicated to follow. This does not necessarily mean that CBT formulations are generally too complicated for Iraqi refugee clients to follow, but rather that my CBT

formulations for exile-related stressors were too complicated to follow. Clients also expressed feeling that CBT terminology was often confusing, even though I translated and simplified it as much as possible without altering content. This was not surprising to me because I personally felt that many CBT terms did not translate well into Arabic. Additionally, I was extremely limited by the lack of psychoeducational material in Arabic to give to my clients to help familiarise them with the model.

The second limitation regarded the assumption that some of my clients' distressing cognitions were not rooted in reality, but were instead a consequence of dysfunctional thinking. The CBT model proposes that thoughts and beliefs are considered as hypotheses to be investigated, data can be collected to test out these thoughts and beliefs (e.g. through behavioural experiments), and new beliefs can be formulated in light of the new evidence (e.g. through Socratic questioning and cognitive restructuring).

CBT is very effective when working with clients who are interpreting social cues in a dysfunctional and unrealistic manner (Westbrook, Kennerly, & Kirk, 2007). But what about the clients who happen to accurately understand certain negative social cues and, as a consequence of this understanding, are feeling the negative and distressing emotions? How can CBT help such clients adopt healthy and positive beliefs about external stimuli that are clearly unhealthy and negative (e.g. racist attacks)?

For example, biased scanning of social settings by a client continuously looking for racists will cause the client to perceive a room as full of racists when in fact there might be two racists in that room of six people. Such a client is likely to benefit from CBT, because he or she needs to understand that his or her perception of the room being full of racists is not rooted in reality and is instead due largely to biased scanning. But what if the room was really full of racists; how can CBT address that? Similarly, when a client, for example, always expects racist hostility from Swedes and therefore generally behaves aggressively towards them, and in doing so manages to elicit aggressive behaviour even from non-racists, which he or she then interprets as evidence of their general racist hostility. CBT can be valuable in helping such a client understand the self-fulfilling prophesy scenario that he or she is stuck in due to this dysfunctional thinking and maladaptive behaviour. Helping such a client to behave differently, as in being polite, to assess the new responses he or she will get, is very much at the core of CBT reasoning. But what can CBT offer the client if he or she still was met with hostility, even after consciously making an effort at being nice, friendly, and polite?

These two limitations suggested the need for another approach with my clients. I needed an approach that was simpler than mainstream CBT and did not entail complex terminology and diagrams of vicious circles and feedback loops. I needed an approach that would not question clients' understanding and interpretation of negative social situations, but that would instead help them adjust to these situations (as they perceive them) while experiencing as little emotional distress as possible. I needed to make it possible for my clients to have healthy ways of relating to clearly unhealthy phenomena – specifically lack of social support, acculturative stress, and societal racism. Although I was asking for a lot, I did indeed find a great deal of these requirements in Albert Ellis's Rational Emotive Behaviour Therapy (REBT).

The REBT conceptualisation of exile-related stressors

REBT is based on Ellis's ABC model (Dryden & Mytton, 1999). The 'A' stands for Activating events which can either be internal (e.g. thoughts) or external (e.g. social situations). The 'B' stands for the Beliefs that people hold about the activating events. These beliefs can either be rational or irrational. The 'C' stands for the cognitive, emotional, and behavioural Consequences of those beliefs. Simply put, Ellis's theory suggests that psychological disturbance is determined primarily by the irrational beliefs (absolutist thinking and rigid demands that are often expressed as musts) that people may hold about themselves, others, and the world. Ellis believed that by challenging irrational beliefs and replacing them with more rational ones, people could live more productive and fulfilling lives. The counselling process in REBT is incorporated in the ABC model by the further additions of 'D' and 'E'. The 'D' stands for Disputing the irrational beliefs and the 'E' stands for replacing the irrational beliefs with Effective rational ones.

Many of my Iraqi refugee clients appreciated the simplicity of the ABC model. Especially the ones that found my CBT formulations too complicated to follow. Many of my clients also appreciated the fact that, in making sense of their emotional distress, we did not have to identify negative automatic thoughts, dysfunctional assumptions, and core beliefs because all we needed to do was to identify the irrational beliefs held about the activating events in order to explain the consequent emotional distress. Additionally, many of my Iraqi refugee clients expressed confidence and comfort in being engaged in REBT because Arabic has specific and accurate words for describing events, beliefs, and consequences (i.e. the ABC model). On the other hand, explaining what negative automatic thoughts, dysfunctional assumptions, and core beliefs are and how they can interact in a CBT formulation, in Arabic, was not as straightforward.

The ABC model also proved to be applicable and very valuable in helping clients make sense of the exile-related stressors of lack of social support, acculturative stress, and societal racism without emphasising clients' dysfunctional interpretations of the social situations that reflected these negative psychosocial phenomena. As a cognitive behavioural approach, REBT does emphasise realistic thinking but, unlike mainstream CBT, it does not emphasise clients' distorted interpretations of social cues (e.g. biased scanning, catastrophic misinterpretation, etc.).

The reason for this lies partly in the ABC model's philosophy of conceptualising activating events (A) as either internal (psychological) or external (social and environmental) thereby allowing for the acceptance of the external activating event (e.g. perceived racist comment) as valid reality. This conceptualisation of activating events as being either external or internal, captures both the psychological and the social components of exile-related stressors and makes tackling the associated emotional disturbance easier to address.

Another reason for REBT's de-emphasis on distorted client interpretations of social cues is that REBT looks at social cues as merely activating events (A) which have no value over and above providing information about the beliefs (B) held about the activating events. It is the beliefs (B) which are responsible for the emotional and behavioural consequences (C), and REBT interventions are all geared towards working on disputing and changing

the irrational beliefs into rational ones (DE). Therefore, in REBT whether the activating event is perceived by the client in an accurate or distorted manner is of less importance than identifying and working with the beliefs held about the activating event. This theoretical stance in REBT is reflective of a humanistic component to the approach and is very much in line with Rogers's belief in that clients can only be understood from their own personal and individual perspectives (Dryden & Mytton, 1999).

This theoretical stance was also particularly welcomed by my Iraqi refugee clients because it was empowering and emotionally validating to hear that their interpretations of negative social situations (for example, a certain facial expression as conveying a racist attitude) were not going to be questioned and were instead accepted as valid reality. This is very much in line with the philosophy of empowerment-based counselling approaches that emphasise social justice and giving a voice to marginalised and minority groups (e.g. Jun, 2010; Kiselica & Robinson, 2001).

Additionally, breaking down and tackling each of the psychosocial stressors of exile according to the ABC model, proved to be theoretically and practically possible in addition to being linguistically appropriate for my Arabic speaking Iraqi refugee clients.

In the next three paragraphs, I will provide a brief outline of some of the most common and recurring ABC conceptualisations of lack of social support, acculturative stress, and societal racism in the REBT work that I have done with my Iraqi refugee clients.

Common and recurring ABC conceptualisations in the three major exile stressors

In lack of social support, the activating events (A) were mainly social isolation and exclusion. The cognitive consequences (C) were thoughts about being an outcast and not belonging. The emotional consequences (C) were often feelings of depression and shame. The irrational beliefs (B) held about being excluded and not having many friends were mainly: "It is shameful to be socially isolated" and "I must make friends". Disputing (D) those irrational beliefs often led to the new and effective (E) rational beliefs being: "It is slightly unfortunate to be socially isolated" and "I would prefer to make friends".

In acculturative stress, the activating events (A) were mainly social situations in which clients were confronted with conflicts regarding their ethnic and cultural identities. The cognitive consequences (C) were thoughts about not knowing whether to think and behave as an Iraqi or as a Swede. The emotional consequences (C) were often feelings of anxiety, anger, and shame. The irrational beliefs (B) held about these conflicts were mainly: "I must choose between being either an Iraqi or a Swede" and "It is unbearable and disgraceful to feel neither Swedish nor Iraqi". Disputing (D) those irrational beliefs often led to the new and effective (E) rational beliefs being: "I can be both Iraqi and Swedish and I do not have to choose" and "It is slightly frustrating to feel neither Iraqi nor Swedish but quite bearable".

In societal racism, the activating events (A) were often racist attacks and subtle institutional racism. The cognitive consequences (C) were thoughts about being discriminated against and treated as less worthy. The emotional consequences (C) were often feelings of inferiority, cultural shame, and anger. The irrational beliefs held

about the societal racial discrimination were mainly: "I cannot handle being discriminated against, so I must hide my refugee and Iraqi background" and "all Swedes are civilised and all Iraqis are primitive, so I must prove to Swedes that I am as civilised as they are and prove to Iraqis that I am not as primitive as they are". Disputing (D) those irrational beliefs often led to the new and effective (E) rational beliefs being: "I can handle being discriminated against and I do not need to hide my refugee and Iraqi background" and "not all Swedes are civilised and not all Iraqis are primitive, and I do not have to prove being civilised neither to Swedes nor to Iraqis".

Although there were many more ABC conceptualisations of lack of social support, acculturative stress, and societal racism in the REBT work that I have done with my Iraqi refugee clients, these were the most recurring across cases. The REBT techniques that I found to be the most helpful when used with Iraqi refugee clients in the context of addressing exile-related stressors were 'disputing strategies', 'semantic precision', and 'shame-attacking exercises'.

Helpful REBT Techniques

Using disputing strategies, I challenged clients' irrational beliefs by highlighting the faulty reasoning in the absolute demands that they were making about themselves, others, and their environment (e.g. "I must never be discriminated against"). Using semantic precision, I encouraged clients to not use language carelessly and to try to be as precise as possible, especially with self-talk, which can perpetuate irrational beliefs (e.g. using words such as 'horrible' and 'impossible' when they actually meant 'unfortunate' and 'difficult'). Using shame-attacking exercises, I encouraged clients to carry out certain behaviours in public that they considered shameful (e.g. speaking Arabic in a Swedish restaurant) so that they could experience the discomfort and learn that they can tolerate it and accept themselves even when they receive disapproval from others.

In adapting the new rational beliefs, and as a consequence of understanding and implementing the idea that 'A' does not cause 'C' and that 'B' is the target for change in order to elicit the healthy types of 'C', many of my clients reported feeling the healthy alternatives to their original unhealthy emotions; mainly concern instead of anxiety, sadness instead of depression, disappointment instead of shame, and annoyance instead of anger. REBT proved to be effective for many of my Iraqi refugee clients who were emotionally disturbed and distressed as a consequence of the negative impacts of exile-related stressors.

Some multicultural considerations

It is important to note, once again, that this theoretical REBT conceptualisation only functions to demonstrate how REBT can potentially be applied to this dimension (i.e. exile-related stressors) of the Iraqi refugee experience. Iraqi refugees are not a homogenous group and come from a variety of different religious, ethnical, and socio-political backgrounds (e.g. Al-Ali, 2007).

Sue (1998) cautions against allowing stereotypes of certain cultural groups to excessively influence counselling practice with clients from such groups, yet at the same time emphasises the importance of acknowledging cultural identity as shaped by links to cultural groups.

To achieve this theoretical perfect balance between not losing the individual traits of the client and acknowledging and understanding the influences of the client's cultural identity, Sue (1998) proposed the skill of 'dynamic-sizing' which refers to the counselling practitioner's ability to know when to generalise and when to individualise. Similarly, Lopez (1997) emphasised the importance of being able to move between the two cultural perspectives of practitioner and client in order to co-construct a narrative that is accessible and comprehensible to both practitioner and client.

Multicultural approaches to counselling and psychotherapy are not driven simply by political correctness, and are currently very much part of the move towards evidence-based practice. The American Psychological Association (APA, 2003), for example, recommends gathering culturally and socio-politically relevant information about client history that includes residency status (e.g. history of migration), fluency in languages, social status post migration, and level of acculturative stress.

Similarly, the American Psychological Association's report on evidence-based practice in psychology (APA Presidential Task Force on Evidence-Based Practice, 2006, p271) defined evidence-based practice as "the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences"; thus acknowledging the importance of considering counselling clients' socio-political characteristics and cultures in informing evidence-based practice.

Conclusion

Considering how REBT was shown to be culturally appropriate, and theoretically applicable, in addressing Iraqi refugee exile-related stressors; it seems reasonable to recommend further exploration of REBT's potential applicability to similar psychosocial problems and with other diverse client groups. If REBT's true potential, as a multicultural and diversity sensitive approach, continues to be explored through systematic theoretical and clinical research, we might eventually see REBT repositioned within the current literature on counselling and psychotherapy to take a much more favourable place.

Biography

Najwan Saaed Al-Roubaiy is a Swedish licensed psychologist and a chartered member of the BPS. Najwan has a BSc in Psychology from the University of East London, an MSc in Counselling Psychology from the London Metropolitan University, and is currently a PhD candidate at the University of Leicester; where he has been engaged for the past three years in conducting research on exile-related stress among Iraqi refugees and its implications for counselling and psychotherapy.

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Mindfulness, MBCT, & REBT: Disciplinary demarcation and integration potential

Patrick Geever

In this paper, a new model of client metacognitive capabilities is used to compare and contrast REBT and MBCT approaches to therapy. On the basis of this analysis, it is proposed that MBCT complements REBT in a number of areas, and that there are clear therapeutic scenarios where REBT therapists may choose either to integrate methods from MBCT, or to partner with MBCT therapists for client benefit.

Keywords: *Metacognition, Rational-Emotive Behaviour Therapy (REBT), Mindfulness, Mindfulness-based Cognitive Therapy (MBCT)*

Introduction

In this paper we shall attempt to answer a number of questions from a REBT perspective:

- *What exactly is MBCT?*
- *How does it relate to REBT?*
- *Could it be a useful addition to the REBT arsenal of techniques?*
- *How could we practically combine MBCT with REBT interventions?*

In order to answer these questions, the approach adopted in this paper has been to create a simplified reference model of client metacognitive capabilities. Using this new model as a guide then makes it much easier for us to compare and contrast MBCT and REBT, and in this way to make conceptually clear where the demarcation lines are – as well as the areas for potential multi-modal integration or partnership. The position taken in this paper is that when we look "under the bonnet" of MBCT and REBT, there are clear areas where multimodal REBT treatment or partnership with MBCT therapists could be of benefit to REBT clients.

Overview of this paper:

1. Brief Overview of MBCT
2. Brief Overview of REBT
3. Metacognition – Managing the cognitive "Factory-Line"
4. Key Client Metacognitive Capability Model
5. Comparative Disciplinary Review of Metacognitive Capabilities
6. Current Disciplinary Demarcation Summary
7. Opportunities for Disciplinary Integration & Partnership
8. Conclusions

We will start with a brief overview of the two disciplines.

1. Brief Overview of MBCT

Kabat-Zinn (2003, p145) defines Mindfulness as "the awareness that emerges through paying attention on purpose in the present moment, and non-judgmentally to the unfolding of experience moment by moment".

The concept of detached focus is a key element in Buddhism, which strongly informs the theory and practice of mindfulness.

MBCT is based on the Mindfulness-based Stress Reduction (MBSR) program developed by Jon Kabat Zinn in 1979 at the University of Massachusetts Medical Center. MBCT was adapted from MBSR so that it could be used to help address depressive relapse – in particular by training clients to catch mood symptoms early to prevent a downward spiral.

MBCT and derivatives (such as MBCT for children) are now also being used more widely for the treatment of conditions such as chronic pain and hypertension, as well as for other psychological problems such as panic and anxiety (Kim et al., 2010, pp590-595).

The ultimate goal of MBCT and derivatives is to assist clients in making a radical shift in their relationship to their thoughts, emotions and sensations. MBCT is an experience-based therapy. It is not evaluative, knowledge-based or goal-based. For example, there is no disputation of existing client beliefs or any attempt to replace them (Teasdale et al., 2000, pp615-623).

MBCT therapy is designed to heighten client awareness of their internal thoughts, emotions, feelings and sensations – and to learn to face and accept them as they are from a detached viewpoint, without passing judgment (Kabat-Zinn, 2004, p. 55-57).

This heightened client self-management – the ability to perceive experientially in a focused manner without reacting (and therefore, without escalating disturbance), is at the heart of the therapy. At the same time, this experiential focus promotes client realism by preventing the cognitive filtering out of all that is worthwhile in the external world. Clients are trained to live mindfully in the real world which provides evidence to dispute their negative and ineffective cognitions.

There is now little scientific doubt concerning the potential benefits of MBCT:

- Research into MBCT effectiveness (Ma & Teasdale, 2004, pp31–40) demonstrated reduced relapse rates of 50 per cent in clients who have been depressed three or more times.
- The UK National Institute for Health and Clinical Excellence (NICE, 2009, p5) has recommended MBCT to prevent relapse in patients who have experienced more than two episodes of depression and who are currently in remission.
- Zindel Segal is one of the co-founders and developers of MBCT along with John Teasdale and Mark William. To quote Segal (2011, p1):

"For the past decade John, Mark and I have been largely concerned with reaching the first milestone of treatment development – reliable evidence for MBCT's effectiveness. Data from 6 Randomized Controlled Trials and 2 meta-analyses (Hoffman, 2010; Piet & Hoogard, 2011) now indicate that Mindfulness Based Cognitive Therapy is associated with a 50 per cent reduction in depressive relapse risk as well as producing symptom relief in anxiety disorders for both adults (Kim et al., 2010, pp590-595) and children (Semple & Lee, 2011)."

2. Brief Overview of REBT

Epictetus summed up the key theme of Rational Emotive Behaviour Therapy (REBT) almost 2,000 years ago with the insight that we are disturbed not by events, but by the views which we take of them.

REBT sits firmly in the Cognitive-Behavioural school of therapy (CBT) by emphasising cognition as the *major* determinant of how we act and feel. If we think effectively about what happens to us, our emotional and behavioural outcomes will be effective, and if we think ineffectively then these outcomes will be ineffective.

This is the basis of the REBT "ABC" model (Yankura & Dryden, 1994). It is not an activating event (A) that determines Emotional and Behavioural outcomes (C), it is our beliefs (B) about (A) that cause (C), the B-C connection. A logical implication of the ABC model is that the past is not the cause of our problems – it is our current beliefs (irrespective of how we came to hold them) – and that these beliefs can be changed today.

REBT has a clear view on what constitutes effective thinking – it is rational. Such thinking is logical, empirically verifiable, flexible, and does not lead to dysfunctional outcomes such as depression, low self-worth, or addictive behaviours – but rather helps us to be healthy and to enjoy life as far as possible and achieve our goals, whilst also helping us to accept that life also brings unavoidable pain and frustration as part of the package.

REBT therapists actively evaluate and dispute irrational beliefs with clients (D), and attempt to convince clients to substitute these thoughts with rational beliefs to produce more effective outcomes (E). Hence the full model: ABC > DE.

REBT does not consider all "negative" emotional outcomes as ineffective or unhealthy. Grief or sadness represent healthy negative counterparts for depression, remorse for guilt, and so on.

REBT distinguishes itself philosophically from other cognitive-behavioural disciplines by concentrating on targeting rigid imperative evaluative beliefs, rather than client inferences and non-imperative evaluations about what happens to them. Albert Ellis (1979, pp3-8), the founding father of REBT, summed up the three irrational "major musts" as follows:

- "I must (do well, get approval, etc)"
- "You must (treat me well, love me, etc)"
- "The world must (give me what I want, treat me fairly, etc)"

… Otherwise "it's awful!", "I can't bear it!", "I'm worthless", etc.

Focusing on changing irrational "core beliefs" in clients is considered the "elegant" solution within REBT because the rational alternative beliefs provide the client with "armour" against a broad spectrum of activating events (Bernard, 2011, pp41-66).

For example, if I believe that "nobody MUST love or like me, and if they do not – this does not make me a worthless person", then this will help me to avoid anxiety, depression and feelings of low self-worth in a multitude of activating situations, even if my inferences about reality are incorrect, for example, I infer that my boss is unhappy with my work – but this is not true.

REBT promotes high frustration tolerance and unconditional acceptance of ourselves, others and life conditions as an integral part of a rational approach to life and reduction of self-inflicted disturbance (Ellis, 2001, pp23-40).

Clients are helped to evaluate, dispute and restructure their irrational thinking in a variety of ways (cognitive, emotive and behaviourally), and to obtain intellectual, and finally emotional, insight as part of the cognitive restructuring process (Ellis, 2008, pp91-95). In other words, to feel as well as to "see" that rational beliefs are leading to better emotional and behavioural outcomes for them.

Finally, a basic tenet of REBT philosophy is that as humans we are fundamentally prone to continued irrational thinking. A key component of the REBT therapeutic process is therefore to equip clients with the metacognitive and methodological tools and insight to continue to recognise and combat disturbance as it arises after therapy has ended – and thereby to take permanent responsibility for their emotions and behaviour.

3. Metacognition – Managing the cognitive "factory-line"

Before looking at a model of key client capabilities, let us now try to get a clearer understanding of metacognition (as a key success factor in therapeutic interventions).

Metacognition represents more than just "thinking about our thinking".

Although the theme can be traced back to writers such as Aristotle and Epictetus, John Flavell is widely regarded as one of the founding fathers of the modern metacognition discipline, and indeed coined the term. Flavell (1976, p232) defined metacognition more precisely as follows:

"In any kind of cognitive transaction with the human or non-human environment, a variety of information processing activities may go on. Metacognition refers, among other things, to the active monitoring and consequent regulation and orchestration of these processes in relation to the cognitive objects or data on which they bear, usually in service of some concrete goal or objective."

From this definition we can see that metacognition really represents an executive function for managing our thoughts as a "factory-line" production process – to produce effective and desired outcomes for ourselves. Metacognitions are also thoughts just like any other – but with intent. Metacognitions have an end in mind.

The evolutionary "gift" of metacognition provides a mechanism to change our outcomes by managing the way we think; to escape a deterministic destiny where event causes outcome, where stimulus inevitably always causes the same maladaptive response. The development of our relatively massive neo-cortex gave us the intellectual facility to reflect on our thoughts and feelings, to consciously observe ourselves in a way that no other organism can even begin to match (Geever, 2010).

Metacognitive processes are there to marshal and focus our thoughts and beliefs – to help us **plan**, **control** and **evaluate** our thinking to become more effective in reaching our goals.

Here are some common examples of metacognitive thoughts for each of these processes to give you a good idea of what metacognition actually means. These thoughts are aimed at improving the quality and outcome of our cognitions.

Plan
(before executing tasks)

- What kind of knowledge do I need for my goals and tasks?
- Do I possess that knowledge? If not, how can I acquire it?
- What kind of thinking strategy can I best employ to reach my goal?
- Is my current thinking model (or paradigm) about my thinking correct?

For example, I may believe that my thinking does not determine how I feel – but is this true?

I plan to focus attention on my internal thoughts, emotions, and sensory experiences without evaluation.
As described above, this is a metacognitive strategy at the heart of Mindfulness – a strategy of NOT employing specific metacognitive faculties!

Monitor and Control
(during cognitive activities to complete tasks)

- Do I fully comprehend the situation or the information I am processing?
- Am I thinking logically and realistically?
- Can I trust the information I have?
- How can I verify that the outcome of my thinking is correct?

Evaluate
(after tasks)

- Was my thinking logical and realistic?
- Did my thinking help me reach my goal? (if I had a goal)
- If not, how could I change it to become more effective?

Having reviewed the nature of metacognition and associated processes, let us now introduce a reference model which distills metacognition down to key client capabilities for successful therapeutic interventions.

4. Key Client Metacognitive Capability Model

As described in the introduction, the author has devised a simplified reference model of key client metacognitive capabilities depicted in *Table 1*. The model provides a framework with which to clarify both the unique aspects of REBT and MBCT, as well as the common ground for potential multimodal integration or partnership between the two disciplines and their respective practitioners.

The capabilities are defined in rough sequence of dependency and relative sophistication to each other, and are not intended to be exhaustive. The capabilities represent key pre-requisites for clients to make therapeutic progress in one form or another. Not all therapeutic disciplines require the client to have all of the capabilities listed, or require the client to possess them to the same degree of competence.

Table 1. Model of Key Client Metacognitive Capabilities

Metacognitive Capability	Definition / Comments
Awareness	Awareness of – and sensitivity to… the stream of Internal Events 1. Thoughts, Feelings, Emotions. 2. Interoceptive awareness of physical sensations including pain.
Detachment	Metacognitive "detachment" of Self as Subject from Internal Events. Subject observes Object (Internal Event). Subject is NOT the Object.
Perceptual Focus	Conscious focus of attention on present Internal Events. Characteristics of focus: – Open, Experiential, Inquisitive, Loving – NOT Evaluative or Judgmental (no perceptual goals)
Evaluation	Assessment of metacognitive strategies and resulting cognitions as effective or ineffective based on goals. Disputation based on a knowledge-base and philosophy (rationality, other). Key Capabilities: Logic, Empiricism, Assessment of strategic effectiveness.
Restructuring	Cognitive Restructuring. Primary goal is philosophical change in client belief system to deliver lasting and more effective emotional and behavioural outcomes. Client ideally learns to apply these techniques himself, rather than to rely permanently on a therapist. Key Capabilities: Evaluation as described above, understanding of theory and methodology (such as REBT), and the ability to apply techniques including substitution and re-enforcement of effective beliefs using a range of approaches and interventions (cognitive, emotive, behavioural).

5. Comparative Disciplinary Review of Metacognitive Capabilities

Now let us review the client Metacognitive Capabilities listed in the model above (*Table 1*) to compare and contrast MBCT and REBT. In this way we can "place" the key components and emphases of both disciplines – and draw out both unique features and areas of overlap for potential disciplinary integration.

5.1 Awareness

Awareness represents the metacognitive capability to discern and identify specific events within our internal "event stream" – thoughts, beliefs, feelings, emotions and sensations.

Both MBCT and REBT foster this awareness. MBCT promotes this awareness primarily in an experiential manner, whereas the focus of REBT is more model and knowledge-based (Yankura & Dryden, 1994). REBT concentrates primarily (but not exclusively) on the belief system of the client, whereas MBCT tends to focus more evenly on all events as they happen. MBCT focuses on the current event stream, whereas REBT also concentrates on future desired event states (promoting awareness and value of more effective thoughts and their associated emotional and behavioural outcomes).

Although the approaches and emphases differ, clients using either discipline become practised in noticing and discerning specific internal events – their thoughts, feelings, emotions and sensations. Both disciplines aim to interrupt the "automatic pilot" mode of cognition whereby thoughts and beliefs are outside the field of conscious awareness.

However, one can argue that MBCT as a discipline utilising the techniques of Mindfulness is likely to make clients more sensitive to all their current internal events than REBT (as improved awareness, sensitivity and control of attention are primary aims of the MBCT discipline; Kabat-Zinn, 2004, pp55-57, pp72-74).

5.2 Detachment

Detachment is critical to both MBCT and REBT. Both disciplines require and train the client to consciously become an observer of internal events, rather than to BE at one with the event. Without the capability for conscious separation of subject and object, clients cannot apply metacognitive processes to those cognitive objects (to focus on, evaluate, or restructure objects such as emotions, beliefs, or pain).

In MBCT, this training is achieved primarily experientially by consciously focusing attention as a subject on current internal events "at a distance" (focus on a depressive mood state, for example). Clients are encouraged to witness thoughts and emotions, rather like passing clouds.

"The tack we take in meditation is simply to witness whatever comes up in the mind or the body and to recognize it without condemning it or pursuing it, knowing that our judgments are unavoidable and necessarily limiting thoughts about experience. What we are interested in in meditation is direct contact with the experience itself—whether it is of an inbreath, an outbreath, a sensation or feeling, a sound, an impulse, a thought, a perception, or a judgment." (Kabat-Zinn, 2004, p55).

In REBT, this detachment is generally fostered indirectly by educating the client in cognitive-behavioural theory and through disputation – particularly disputation of beliefs (Ellis, 2008, pp91-95). Once clients become practised in disputing their beliefs, they also come to realise (if they had not already done so) that they are de facto separate from those beliefs (because they are evaluating their effectiveness in a subject-object relationship).

5.3 Perceptual Focus

Perceptual focus represents client capability for conscious focus of attention on present internal cognitive events such as thoughts and feelings. The nature and characteristics of

this focus are very closely aligned with the core features of Mindfulness and MBCT (Kabat-Zinn, 2004). It is this metacognitive capability that exhibits the most contrast and demarcation between MBCT and REBT therapeutic approaches.

Perceptual Focus has a number of key characteristics and outcomes which we shall review and compare between the two disciplines:

5.3.1 Characteristics of Perceptual Focus

Experiential

As implied by the word perceptual, the focus is not evaluative or judgmental. This is because the focus is not on specific goals, but on the experience of the object in itself without judgment as we become aware of it – and consciously give it our full attention in the moment. In other words, we are in a "meditative" state of full awareness without engaging our critical faculties. Thoughts such as "she does not love me" or "I must be perfect" are explored at face value rather than dissected for their validity, underlying meaning to the client, or their effectiveness. Perceptual focus ("being-mode") precludes evaluative attempts to "solve" ("doing-mode") unpleasant emotions or sensations which might trigger rumination or other unhelpful cognitions.

Open

Perceptual Focus is open to whatever internal events we become aware of. We do not practise avoidance or suppression. We face unpleasant thoughts, emotions or pain – and experience them as they are without judgment, challenge or struggle. However, there is an element of implicit suppression when we have developed heightened capability for focus on specific objects such as an emotion – without evaluation. This brings potential benefits which we shall discuss shortly with regard to outcomes of Perceptual Focus.

Inquisitive

Our capability for detachment allows us to view our experience as an object, to come to know more about it as our sensitivity to our internal states grows with practice. We can "play" with our experience as a child might play with a toy – reflecting on it without evaluating it – whether it be a thought, emotion or physical sensation.

Loving

Loving might seem like a strange characteristic of Perceptual Focus, but is important because loving and tending to every part of ourselves (however unpleasant, painful or disturbing) has implications for the outcomes of this focus as we shall now discuss.

5.3.2 Outcomes of Perceptual Focus

The characteristics of Perceptual Focus discussed above lead to a series of beneficial outcomes as follows:

Self-Knowledge

The inquisitive and open nature of Perceptual Focus promotes self-discovery. We face our potentially unpleasant or disturbing internal thoughts and feelings rather than

suppressing them or avoiding them. In this way we are more likely to find out what we are feeling and thinking. This knowledge is valuable in itself to help us identify emotions or beliefs that may be problematic for us. *From a REBT point of view, getting "automatic" beliefs and emotions to surface is of particular interest because otherwise the therapeutic processes of evaluation (disputation) and restructuring cannot begin!*

Acceptance

Sensitivity and openness to experience rather than avoidance or suppression promotes de facto acceptance. Why de facto? Because we ARE experiencing that thought, that sensation, or that emotion right NOW. It exists and we acknowledge that existence in a non-evaluative manner. We do not reject the experience, and consequently do not reject a part ("local" acceptance) or all of ourselves (global unconditional self-acceptance – USA).

Note that "local" acceptance is related to High Frustration Tolerance and global acceptance is related to USA. With regard to USA, REBT therapists work to convince clients that they have value irrespective of external conditions such as perfection or approval – and ultimately we try to wean clients away completely from (de)valuing their illusory global "self" (Ellis, 2001, pp23-40).

Unlike MBCT, REBT does not primarily address experiential acceptance (emotional insight) of existing "local" emotions or pain by focusing on them perceptually. The difference between local and global acceptance is that clients are not rejecting their whole selves based on "local" rejection – they are merely refusing to accept, or are awfulising about specific emotions, specific illnesses or chronic pain – to the detriment of their emotional and physical well-being. For example, physical pain feels much worse without acceptance – fuelled by imperative cognitions such as "it must not exist", "I can't bear it", or "I must not have to experience discomfort". These are thinking themes characteristic of low frustration tolerance and generate additional anxiety about discomfort. In effect, unnecessary suffering is layered on top of pain that must be borne, whether physical or emotional.

De-Escalation

It is perhaps no accident that depression has long been a primary focus for MBCT therapeutic interventions. Depression is notoriously difficult to treat, and MBCT has proven itself as a therapeutic intervention in this area. The MBCT combination of client awareness, detachment and perceptual focus primarily on depressive mood, is clearly beneficial, as the evidence cited at the beginning of this paper attests.

Why is this?

There are two key processes at work here:

- De-Coupling (of emotions and sensations from thoughts)
- De-sensitisation (by repeated non-evaluative focus on emotions, sensations, or thoughts – Whitfield, 2006, pp205-217)

When clients start to feel down, they frequently believe their emotions represent a problem to be solved by using critical thinking strategies. When this evaluative thinking

fails, clients often get into a vicious circle of ruminating and living in their minds rather than in the real world. In addition, cognitive evaluation of mood can trigger well-known ineffective beliefs that fuel depression – such as "I am a failure", "The world is a terrible place", or "The future is bleak".

Early awareness of low mood and ineffective thinking patterns gives clients the ability to intervene by exercising Perceptual Focus on their mood and thoughts. In this state, clients are preventing escalation of low mood early by focusing in a non-evaluative manner. Clients experience the world directly, non-conceptually and non-judgmentally. Clients experience reduced debilitating rumination in this state.

MBCT helps to halt the escalation of low mood caused by the interaction of mood and ineffective thoughts by NOT focusing on both mood and thoughts at the same time. We can call this process De-Coupling as mentioned earlier. By focusing on only one part of our experience, by definition, we are preventing escalation of the downward depressive spiral – because emotions and thoughts are not coming together to "fuel" the depressive state.

Crucially, this is a "being" experiential focus rather than a "doing" evaluative focus which tends to trigger ruminatory, goal-driven thoughts – where the client tries vainly to solve his depressive mood or other perceived problems.

In a similar fashion to Hatha Yoga, which aims to deflect evaluative thought by concentrating on physical movement, MBCT aims to deflect evaluative thought by focusing on the experiential, by being in the moment. Mindfulness and MBCT do not encourage suppression of evaluative thought, but only its reduction through increasing client capability in Perceptual Focus. (In other words, we aim to focus on the "giraffe", rather than NOT to focus on the pink elephant! Being told not to focus on something is generally ineffective.)

This is a very different approach to REBT, which is almost always evaluative in nature. Note that perceptual focus (MBCT) and evaluative focus (REBT) approaches are almost mutually exclusive! For example, as soon as we switch on our critical faculties when "viewing" a depressive mood, we are likely to trigger ineffective cognitions and the start of a downward spiral of mood.

We can surmise based on the concept of de-coupling that regular perceptual focus by clients on emotions, moods or sensations (without critical evaluation) may help to change the physiological coupling of emotions or sensations with ineffective cognitions – to actually help weaken and de-couple these links. This may be a fruitful area for empirical research.

In addition, the process of desensitisation is at work here. When a client focuses as subject either on a mood, sensation or thought on an object "at a distance" – the client practises detachment. The client can view his depressive mood or ineffective thoughts as objects in themselves rather than an inseparable part of himself, rather than being engulfed. I am not depressed, but I do exhibit depressive symptoms. I am NOT my depression. Why is singing or listening to Blues music paradoxically so helpful when we are feeling down? It is because we accept ourselves and can view our mood at a distance, rather than being the mood.

This detachment gives clients the ability to desensitise themselves to experiential internal objects – and to become aware that they are nothing more than individual

objects. For example, prolonged perceptual focus on the belief "I am worthless" can help clients to achieve the emotional insight that this is just a thought and has no meaning or consequence in its own right. This desensitisation process can help reduce the impact of "hot" cognitions, for example. These are thoughts that are emotionally laden and fuel poor outcomes for us – such as depression or anxiety.

Desensitisation of emotions and sensations can also help clients increase their frustration tolerance for physical and emotional discomfort. When we openly and experientially face our pain and discomfort without avoidance, we build up our tolerance to face and where necessary to bear that discomfort. For example, to put aside anxiety related to beneficial life change such as taking a new job, presenting in public or overcoming shyness. In effect, through acceptance and desensitisation, we reduce our discomfort anxiety. We generate less emotional pain about our physical and emotional discomfort! This is a slightly different approach to REBT – where we aim primarily to encourage clients (using evaluative disputation) to adopt more rational beliefs about discomfort to lead to reduced discomfort anxiety. For example, to substitute, "I must be comfortable at all times, otherwise I can't stand it!" with "I prefer to be comfortable but there is no law stating that this must be so, it is not terrible if I am uncomfortable, I can bear it, and doing so is often in my best interest".

De-escalation based on de-coupling and desensitisation is also commonly applied within MBSR/MBCT to anxiety, stress, panic and chronic pain, for example, where the same theme of disturbance escalation is a common problem for clients.

Realism

With good reason, depression is often called a crisis of the imagination. Clients exhibiting depressive mood symptoms often cannot be realistic about their lives, and commonly indulge in cognitively filtering out all that is good in themselves and in the world around them. This process is clinically known as 'anhedonia'. Clients lose touch with their senses and are unable to enjoy the things in life that previously gave them pleasure.

The open and experiential nature of Perceptual Focus counteracts anhedonia as clients become mindful of ALL internal events in consciousness through heightened sensitivity and training in focus. In this way, clients gain a more balanced view of the real world – including all that is beautiful and good, by living and focusing in the present moment. This includes awareness of all the five senses – which commonly become dulled under the influence of depression and other disturbances. Clients emerge from living in their heads to living in the "real world" where they can find evidence to contest their mood state and their invalid or ineffective thoughts. This emergence may also be assisted by additional methods such as relaxation techniques (breathing, other).

Living in and focusing on the present also helps to prevents clients from reliving their past or pre-living a <bleak> future.

Healing

Although we may be on empirical thin ice, there is at least enough experiential data to say there appears to be a healing element to perceptual focus due to the combination of focused attention, detachment and acceptance. When we consciously confront and

accept physical pain, bad memories, unpleasant thoughts and painful emotions – this loving acceptance and attention to all parts of ourselves appears to have a positive effect on our well-being.

For example, perceptual focus on chronic pain clearly helps to reduce the secondary "sting" attached to it. We do not shy away from it, but face it, experience and accept it, and crucially do not demand that it should not exist or is unbearable – cognitions which lead to the secondary pain of discomfort anxiety (as mentioned earlier in the section on acceptance).

In his book *Angry White Pyjamas*, Robert Twigger (1997, p111) makes exactly this distinction when referring to the pain of accelerated Aikido black belt training with the Japanese riot police – one of the toughest courses in the world. He describes slowly discovering the difference between the actual objective sensation of pain, and the subjective evaluation of that pain as two separate entities. It is acceptance of the former that reduces the impact of the latter. The course taught him (experientially!) to "lose" the subjective pain which he describes as "everywhere and not localized, as if it is attacking your brain directly". This subjective pain is triggered by the irrational desire for it to go away ("it hurts… please stop now"). Once subjective pain is conquered, one can concentrate on managing and coping with localised objective pain.

Again in Aikido, we can find another physical example. When an opponent catches one in an unbreakable arm-lock, Aikidokas (including the author) are taught not to resist, but to accept, submit relax physically and mentally rather than tense up, and to "go with the flow" of the opponent. This action minimises additional physical pain – and the possibility of torn muscles or broken bones, as well as the secondary emotional pain of discomfort anxiety or "pain about the pain".

Note that the healing and ameliorating effect of this acceptance and submission applies equally to the "pain" of negative emotions as to physical pain. For example, experientially focusing fully on our discomfort anxiety when we desire a cigarette can help us to accept and tolerate the emotion rather than to "flee to comfort" and light up. This experiential focus on emotional pain does not rely on "helping" effective cognitions to have beneficial effect.

5.3.3 Disciplinary Comparison of Perceptual Focus

Let us now briefly compare the MBCT and REBT disciplines with regard to Perceptual Focus. Perceptual Focus correlates almost completely with the approach and techniques of Mindfulness and MBCT.

The approach is predicated primarily on coping strategies based on the current experiential world of the client – and on the client forming a different kind of relationship with his internal experiences (Teasdale et al, 2000, pp615-623). This is a very different approach to the evaluative and cognitive restructuring approach of REBT based on a conceptual model of rationality. MBCT is very much rooted in the client's current experiential world, whereas REBT aims to philosophically re-structure that world (as far as reasonably possible) to help the client become more effective based on rational beliefs – rather than to cope better with his current cognitive, emotional and behavioural state. REBT is essentially future-state driven, whereas MBCT is primarily based on disturbance prevention, acceptance and swift de-escalation from the client's current state

Due to the perceptual nature of the focus, it is almost mutually exclusive to the evaluative nature of REBT where we are interested in finding out what cognitions mean to a client. As soon as one begins to evaluate and think critically – a "mindful" state is lost by definition! In a way, this is analogous to the nature of matter as particle or energy wave. We may view one or the other as an observer, but not both at the same time. In effect, MBCT focuses on the client in "being" mode, whereas REBT focuses on the client in "doing" mode.

However, MBCT in focusing on the client's actual experience, does contribute as described above to REBT goals such as unconditional self-acceptance, high frustration tolerance for pain and discomfort and avoidance of "awfulising" (catastrophic thinking where this is not borne out by reality; Ellis, 2001, pp23-40). MBCT also promotes in situ emotional insight experientially – a goal shared with REBT. We say in situ, because MBCT does not attempt to change an ineffective emotion such as guilt, for example, but only to experience and view it in a different way. In addition, heightened experiential awareness by the client can bring submerged cognitions to the surface which can be used as input for REBT evaluation and cognitive re-structuring techniques.

REBT does utilise "in vivo" techniques – primarily to promote de-sensitisation and high frustration tolerance (Ellis, 2001, pp23-40), but these are slightly different to the MBCT focus on the internal object stream as it happens in the moment. IN REBT, clients "manufacture" current state problems such as anxiety by practising with the irrational beliefs that trigger that emotion. In this way clients learn to clearly understand, both intellectually and emotionally, the connection between their irrational thinking and ineffective emotional or behavioural outcomes. *However, within REBT, evaluative weakening of the irrational "B-C" connection through disputation is not seen as an end in itself, but as a precursor to cognitive restructuring. The nature of evaluation as a metacognitive process will be explored further in the next section.*

Finally, MBCT's primary focus on the experiential is in some ways less demanding and more natural for the client – who does not have to learn a new paradigm in the form of REBT before therapeutic benefit can be gained (Teasdale et al, 2000, pp615-623).

5.4 Evaluation

As discussed in the section on metacognition, evaluation reflects our metacognitive capacity to review the effectiveness of our thinking strategies and actual cognitions given our goals, philosophical approach and knowledge.

Well-developed evaluative capabilities allow us to differentiate between our cognitive perceptions, inferences and evaluations – and to effectively analyse them.

For example, within REBT we evaluate (dispute) cognitions using logic and empiricism based on the cognitive-behavioural premise that irrational thinking produces disturbed emotional and behavioural outcomes. Are my thoughts true, are they logically consistent, and will they help me stay healthy and enjoy life as much as possible? (Ellis, 2002)

For example, is it logically consistent to believe that I have no worth if I am not loved? Is it true that I cannot bear to be uncomfortable?

We can also evaluate experimentally using emotive and behavioural techniques. By acting differently to test if our beliefs are true, for example.

Evaluation provides us with the ammunition to restructure our metacognitive strategies (and our actual thinking) if the current outcomes are not working for us, for example, if we are not learning effectively, if we are emotionally disturbed, or if we are behaving self-destructively. Note that this evaluation requires a context and value system against which to measure. Within REBT, the philosophy of rationality provides a framework for evaluation within the conceptual model of cognitive behavioural psychology.

Mindfulness and MBCT consciously discourage evaluative thinking as it is almost mutually exclusive to the experiential nature ("being-mode") of Perceptual Focus as described earlier. However, MBCT clients obviously evaluate their thinking to some extent ("doing-mode") in order to determine if their thinking strategy (aware, experiential, detached and non-evaluative) is working and producing the desired emotional, behavioural and cognitive outcomes.

In addition, Perceptual Focus (or mindful thinking) prevents cognitive filtering out of all that is enjoyable and worthwhile in the real world. In effect, clients evaluate or dispute their thinking experientially rather than evaluatively.

5.5 Restructuring

Once we have evaluated our thinking strategies and actual cognitions, we may decide to change them in order to create more effective outcomes for ourselves. We may, for example, change the way in which we study in order to learn more effectively.

Within the bounds of REBT therapy, this process is achieved by helping the client to accept and substitute effective rational beliefs and by re-enforcing these beliefs with a variety of cognitive, emotive and behavioural techniques. This is the process of cognitive restructuring (Ellis, 2008, pp91-95).

This acceptance and insight is likely to be intellectual at first, and eventually to be emotional (Ellis and Dryden, 1997). For example, a client may intellectually "see" that he fears devaluation when presenting in public, but his anxiety may only reduce after repeatedly facing his anxiety whilst "carrying" his effective new beliefs with him (for example, "Even if I fail at presenting, I cannot be devalued as a person"). Behavioural evidence is usually required to reinforce the emotional insight that the ineffective emotion or behaviour is weakening due to the effective cognition – and the client feels the effect of this virtuous circle as the effective cognition strengthens.

REBT also aims to arm clients with these metacognitive restructuring tools so they can continue this process of addressing irrational beliefs and associated disturbance after therapy ends.

MBCT explicitly does NOT attempt to restructure client cognitions, but as mentioned earlier, the practice of perceptual focus may lead to restructuring as a beneficial by-product of de-coupling and desensitisation – by weakening the physiological relationship between ineffective cognitions and emotions. This may be one of the factors accounting for the empirically proven validity of MBCT as a therapy.

6. Current Disciplinary Demarcation Summary

In *Table 2* below, a high-level summary of the broad current demarcation lines between the two disciplines regarding client metacognitive capabilities is depicted.

Table 2. Disciplinary Comparison of Client Metacognitive Capabilities

Metacognitive Capability	Focus MBCT	Focus REBT
Awareness	High	Medium
Detachment	High	Medium
Perceptual Focus	High	Low
Evaluation	Low	High
Restructuring	Medium	High

MBCT and REBT show convergence in the promotion of internal **Awareness** and **Detachment** in clients. MBCT gives slightly higher priority to these core capabilities experientially as an inherent part of the discipline, whereas these skills are learnt more indirectly through REBT therapy as discussed earlier.

Perceptual Focus encapsulates the heart of Mindfulness, and is clearly MBCT territory, as documented above. The focus is non-evaluative, non-critical and non-judgmental – and is directed wholeheartedly at the client's current experiential state. MBCT essentially teaches clients to form a different kind of relationship with their internal selves ("being-mode") to enable improved self-management for improved outcomes, such as de-escalation of incipient depressive mood, increased frustration tolerance for chronic pain, reduction in depressive relapse and reduced anxiety.

In this mode, clients do not avoid, challenge or struggle evaluatively with their experiences by trying to solve them – actions which often paradoxically worsen the situation. REBT, in contrast, does not target improvement of the client "as is" or coping strategies, but looks instead to effect philosophical, paradigm-based change on the basis of rationality and the causal linkage between cognition, emotion and behaviour.

Evaluation and Cognitive Restructuring are clearly the primary domain of REBT, as reviewed earlier. While MBCT clients are often taught to recognise thought patterns triggering disturbance as they appear, and to look at their experiences from different viewpoints, formal model-based evaluation, disputation and restructuring of thoughts and emotions do not represent the core focus of the discipline (Teasdale et al, 2000, pp615-623).

However, MBCT clients through the experiential process of perceptual focus, may gain emotional insight and weaken the links between ineffective cognitions and emotions *(while lacking the methodology and knowledge-base of REBT to determine and effect change by substitution of more effective beliefs).*

For this reason, MBCT has been assigned "Medium" rather than "Low" for focus on Restructuring in the table above. Clients may attain some emotional insight (and therefore cognitive Restructuring) by a more direct experiential route than is normally the case with REBT. *Note that this is a radically different approach compared to REBT and*

cognitive behavioural therapy in general. In effect, "hot" ineffective cognitions may be "cooled" in situ, (by de-sensitisation and de-coupling of cognition from emotion), rather than replaced. For example, a client may continue to think "I am worthless" without generating feelings of depression (or vice versa from emotion to cognition). The author is not currently aware of formal empirical research in this area, but it does seem to present an interesting and potentially fruitful area for study.

Finally, the use of behavioural techniques and "behavioural disputing" is pure REBT territory. Techniques such as shame attacking and building high-frustration tolerance in an anxiety-generating situation (Ellis, 2002), are not generally practised in MBCT.

7. Opportunities for Disciplinary Integration & Partnership

7.1 What?

Based on the disciplinary comparison (*Table 2*) earlier, there are clearly opportunities for REBT therapists to improve the metacognitive capabilities of clients (and by extension, to improve client therapeutic outcomes) by incorporating some of the techniques of MBCT.

What exactly are these opportunities?

- It is clear that MBCT is very effective in promoting metacognitive awareness and detachment in clients – which are also critical client skills in REBT interventions.
- Perceptual Focus and associated benefits are currently barely in scope for REBT therapists. This is clearly a potentially rich seam for improving client capabilities as documented earlier (Self-Knowledge, Acceptance, De-Escalation, Realism and Healing).
- REBT is very strong in Evaluation and Cognitive Restructuring, but even here, the potential for clients to gain direct experiential emotional insight and reduce disturbance through perceptual focus is certainly of great interest.

7.2 When?

Given the above areas of potential capability overlap between the disciplines, when might REBT therapists want to use MBCT techniques to improve these capabilities?

- **Clients with poor or impaired capacity for metacognition**

REBT does not focus primarily on how good clients are at metacognition. As therapists we tend to assume they will "pick it up" as part of the process. But clients vary in their cognitive capability for introspection and thinking about their thinking. Highly intelligent and self-aware clients may pick up the concepts and techniques easily, while others struggle. MBCT may therefore be particularly beneficial with those clients assessed as possessing poorly developed metacognitive capacities (or for children). The experiential approach of MBCT may help to develop awareness and detachment in these challenged clients. For example, clients may be able to bring irrational thoughts to the surface for further treatment. Once these metacognitive skills have been developed, standard REBT techniques are likely to be much more effective.

● **Clients experiencing acute disturbance**

Where clients are experiencing acute disturbance, they may not be amenable to evaluative techniques such as disputation or to cognitive restructuring. They need help "closer to home" in their subjective world to nip their problems in the bud, to cope, and to get a different perspective on their experiences. Depression is a good example. The experiential coping and "de-escalatory" approach of MBCT based on Perceptual Focus can help to alleviate client symptoms to a level where they may be amenable and receptive to REBT – ie: to a more evaluative approach to achieve permanent improvement by cognitive restructuring of ineffective beliefs.

● **Clients unable to reach emotional insight**

As discussed earlier in the section on Restructuring, part of the REBT process is to enable clients to reach insight into both the irrationality and ineffectiveness of their current state, and to the desirability of change to a more effective state. However, many clients have difficulty for a variety of reasons in achieving emotional insight using the traditional REBT techniques. For these clients, MBCT may offer a less challenging experiential route to emotional insight – at least into their current ineffective thoughts and emotions. Thereafter, they may be more amenable to standard REBT techniques (to substitute remorse for guilt, concern for anxiety, etc).

● **Clients resistant to change**

For clients who philosophically, for whatever reason, do not wish to change, but do want to alleviate their disturbed state, MBCT may be a good alternative option acceptable to the client. The therapy is "non-invasive" in the sense that the client is not challenged through the process of disputation. The client simply learns to create a different relationship with his existing internal experiences – rather than to effect change in his world based on a new paradigm of rationality.

Onward referral meshes well with standard REBT philosophy. The client always reserves the right to think and act as he sees fit, including the rejection of REBT as a valid or useful approach (Ellis, 2002)

7.3 Integrate or Partner?

If, as REBT therapists, we see benefit in MBCT for our clients, then we will need to consider the form in which we interact with MBCT.

Should we learn and integrate MBCT techniques into our own practice, or should we re-direct clients (at least temporarily) to MBCT therapists in partnership?

The skillset of a good REBT therapist regarding dialogue and interaction with a client is relatively sophisticated, so, on paper, there is no reason why a REBT therapist cannot learn and apply MBCT techniques (*examples provided in the next section*). However, there are two major considerations to bear in mind when deciding whether to integrate MBCT into your own practice, or to partner with an MBCT therapist.

Therapist temperament and goals

This is the critical issue for every therapist. REBT therapists are well versed in disputation and cognitive restructuring techniques based on a clear rational paradigm and model of behaviour - and are generally very analytical, direct, evaluative, and challenging in their approach. They generally have a strong desire to help the client to change – to become more effective, rather than to cope in their current state. They want to go ABC > DE!

Many REBT therapists will therefore not be comfortable with the difference in approach and techniques required for MBCT, and will not wish to practice multi-modally. Others will take to it like a duck to water. Every REBT therapist must make their own decision – possibly after a little experimentation. However, for therapists who choose not to use MBCT techniques, the author hopes this paper will help clarify when their clients will potentially gain benefit from referral for MBCT therapy.

If REBT therapists believe they are temperamentally suited to integrate MBCT techniques into their work, the second major consideration is, how to successfully conduct multimodal therapy.

Separation of Disciplines

As discussed earlier, there is a fundamental difference in approach between MBCT and REBT, making the disciplines almost mutually exclusive. MBCT requires a mindful, non-evaluative approach. Therapists cannot easily therefore practise both disciplines without triggering evaluative thoughts in the client – which are likely to diminish the effect of MBCT, and seriously confuse the client! If we vigorously dispute the thought "I am worthless" with a client using logic and empirical analysis – and then ask him to focus merely perceptually on that thought without evaluating it, the results are likely to be sub-optimal.

There are a number of ways to address this.

Firstly, the client needs to be adequately prepared metacognitively to understand which discipline is being used – and how he is expected to think and respond (Whitfield, 2006, pp205-217).

Secondly, the author believes that dedication of a specific therapeutic session to either REBT or MBCT techniques is likely to be the most effective approach – to avoid "evaluation seepage" in MBCT sessions (and vice versa for REBT sessions where we want client evaluative faculties switched on).

REBT therapists who do not believe they can effectively manage separation of disciplines may opt to partner with MBCT therapists as described in the "When?" section above. For example, by referring a client with poor metacognitive abilities to an MBCT therapist (and taking the client back, if and when the client has developed adequate skills to benefit from REBT).

7.4 How to Integrate?

For those REBT therapists wishing to integrate MBCT techniques multimodally into their own practice, there are a number of potential experiential applications, such as emotional

insight into the B-C connection, increasing client tolerance for frustration, alternative routes to emotional insight, or the promotion of more self-knowledge, acceptance and realism, as detailed earlier. For more potential application examples and an overview of MBCT-REBT integration, see Whitfield (2006, pp205-217), who is a proponent of such multimodal treatments.

To paraphrase Whitfield (2006, pp205-217), here are sample REBT therapist questions for an "MBCT dialogue":

- Focus on your thought "I am unlovable".
- Describe the "appearance" of that thought.
- How might you feel about that thought?
- How would it feel in your body?

Note the characteristics of this kind of dialogue. Evaluative thinking is not triggered, merely reflection by the client. There is no disputation or discussion on effectiveness of the thought. There are no correct answers. The client is likely to become experientially aware of emotional and physical linkage (the B-C connection).

Repetition of this form of dialogue is an important part of the approach – and this may also help to desensitise and de-couple "hot" cognitions – to experientially reduce their significance, to reduce client emotional attachment to them, and hence reduce the degree of associated disturbance (low self-worth, anxiety, depression, etc).

As mentioned earlier, it is imperative for the REBT therapist to avoid evaluation – and to ensure that the client does the same.

8. Conclusions

As REBT therapists, we need to take a holistic view of our clients and to understand where there are gaps in our treatment capabilities based on the specifics of each unique client and the paradigm and methodology of the REBT approach.

Based on the material presented in this paper, the author believes that there are clear scenarios where MBCT can augment traditional REBT therapeutic approaches, either multimodally or in partnership with MBCT therapists. REBT therapists are therefore encouraged to be open-minded, to learn, to experiment and to partner in the best interests of their clients.

Finally, the proven efficacy of MBCT gives potential grounds for a partial shift of focus within REBT and other cognitive-behavioural disciplines. To quote Zindel Segal (2011, p1):

"Having addressed the efficacy question, we are still left to ponder how exactly this multimodal treatment achieves its benefits. For example, what is the relative contribution of cognitive therapy principles versus mindfulness practice to outcome? What about the role of kindness and compassion, both of which are implicit in the program…".

Causal attribution is notoriously difficult in this area, but as discussed earlier in this paper, the efficacy of Mindfulness and MBCT may at least in part be due to cognitive restructuring within the bounds of the ABC model and without the necessity for effective

belief substitution. By de-coupling and desensitising ineffective beliefs "in situ" (weakening the B-C connection while in experiential "being-mode"), clients may achieve lasting beneficial emotional, behavioural and cognitive outcomes without holding rational beliefs. This is a radically different approach to standard REBT.

In effect, two processes may be at work here. Firstly, the short-term "intervention" effect of perceptual focus (experiential, mindful thinking) to prevent escalation of depressive mood, panic etc. The client selects the appropriate thinking style (being-mode) when required. Secondly, the cumulative long-term effect of this form of experiential awareness resulting in weakening or removal of the physiological link between cognition and emotion as described above.

It might not be elegant, but if clients can entertain cognitions such as "I am worthless", "There is no hope", or "I must be perfect" without triggering, for example, depression, anxiety, panic or feelings of low self-worth, then this is clearly of major therapeutic benefit. The reverse scenario is just as valuable – where clients experience unpleasant emotions such as depression, but do not trigger escalating cognitions (such as excessive rumination).

Empirical evidence may be hard to come by, but the author believes this is certainly an approach for REBT therapists to seriously consider in their practice to augment standard REBT techniques and goals, at least for those clients <currently> unable to benefit from cognitive restructuring via rational belief substitution à la REBT for the reasons described earlier in this paper.

As REBT therapists we tend to primarily inhabit the "doing-mode" world of critical evaluation and cognitive re-structuring with our clients based on philosophical and psychological models, a knowledge-base and goals. Perhaps we should focus a little more on client relationship to thinking as well as the content?

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Biography

Patrick holds Advanced Certification in REBT and works in private practice with clients in The Netherlands and in the UK. He is the author of T*he Adventurer's Companion – A Practical Guide to Life Change*, which is heavily informed by both the theory and practice of REBT. His next literary project is to make key REBT concepts more accessible to a wider audience. Patrick also runs an IT Information Architecture company.

Comment

REBT and IAPT

New hope has been fostered for using REBT as an alternative therapeutic protocol in a local IAPT hub. Those of us that work within IAPT are fully aware of the need to work with evidence based CBT protocols when treating clients with mild to moderate emotional distress. These protocols are normally based on careful research conducted with randomized control trials, however with the current pressures on IAPT hubs to see more and more clients and produced more effective outcomes, less time and money seems to be available on producing the evidence needed.

Subsequently, newer models seem to be used that are not based on such rigorous research, which in my opinion paves the way for the use of REBT, especially when working with more complex and comorbid conditions. It is acknowledged that these clients are not always accepted into many services due to their level of complexity, however in the hubs that do, REBT may be the effective solution in producing change within a very limited time.

However, it would be up to each and every REBT practitioner working within IAPT to encourage and provide the evidence already published to motivate the use of this therapy. Collectively, the effective outcomes produced by using REBT would be acknowledged and it would finally be accepted as a NICE approved form of treatment in its own right.

Edelweiss Collings

Accreditation issues

An update

It has been more than a year since AREBT and BABCP joint forces to nationals the CBT accreditation standard.

At present we are working together with the BABCP on regulating number of accreditation matters and they are as follow:

1) Creating the dual accreditation system. The aim is that all our accredited members, who are also accredited by the BABCP, will have their re-accreditation examine at the same time and they will be issued with one certificate that state that these members are accredited by the two organisations.

2) Monitoring the accredited members continued professional development (CPD) progression and their continued clinical supervision on line, aiming to end the one in five years re-accreditation process.

3) To find ways to simplify the KSA rout for accreditation, without lowering the standard.

Regretfully only five AREBT members applied for accreditation this year, in which two of them are now fully accredited. We have 49 of our members accredited now and one hope to see more accredited members in a year time.

We need to remember that the accreditation system is not yet another academic degree, but a clinical method to regulate our members and to help them to stay accountable for their clinical work. Mainly because AREBT is a caring organisations, which dose all it can to protect the public from the rough traders.

Meir Stolear, AREBT director of accreditation

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

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