R

Rational Emotive Behavior Therapy

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Rational Emotive Behavior Therapy (REBT) was founded in 1955 by Albert Ellis, a U.S. clinical psychologist. Originally trained as a psychoanalyst, Ellis was disappointed at the results he obtained from this form of therapy and after a period of experimentation in various therapeutic methods of the time, he brought together his early interests in a number of fields to form REBT. These fields included the practical application of philosophers such as Epictetus, Marcus Aurelius, and Bertrand Russell who all stressed the importance of cognition in understanding human affairs and the work of the early behavior therapists such as John B. Watson and Mary Cover Jones whose ideas helped Ellis to overcome public speaking anxiety and fears of approaching women. Originally, Ellis called his approach Rational Therapy (RT) because he wanted to emphasize its rational and cognitive features, but in 1961, he changed its name to Rational-Emotive Therapy to show critics that it did not neglect emotions. Over 30 years later (in 1993), Ellis renamed the approach Rational Emotive Behavior Therapy (REBT) to show critics that it did not neglect behavior.

In 1962, Ellis published *Reason and Emotion in Psychotherapy*, a collection of largely previously printed papers or previously delivered lectures, but which became a seminal work in the history of psychotherapy. Most of REBT's major, present-day features are described in Ellis's book, albeit some in embryonic form: the pivotal role of cognition in psychological disturbance, the principle of psychological interactionism where cognition, emotion, and behavior are seen as interacting, not separate systems, the advantages of self-acceptance over self-esteem in helping clients with their disturbed views of their self, the role that low frustration tolerance has in perpetuating psychological disturbance, and the importance of an active-directive therapeutic style to name but a few. Present-day features of REBT not found in this seminal book include its constructivistic and postmodern aspects.

BASIC ASSUMPTIONS

In REBT, rationality is a concept that is applied to a person's beliefs. Rational beliefs, which are deemed to be at the core of psychological health in REBT, are flexible, consistent with reality, logical, and self- and relationship-enhancing. Irrational beliefs, which are deemed to be at the core of psychological disturbance, are rigid, inconsistent with reality, illogical, and self- and relationship-defeating.

In REBT theory (Ellis, 1962, 1994), there are four types of rational beliefs: flexible preferences ("I want to be approved, *but* I don't have to be"), non-awfulizing beliefs ("It's bad to be disapproved, *but* it isn't the end of the world"), high-frustration-tolerance beliefs ("It is difficult to face being disapproved, *but* I can tolerate it and it is worth tolerating"), and acceptance beliefs (e.g., unconditional self-acceptance [USA]: "I failed to be approved, *but* I am not worthless. I am a fallible human being capable of being approved, disapproved, and treated neutrally," unconditional other-acceptance [UOA]: "You disapproved of me, *but* you

are not a bad person for doing so. Rather, you are a fallible human being capable of good, bad, and neutral deeds," and unconditional life acceptance [ULA]: "Life conditions are really hard for me because of your disapproval, *but* life is not all bad. It is a tremendously complex mixture of good, bad, and neutral events").

Similarly, there are four types of rational beliefs: rigid demands ("I must be approved"), awfulizing beliefs ("If I'm disapproved, it's the end of the world"), low-frustration-tolerance beliefs ("I can't tolerate being disapproved"), and depreciation beliefs (e.g., self-depreciation: "I am worthless if I am disapproved," other-depreciation: "You are a horrible person if you disapprove of me" and life-depreciation: "Life is all bad because I have been disapproved").

REBT advocates an ABC model of psychological disturbance and health. "A" stands for activating event which can be actual or inferred, "B" stands for belief (rational or irrational), and "C" stands for consequences of holding a belief about A and can be emotional, behavioral, and cognitive. Thus, A's do not cause C's but contribute to them. B's are seen as the prime but not only determiner of C's.

REBT theory states that holding a rational belief about an A leads to healthy emotions, functional behavior, and realistic subsequent thinking, whereas holding an irrational belief about the same A leads to unhealthy emotions, dysfunctional behavior, and unrealistic subsequent thinking.

REBT theory holds that human beings are capable of thinking rationally and irrationally. The ease with which we transform our strong desires into rigid demands, for example, suggests that the tendency toward irrational thinking is biologically based, but can be buffered or encouraged by environmental contexts (Ellis, 1976). Clients often have the unfortunate experience of inheriting tendencies toward disturbance and being exposed to their parents' disturbed behavior. REBT is optimistic and realistic here. It argues that if such clients work persistently and forcefully to counter their irrational beliefs and act in ways that are consistent with their rational beliefs, then they can help themselves significantly. However, REBT also acknowledges that most clients will not put in this degree of effort over a long period of time and will therefore fall far short of achieving their potential for psychological health.

ORIGIN AND MAINTENANCE OF PROBLEMS

Paraphrasing the famous dictum of Epictetus, we say in REBT that people are not disturbed by events but by the rigid and extreme view they take of them. This means that while negative events contribute to the development of disturbance, particularly when these events are highly aversive, disturbance occurs when people bring their tendencies to think irrationally to these events.

REBT does not have an elaborate view of the origin of disturbance. Having said this, it does acknowledge that it is very easy for humans when they are young to disturb themselves about highly aversive events. However, it argues that even under these conditions people react differently to the same event, and thus we need to understand what a person brings to and takes from a negative activating event.

People learn their standards and goals from their culture, but disturbance occurs when they bring their irrational beliefs to circumstances where their standards are not met and their pursuit toward achieving their goals is blocked. In contrast, REBT has a more elaborate view of how disturbance is maintained. It argues that people perpetuate their disturbance for a number of reasons including the following: (1) They lack the insight that their disturbance is underpinned by their irrational beliefs and think instead that it is caused by events; (2) they think that once they understand that their problems are underpinned by irrational beliefs, this understanding alone will lead to change; (3) they do not work persistently to change their irrational beliefs and to integrate the rational alternatives to these beliefs into their belief system; (4) they continue to act in ways that are consistent with their irrational beliefs; (5) they lack or are deficient in important social skills, communication skills, problem-solving skills, and other life skills; (6) they think that their disturbance has payoffs that outweigh the advantages of the healthy alternatives to their disturbed feelings and/or behavior; and (7) they live in environments that support the irrational beliefs that underpin their problems.

CHANGE

REBT therapists consider that the core facilitative conditions of empathy, unconditional positive regard, and genuineness are often desirable, but neither necessary nor sufficient for constructive therapeutic change. For such change to take place, REBT therapists need to help their clients to do the following:

- Realize that they largely create their own psychological problems and that while situations contribute to these problems, they are in general of lesser importance in the change process
- Fully recognize that they are able to address and overcome these problems
- Understand that their problems stem largely from irrational beliefs
- Detect their irrational beliefs and discriminate between them and their rational beliefs
- Question their irrational beliefs and their rational beliefs until they see clearly that their irrational beliefs are false, illogical, and unconstructive while their rational beliefs are true, sensible, and constructive

- Work toward the internalization of their new rational beliefs by using a variety of cognitive (including imaginal), emotive, and behavioral change methods while refraining from acting in ways that are consistent with their old irrational beliefs
- Extend this process of challenging beliefs and using multimodal methods of change into other areas of their lives and to commit to doing so for as long as necessary

SKILLS AND STRATEGIES

REBT therapists see themselves as good psychological educators and therefore seek to teach their clients the ABC model of understanding and dealing with their psychological problems. They stress that there are alternative ways of addressing these problems and strive to elicit their client's informed consent at the outset and throughout the therapeutic process. If they think that a client is better suited to a different approach to therapy, they do not hesitate to effect a suitable referral.

REBT therapists frequently employ an active-directive therapeutic style and use both Socratic and didactic teaching methods. However, they vary their style from client to client (Dryden, 2002). They often begin by working with specific examples of identified client problems and help their clients to set healthy goals. They employ a sequence of steps in working on these examples that involves using the ABC framework, challenging beliefs, and negotiating suitable homework assignments with their clients. Helping clients to generalize their learning from situation to situation is explicitly built into the therapeutic process as is helping clients to identify, challenge, and change core irrational beliefs which are seen as accounting for disturbance across a broad range of relevant situations.

A major therapeutic strategy involves helping clients to become their own therapists. In doing this, REBT therapists teach their clients how to use a particular skill such as challenging irrational beliefs, model the use of this skill, and sometimes give the clients written instructions on how to use the skill on their own (Dryden, 2001). Constructive feedback is given to encourage the refinement of the skill. As clients learn how to use the skills of REBT for themselves, their therapists adopt a less active-directive, more prompting therapeutic style in order to encourage them to take increasing responsibility for their own therapeutic change.

REBT may be seen as an example of theoretically consistent eclecticism in that its practitioners draw on procedures that originate from other therapeutic approaches, but do so for purposes that are consistent with REBT theory (Dryden, 1995). REBT therapists are selective in their eclecticism and avoid the use of methods that are inefficient, mystical, or of dubious validity. REBT therapists have their preferred therapeutic goals for their clients, i.e., to help them to change their core irrational beliefs and to develop and internalize a set of core rational beliefs. However, they are ready to compromise these objectives when it becomes clear that their clients are unable or unwilling to change their core irrational beliefs. In such cases, REBT therapists help their clients by encouraging them to change their distorted inferences, to effect behavioral changes without necessarily changing their irrational beliefs or to remove themselves from negative activating events (Dryden, 1995).

The fact that REBT therapists are theoretically consistent in their eclecticism and are prepared to make compromises with their preferred therapeutic strategy shows that they are informed by REBT theory, but are flexible in their implementation of it in the consulting room. Since flexibility is a key concept in REBT, good REBT therapists in being therapeutically flexible demonstrate that they practice what they preach.

RESEARCH EVIDENCE

There is quite a lot of research indicating that psychological disturbance is correlated with irrational beliefs, but studies indicating that these beliefs are at the core of disturbance have yet to be carried out. Most scales that measure irrational and rational beliefs are deficient in one respect or another and there is a need to develop a scale with excellent psychometric properties.

Numerous studies on the effectiveness of REBT have been carried out and various meta-analyses of REBT outcome studies have been conducted which have come to different conclusions about the effectiveness of REBT. Well-controlled trials of REBT need to be done with clinical populations, employing well-trained REBT therapists who can be shown to adhere to a properly designed REBT adherence scale. Work is currently in progress to design such an adherence scale.

FUTURE DIRECTIONS

The future of REBT was considered a number of years ago in a survey of the then membership of the International Training Standards and Review Committee of the Albert Ellis Institute (Weinrach et al., 1995). Of the nine members of this committee, seven were basically optimistic about REBT's future and two were relatively pessimistic. Since I was one of the most pessimistic, I would like to explain the major source of my pessimism. My prediction is that in

the future there will be increasing emphasis on empirically supported therapies (ESTs) in our field and REBT in its specific form will fail to meet the criteria of an EST. Indeed, REBT is not even mentioned in Lyddon and Jones's (2001) edited text on the empirically supported cognitive therapies. There are no academic centers of excellence where the empirical study of REBT is being conducted and as I noted in a previous section there is no well-validated therapist adherence or competency scale to determine that REBT will be correctly and competently delivered in any future efficacy studies.

Having said that, I do think that REBT's ideas will continue to be incorporated into generic CBT and will have their impact in future psychological education programs to which they are particularly suited. As such, REBT concepts will be alive and well but perhaps not under the rubric of REBT. Whether future authors acknowledge REBT as their source is debatable. But as Ellis reminds us, if this does not happen, it would be bad, but it would not be awful.

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Rehabilitation Psychology

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The rate of permanent disability has increased steadily over the years, accompanying the aging of our population, increasing rates of survival from severe physical trauma, and the precipitous rise of debilitating, incurable chronic disease. Considerable evidence attests that people who possess adaptive social–cognitive characteristics typically experience a more optimal adjustment following disability than persons who have deficits in these characteristics (for a comprehensive overview on this field, see Frank & Elliott, 2000). These characteristics are essential in adhering to self-care regimens, preventing further complications and enhancing quality of life. CBT has great potential in promoting adjustment, well-being, and personal health among persons with disabling conditions. Cognitive–behavioral interventions are the most promising and widely accepted treatments in rehabilitation psychology.

Thus, the great variety of patient and family needs in rehabilitation and community settings provides a wonderful opportunity for application of virtually all CBT approaches: behavior management, learning theory as it applies to didactics and patient education, cognitive techniques that inform psychoeducational interventions, and empirically supported CBT protocols for specific disorders and adjustment difficulties. In rehabilitation settings, CBT may be conceptualized in its broadest form.

VARIED APPLICATIONS

Types of Injury/Illness

The successful practitioner of CBT must have familiarity with all of the different disorders that are commonly encountered in various rehabilitation settings. Disorders may be classified as central neurologic (stroke, head trauma), peripheral neurologic (spinal cord injury, Guillian–Barré syndrome), orthopedic (fractures, joint replacements), medical (major surgery, chronic metabolic illness), psychiatric (schizophrenia, mental retardation), and combined. Substance use disorders are considered elsewhere in this volume; however, they are certainly prevalent in rehabilitation settings (alcohol abuse, therapeutic dependence on pain medication) and often these disorders contribute to the onset of a disability and to the development of preventable secondary complications following disability (e.g., ER visits, infections, skin ulcers).

Treatment Settings

There has been a definite trend over the past 15 years for rehabilitation resources to be reallocated from the traditional inpatient postacute setting to outpatient and home-based programs. In addition, new initiatives such as telehealth approaches are being developed to augment