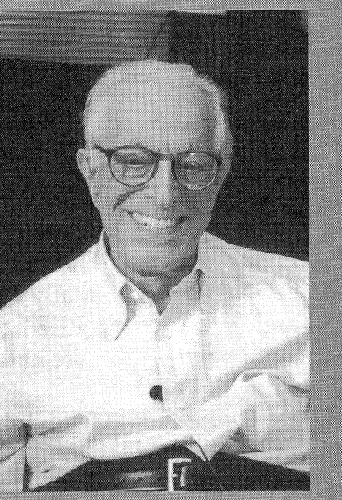

Albert Ellis (1913–2007)

6 RATIONAL EMOTIVE BEHAVIOR THERAPY

Albert Ellis[1]

OVERVIEW

Rational emotive behavior therapy (REBT), a theory of personality and a method of psychotherapy developed in the 1950s by clinical psychologist Albert Ellis, holds that when a highly charged emotional consequence (C) follows a significant activating event (A), event A may seem to, but actually does not, cause C. Instead, emotional consequences are largely created by B—the individual's *belief system.* When an undesirable emotional consequence occurs, such as severe anxiety, this usually involves the person's irrational beliefs, and when these beliefs are effectively disputed (at point D), by challenging them rationally and behaviorally, the disturbed consequences are reduced. From its inception, REBT has viewed cognition and emotion integratively, with thought, feeling, desires, and action interacting with each other. It is therefore a comprehensive cognitive–affective–behavioral theory and practice of psychotherapy (Ellis, 1962, 1994; Ellis & Dryden, 1997; Ellis & MacLaren, 1998).

[1] Albert Ellis worked on revising this chapter during the last months before his death. The changes to the chapter were finalized and approved by his wife, Debbie Joffe Ellis. This chapter represents the culmination of a lifetime spent practicing, writing about, and thinking about how to help people change self-defeating thoughts and behaviors so that they could create lives with less emotional suffering and experience greater joy.

Formerly known as rational emotive therapy (RET), this approach is more accurately referred to as rational emotive behavior therapy (REBT). From the beginning, REBT considered the importance of both mind and body or of thinking/feeling/wanting (contents of the mind according to psychology) and of behavior (the operations of the body). It has stressed that personality change can occur in both directions: therapists can talk with people and attempt to change their minds so that they will behave differently, or they can help clients to change their behaviors and thus modify their thinking. As stated in several early writings on REBT that are reprinted in *The Albert Ellis Reader* (Ellis & Blau, 1998), REBT theory states that humans rarely change a profound self-defeating belief unless they act against it. Thus, it is most accurately called rational emotive behavior therapy.

Basic Concepts

The main propositions of REBT can be described as follows:

1. *People are born with a potential to be rational (self-constructive) as well as irrational (self-defeating).* They have predispositions to be self-preserving, to think about their thinking, to be creative, to be sensuous, to be interested in other people, to learn from their mistakes, and to actualize their potential for life and growth. They also tend to be self-destructive, to be short-range hedonists, to avoid thinking things through, to procrastinate, to repeat the same mistakes, to be superstitious, to be intolerant, to be perfectionistic and grandiose, and to avoid actualizing their potential for growth.

2. *People's tendency to irrational thinking, self-damaging habituations, wishful thinking, and intolerance is frequently exacerbated by their culture and their family group.* Their suggestibility (or conditionability) is greatest during their early years because they are dependent on, and highly influenced by, family and social pressures.

3. *Humans perceive, think, emote, and behave simultaneously.* They are, therefore, at one and the same time cognitive, conative (purposive), and motoric. They rarely act without implicit thinking. Their sensations and actions are viewed in a framework of prior experiences, memories, and conclusions. People seldom emote without thinking because their feelings include and are usually triggered by an appraisal of a given situation and its importance. People rarely act without simultaneously perceiving, thinking, and emoting because these processes provide reasons for acting. For this reason, it is usually desirable to use a variety of perceptual–cognitive, emotive–evocative, and behavioralistic–reeducative methods (Bernard & Wolfe, 1993; Ellis, 1962, 1994, 2001a, 2001b, 2002, 2003a; Walen, DiGiuseppe, & Dryden, 1992).

4. *Even though all the major psychotherapies employ a variety of cognitive, emotive, and behavioral techniques, and even though all (including unscientific methods such as witch doctoring) may help individuals who have faith in them, they are probably not all equally effective or efficient.* Highly cognitive, active–directive, homework-assigning, and discipline-oriented therapies such as REBT are likely to be more effective, usually in briefer periods and with fewer sessions.

5. *REBT emphasizes the philosophy of unconditional acceptance: specifically unconditional self-acceptance (USA), unconditional other acceptance (UOA), and unconditional life acceptance (ULA).* This is explained in *The Myth of Self-Esteem* (Ellis, 2005). The humanistic principle of unconditional acceptance holds this assumption regarding human worth: I exist, I deserve to exist, I am a fallible human and I can choose to accept myself unconditionally with my flaws and mistakes, with or without great achievements—simply because I am alive, simply because I exist. It says that conditional self-esteem is one of the greatest of all human disturbances, as it leads to people praising themselves when they do well and are approved by others and damning themselves if they don't do well and

others disapprove of them. Rating traits and behaviors can be beneficial, as it allows one to learn from mistakes and to improve and grow, but to overgeneralize and rate one's whole worth, being, and totality as "good" or "bad" is inaccurate and harmful. A person's totality is too complex and ephemeral to define and measure. Hence, USA, not self-esteem, is recommended in REBT.

UOA holds that people condemn others' iniquitous thoughts, feelings, and actions but accept the others as fallible humans—just as they are. ULA encourages acceptance of adversities that we neither create nor can change—such as death of loved ones, physical disabilities, hurricanes, and floods.

REBT recognizes that life contains inevitable suffering as well as pleasure and that accepting the unpleasant circumstances that can't be changed can lead to emotional stability, self-actualization, and great fulfillment.

6. *Rational emotive behavior therapists do not believe a warm relationship between client and counselor is a necessary or a sufficient condition for effective personality change, although it is quite desirable.* They stress unconditional acceptance of and close collaboration with clients, but they also actively encourage clients to unconditionally accept themselves with their inevitable fallibility. In addition, therapists may use a variety of practical methods, including didactic discussion, behavior modification, bibliotherapy, audiovisual aids, and activity-oriented homework assignments. To discourage clients from becoming unduly dependent, therapists often use hardheaded methods of convincing them that they had better resort to self-discipline and self-direction.

7. *Rational emotive behavior therapy uses role playing, assertion training, desensitization, humor, operant conditioning, suggestion, support, and a whole bag of other "tricks."* As Arnold Lazarus points out in his "multimodal" therapy, such wide-ranging methods are effective in helping clients achieve deep-seated cognitive change. REBT is not just oriented toward symptom removal, except when it seems that this is the only kind of change likely to be accomplished. It is designed to help people examine and change some of their basic values—particularly those that keep them disturbed. If clients seriously fear failing on the job, REBT does not merely help them give up this particular symptom; it also tries to show them how to minimize their basic "awfulizing" tendencies.

The usual goal of REBT is to help people reduce their underlying symptom-creating propensities. There are two basic forms of rational emotive behavior therapy: general REBT, which is almost synonymous with cognitive–behavior therapy, and preferential REBT, which includes general REBT but also emphasizes a profound philosophical change. General REBT tends to teach clients rational or healthful behaviors. Preferential REBT teaches them how to dispute irrational ideas and unhealthful behaviors and to become more creative, scientific, and skeptical thinkers.

8. *REBT holds that most neurotic problems involve unrealistic, illogical, self-defeating thinking and that if disturbance-creating ideas are vigorously disputed by logico-empirical and pragmatic thinking, they can be minimized.* No matter how defective people's heredity may be, and no matter what trauma they may have experienced, the main reason why they usually now overreact or underreact to adversities (at point A) is that they *now* have some dogmatic, irrational, unexamined beliefs (at point B). Because these beliefs are unrealistic, they will not withstand rational scrutiny. They are often deifications and devilifications of themselves and others, and they tend to wane when empirically checked, logically disputed, and shown to be impractical. Thus, a woman with severe emotional difficulties does not merely believe it is undesirable if her lover rejects her. She tends to believe, also, that (a) it is awful; (b) she cannot stand it; (c) she should not, *must* not be rejected; (d) she will never be accepted by a desirable partner; (e) she is a worthless person because one lover has rejected her; and (f) she deserves to be rejected for being so worthless. Such common covert hypotheses are illogical, unrealistic, and destructive. They can

be revealed and disputed by a rational emotive behavior therapist who shows clients how to think more flexibly and scientifically, and the rational emotive therapist is partly that: an exposing and skeptical scientist.

9. *REBT shows how activating events or adversities (A) in people's lives contribute to but do not directly cause emotional consequences (C); these consequences stem from people's interpretations of the activating events or adversities—that is, from their unrealistic and overgeneralized beliefs (B) about those events.* The "real" cause of upsets, therefore, lies mainly in people, not in what happens to them (even though gruesome experiences obviously have considerable influence over what people think and feel). REBT provides clients with several powerful insights. Insight number one is that a person's self-defeating behavior usually follows from the interaction of A (adversity) and B (belief about A). Disturbed consequences (C) therefore usually follow the formula A–B–C.

Insight number two is the understanding that although people have become emotionally disturbed (or have *made* themselves disturbed) in the past, they are *now* upset because they keep indoctrinating themselves with similar constructed beliefs. These beliefs do not continue because people were once "conditioned" and so now hold them "automatically." No! People still, here and now, actively reinforce them, and their present active self-propagandizations and constructions keep those constructed beliefs alive. Unless people fully admit and face their own responsibilities for the continuation of their dysfunctional beliefs, it is unlikely that they will be able to uproot them.

Insight number three acknowledges that *only hard work and practice* will correct irrational beliefs—and keep them corrected. Insights 1 and 2 are not enough! Commitment to repeated rethinking of irrational beliefs and repeated actions designed to undo them will likely extinguish or minimize them.

10. *Historically, psychology was considered an S–R science, where S means "stimulus" and R means "response."* Later, it became evident that similar stimuli produce different responses in different people. This was presumed to mean that something between the S and the R is responsible for such variations.

An analogy may be helpful. If you hit the same billiard ball from the same spot with exactly the same force and let it bounce off the side of the billiard table, that ball will always come back to exactly the same spot. Otherwise, no one would play billiards. Therefore, hitting the billiard ball is the S (stimulus) and the movement of the ball is the R (response). However, suppose there were a tiny person inside a billiard ball who could control, to some degree, the direction and velocity of the ball after it was hit. Then the ball could move to different locations because the tiny person inside could guide it to a certain extent.

An analogous concept was introduced into psychology in the late 1800s by James McKeen Cattell, an American psychologist studying with Wilhelm Wundt in Leipzig, Germany. In so doing, he launched an entirely different kind of psychology known as *idiographic psychology,* in contrast to the *nomothetic psychology* that Wundt and his students were working on. Wundt and his followers were looking for average behavior, or S–R behavior, and were discounting individual variations. The truth was, according to them, the average. Cattell disagreed, and he introduced a psychology that acknowledged the importance of recognizing *individual differences.* As a result, the S–R concept changed to S–O–R. The O stood for "organism," but what it really meant was that the ball (or the person) had a mind of its own and that it did not go precisely where a ball with no mind of its own would go, because O had some degree of independence.

REBT includes precisely the same concept. RE represents the contents of the mind: rationality and emotions. REBT therapists attempt to change people's thinking and feelings (let's call the combination the *philosophy* of a person), with the goal of enabling them to change their behavior via a new understanding (rationality) and a new set of feelings (emotions) about self and others. By showing their clients how to combine

thinking and feeling, REBT therapists have given the little man in the billiard ball the ability to change directions. When the ball is hit (confronted with particular stimuli) again, it no longer goes where it used to go.

In REBT, we want to empower individuals, by changing their thinking and feelings, to act differently—in a manner desired by the client, by the therapist, and by society. At the same time, REBT encourages people to act differently—this is where the B (for "behavior") comes in—and thereby to think and feel differently. The interaction goes both ways! Thinking, feeling, and behaving seem to be separate human processes, but as Ellis said in his first paper on REBT in 1956, they actually go together holistically and inevitably influence each other. When you think, you feel and act; when you feel, you think and act; and when you act, you think and feel. That is why REBT uses many cognitive, emotive, and behavioral methods to help clients change their disturbances.

Other Systems

REBT differs from psychoanalytic schools of psychotherapy by eschewing free association, compulsive gathering of material about the client's history, and most dream analysis. It is not concerned with the presumed sexual origins of disturbance or with the Oedipus complex. When transference does occur in therapy, the rational therapist is likely to attack it, showing clients that transference phenomena tend to arise from the irrational belief that they must be loved by the therapist (and others). Although REBT practitioners are much closer to modern neoanalytic schools, such as those of Karen Horney, Erich Fromm, Harry Stack Sullivan, and Franz Alexander, than to the Freudian school, they employ considerably more persuasion, philosophical analysis, homework activity assignments, and other directive techniques than practitioners of these schools.

REBT overlaps significantly with Adlerian theory, but it departs from the Adlerian practices of stressing early childhood memories and insisting that social interest is the heart of therapeutic effectiveness. REBT is more specific than Adler's Individual Psychology in disclosing, analyzing, and disputing clients' concrete internalized beliefs and is closer in this respect to general semantic theory and philosophical analysis than to Individual Psychology. It is also much more behavioral than Adlerian therapy.

Adler (1931, 1964) contended that people have basic fictional premises and goals and that they generally proceed quite logically on the basis of these false hypotheses. REBT, on the other hand, holds that people, when disturbed, may have both irrational premises and illogical deductions from these premises. Thus, in Individual Psychology, a male who has the unrealistic premise that he *should* be the king of the universe but actually has only mediocre abilities is shown that he is "logically" concluding that he is an utterly inferior person. But in REBT this same individual, with the same irrational premise, is shown that in addition to his "logical" deduction, he may be making several other illogical conclusions. For example, he may be concluding that (1) he should be king of the universe because he was once king of his own family; (2) his parents will be impressed by him only if he is outstandingly achieving and *therefore* he must achieve outstandingly; (3) if he cannot be king of the universe, he might as well do nothing and get nowhere in life; and (4) he deserves to suffer for not being the noble king that he should be.

REBT has much in common with parts of the Jungian therapeutic outlook, especially in that it views clients holistically, holds that the goals of therapy include growth and achievement of potential as well as relief of disturbed symptoms, and emphasizes enlightened individuality. However, REBT deviates radically from Jungian treatment because Jungians are preoccupied with dreams, fantasies, symbol productions, and the mythological or archetypal contents of their clients' thinking—most of which the REBT practitioner deems a waste of time.

REBT is in close agreement with person-centered or relationship therapy in some ways: they both emphasize what Carl Rogers (1961) calls *unconditional positive regard* and what in rational emotive psychology is called *full acceptance, unconditional acceptance,* or *tolerance.* Rational therapists differ from Rogerian therapists in that they actively *teach* (1) that blaming is the core of much emotional disturbance; (2) that it leads to dreadful results; (3) that it is possible, though difficult, for humans to learn to avoid rating themselves even while continuing to rate their performances; and (4) that they can give up self-rating by challenging their grandiose (*must*urbatory), self-evaluating assumptions and by deliberately risking (through homework activity assignments) possible failures and rejections. The REBT practitioner is more active–directive and more emotive–evocative than the person-centered practitioner (Ellis, 1962, 2001a, 2001b; Hauck, 1992).

REBT is in many respects an existential, phenomenologically oriented therapy because its goals overlap with the usual existentialist goals of helping clients to define their own freedom, cultivate individuality, live in dialogue with others, accept their experiencing as highly important, be fully present in the immediacy of the moment, and learn to accept limits in life (Ellis, 2001b, 2002). Many who call themselves existential therapists, however, are rather anti-intellectual, prejudiced against the technology of therapy, and confusingly nondirective, whereas REBT makes much use of incisive logical analysis, clear-cut techniques (including behavior modification procedures), and directiveness and teaching by the therapist.

REBT has much in common with behavior modification. Many behavior therapists, however, are mainly concerned with symptom removal and ignore the cognitive aspects of conditioning and deconditioning. REBT is therefore closer to cognitive and multimodal modifiers such as Aaron Beck, Arnold Lazarus, and Donald Meichenbaum.

HISTORY

Precursors

The philosophical origins of rational emotive behavior therapy go back to some of the Asian philosophers, such as Confucius, Lao-Tsu, and Buddha, and especially to Epicurus and the Stoic philosophers Epictetus and Marcus Aurelius. Although most early Stoic writings have been lost, their essence has come down to us through Epictetus, who in the 1st century AD wrote in *The Enchiridion,* "People are disturbed not by things, but by the view which they take of them."

The modern psychotherapist who was the main precursor of REBT was Alfred Adler. "I am convinced," he stated, "that *a person's behavior springs from his ideas*" (1964, italics in original). According to Adler (1964),

> The individual . . . does not relate himself to the outside world in a predetermined manner, as is often assumed. He relates himself always according to his own interpretation of himself and of his present problem. . . . It is his attitude toward life which determines his relationship to the outside world.

Adler (1931) put the A–B–C or S–O–R (stimulus–organism–response) theory of human disturbance neatly: No experience is a cause of success or failure. We do not suffer from the shock of our experiences—the so-called *trauma*—but we make out of them just what suits our purposes. We are self-determined by the meaning we give to our experiences, and it is almost a mistake to view particular experiences as the basis of our future life. Meanings are not determined by situations, but we determine ourselves by the meanings we give to situations. In his first book on Individual Psychology, Adler's motto was *Omnia ex opinione suspense sunt* ("Everything depends on opinion").

Another important precursor of REBT was Paul DuBois, who used persuasive forms of psychotherapy. Alexander Herzberg was one of the inventors of homework assignments. Hippolyte Bernheim, Andrew Salter, and a host of other therapists have employed hypnosis and suggestion in a highly active–directive manner. Frederick Thorne created what he called directive therapy. Franz Alexander, Thomas French, John Dollard, Neal Miller, Wilhelm Stekel, and Lewis Wolberg all practiced forms of psychoanalytic psychotherapy that diverged so far from the Freudian therapy that they resemble active–directive therapy more closely and are in many ways precursors of REBT.

In addition, a large number of individuals during the 1950s, when REBT was first being formulated, independently began to arrive at some theories and methodologies that significantly overlap with the methods outlined by Ellis (1962). These theorists include Eric Berne, Jerome Frank, George Kelly, Abraham Low, E. Lakin Phillips, Julian Rotter, and Joseph Wolpe.

Beginnings

After practicing psychoanalysis for several years during the late 1940s and early 1950s, Ellis discovered that no matter how much insight his clients gained or how well they seemed to understand events from their early childhood, they rarely lost their symptoms and still retained tendencies to create new ones. He realized that this was because they were not merely indoctrinated with irrational, mistaken ideas of their own worthlessness when they were young, but also *constructed* dysfunctional demands on themselves and others and kept *reindoctrinating* themselves with these commands (Ellis, 1962, 2001b, 2002, 2003a, 2004a; Ellis & MacLaren, 1998).

Ellis also discovered that as he pressed his clients to surrender their basic irrational premises, they often tended to resist giving up these ideas. This was not, as the Freudians hypothesized, because they hated the therapist or wanted to destroy themselves or were still resisting parent images but because they *naturally,* one might say *normally,* tended to *must*urbate. They insisted (a) that they *must* do well and win others' approval, (b) that other people *must* act considerately and fairly, and (c) that environmental conditions *must* be gratifying and free of frustration. Ellis concluded that humans are *self-talking, self-evaluating,* and *self-construing.* They frequently take strong preferences, such as desires for love, approval, success, and pleasure, and misleadingly *define* them as needs. They thereby create many of their "emotional" difficulties.

People are not exclusively the products of social learning. Their so-called pathological symptoms are the result of *bio*social processes. *Because they are human,* they tend to have strong, irrational, empirically misleading ideas; and as long as they hold on to these ideas, they tend to be what is commonly called "neurotic." These irrational ideologies are not infinitely varied or hard to discover. They can be listed under a few major headings and, once understood, quickly uncovered by REBT analysis.

Ellis also discovered that people's irrational assumptions were so biosocially deep rooted that weak methods were unlikely to budge them. Passive, nondirective methodologies (such as reflection of feeling and free association) rarely changed them. Warmth and support often helped clients live more "happily" with unrealistic notions. Suggestion or "positive thinking" sometimes enabled them to cover up and live more "successfully" with underlying negative self-evaluations. Abreaction and catharsis frequently helped them to feel better but tended to reinforce rather than eliminate their demands. Classic desensitizing sometimes relieved clients of anxieties and phobias but did not undermine their anxiety-arousing, phobia-creating fundamental meanings and philosophies.

The REBT Network provides information on the theory and practice of rational emotive therapy to mental health professionals, paraprofessionals, and the public through its Web site, publications, affiliations, and training. The REBT Network is in no way associated with the Albert Ellis Institute. In 2006, Ellis stated that the Albert Ellis Institute was following a program that was in many ways inconsistent with the theory and practice of REBT.

The REBT network has a register of numerous psychotherapists who have received training in REBT. In addition, thousands of other therapists primarily follow REBT principles, and a still greater number use some major aspects of REBT in their work. Cognitive restructuring, employed by almost all cognitive–behavior therapists today, stems mainly from REBT. But REBT also includes many other emotive and behavioral methods.

In 2004, Albert Ellis married Australian psychologist Debbie Joffe, whom he called "the greatest love of my life." She worked closely with Dr. Ellis in every aspect of his work up until his death and continues to write and give presentations and workshops on REBT. She also works with clients in private practice and is dedicated to continuing the work of her husband. Anyone interested in learning more about the life of Albert Ellis and the history of REBT will benefit from reading *Rational Emotive Behavior Therapy—It Works for Me—It Can Work for You* (Ellis, 2004a) and his autobiography, *All Out!* (Ellis, 2010).

Research Studies

Many researchers have tested the main hypotheses of REBT, and the majority of their findings support central REBT contentions (Hajzler & Bernard, 1991; Lyons & Woods, 1991; McGovern & Silverman, 1984; Silverman, McCarthy, & McGovern, 1992). These research studies show that (1) clients tend to receive more effective help from a highly active–directive approach than from a more passive one; (2) efficient therapy includes activity-oriented homework assignments; (3) people largely choose to disturb themselves and can choose to surrender these disturbances; (4) helping clients modify their beliefs helps them to make significant behavioral changes; and (5) many effective methods of cognitive therapy exist, including modeling, role playing, skill training, and problem solving.

REBT in conjunction with medication is more effective than medication alone in certain conditions. This has been shown for conditions such as major depression (Macaskill & Macaskill, 1996) and dysthymic disorder (Wang, Jia, Fang, Zhu & Huang, 1999). REBT has been shown to be an effective adjunct with inpatients with schizophrenia (Shelley, Battaglia, Lucely, Ellis & Opler, 2001), and has also been shown superior to control conditions in the treatment of obsessive–compulsive disorder, social phobia, and social anxiety (Dryden & David, 2008).

Since REBT was the first of the cognitive–behavioral psychotherapies (CBTs), all of which incorporate aspects of REBT, the research programs of CBT—especially those of Aaron T. Beck's Cognitive Therapy (CT)—serve to also support the efficacy of REBT's clinical applications. A comprehensive survey of meta-analyses that offer empirical validation for CBT in different clinical applications is found in Butler, Chapman, Forman, and Beck (2005).

Although it was the forerunner of all current cognitive–behavioral psychotherapies, REBT still offers a unique theory of emotional disturbance, one that is not completely shared by the other CBT psychotherapies. The uniqueness of REBT's model stems first of all from its claim that emotional disturbance arises from the human propensity to turn "preferences" into "demands." REBT hypothesizes that human "musts" precede Beck's (1976) "automatic thoughts" (Ellis & Whiteley, 1979).

In addition, hundreds of clinical and research papers present empirical evidence supporting REBT's main theories of personality. Many of these studies are reviewed in Ellis and Whiteley (1979). These studies tend to substantiate the following hypotheses:

1. Human thinking and emotion do not constitute two disparate or different processes but, instead, significantly overlap.
2. Although activating events or adversities (A) significantly contribute to emotional and behavioral consequences (C), people's beliefs (B) about A more importantly and more directly cause C.
3. The kinds of things people say to themselves, as well as the form in which they say these things, affect their emotions and behavior and often disturb them.
4. Humans not only think and think about their thinking but also think about thinking about their thinking. Whenever they have disturbances at C (consequence) after something unfortunate has happened in their lives at A (adversity), they tend to make C into a new A—to perceive and think about their emotional disturbances and thereby often create new ones.
5. People think about what happens to them not only in words, phrases, and sentences but also via images, fantasies, and dreams. Nonverbal cognitions contribute to their emotions and behaviors and can be used to change such behaviors.
6. Just as cognitions contribute to emotions and actions, emotions also contribute to or cause cognitions and actions, and actions contribute to or cause cognitions and emotions. When people change one of these three modalities of behaving, they concomitantly tend to change the other two (Ellis, 1994, 1998; Ellis & Dryden, 1997; Ellis & MacLaren, 1998).
7. REBT, uniquely among the schools of CBT, uses a philosophical approach that attempts to promote an overall change in the client's belief system and philosophy of life, especially in regard to demandingness and nonacceptance (Ellis, 2005), and to improve his or her functioning outside of psychotherapy (Ellis, 2004a). Furthermore, research has shown that REBT can be effectively done outside the therapeutic setting, e.g., in public presentations, to the benefit of participating volunteers and their audience members (Ellis & Joffe, 2002). Various nonpsychotherapeutic applications of REBT have been summarized by Ellis and Blau (1998). Froh, Fives, Fuller, Jacofsky, Terjesen, and Yurkewicz (2007) documented that irrationality predicted lower levels of life satisfaction, but this relationship was at least partially mediated by interpersonal relations.

PERSONALITY

Theories of Personality

Physiological Basis of Personality

REBT emphasizes the biological aspects of human personality. Obliquely, some other systems do this, too, saying something like this: "Humans are easily influenced by their parents during early childhood and thereafter remain similarly influenced for the rest of their lives unless some intervention, such as years of psychotherapy, occurs to enable them to give up this early suggestibility and to start thinking much more independently." These psychotherapeutic systems implicitly posit an "environmentalist's" position, which is actually physiologically and genetically based, because only a *special, innately predisposed* kind of person would be so prone to be "environmentally determined."

Although REBT holds that people are born constructivists and have considerable resources for human growth, and that they are in many important ways able to change their social and personal destinies, it also holds that they have powerful innate tendencies to think irrationally and to defeat themselves (Ellis, 1976, 2001b, 2003a, 2004b).

Most such human tendencies may be summarized by stating that humans are born with a tendency to want, to "need," and to condemn (1) themselves, (2) others, and (3) the world when they do not immediately get what they supposedly "need." They consequently tend to think "childishly" (or "humanly") all their lives and are able only with real effort to achieve and maintain "mature" or realistic behavior. This is not to deny, as Abraham Maslow and Carl Rogers have pointed out, that humans have impressive self-actualizing capacities. They do, and these are strong inborn propensities, too. But, alas, people frequently defeat themselves by their inborn and acquired self-sabotaging ways.

There is a great deal of evidence that people's basic personality or temperament has strong biological, as well as environmental, influences. People are born, as well as reared, with greater or lesser degrees of demandingness, and therefore they can change from demanding to *desiring* only with great difficulty. If their demandingness is largely acquired rather than innate, they still seem to have difficulty in ameliorating this tendency toward disturbance. REBT emphasizes that people nonetheless have the *choice* of changing their dysfunctional behaviors and specifically shows them many ways of doing so. It particularly stresses flexible thinking and behaving that help them remove the rigidities to which they often easily fall victim.

Social Aspects of Personality

Humans are reared in social groups and spend much of their lives trying to impress, live up to the expectations of, and outdo the performances of other people. On the surface, they are "ego-oriented," "identity-seeking," or "self-centered." Even more important, however, they usually define their "selves" as "good" or "worthwhile" when they believe that others accept and approve of them. It is realistic and sensible for people to find or fulfill themselves in their interpersonal relations and to have a good amount of what Adler calls "social interest." For, as John Donne beautifully expressed it, no one is an island unto himself or herself. The healthy individual finds it enjoyable to love and be loved by significant others and to relate to almost everyone he or she encounters. In fact, the better one's interpersonal relations are, the happier one is likely to be.

However, what is called *emotional disturbance* is frequently associated with caring *too much* about what others think. This stems from people's belief that they can accept themselves *only* if others think well of them. When disturbed, they escalate their desire for others' approval, and the practical advantages that normally go with such approval, into an absolutistic *dire need* to be liked, and in so doing they become anxious and prone to depression. Given that we have our being-in-the-world, as the existentialists point out, it is quite *important* that others to some degree value us. But it is our tendency to exaggerate the importance of others' acceptance in a way that often leads to self-denigration (Ellis, 1962, 2001a, 2002, 2005; Ellis & Harper, 1997; Hauck, 1992).

Psychological Aspects of Personality

How, specifically, do people become psychologically disordered? According to REBT, they usually needlessly upset themselves as follows: When individuals feel upset at point C after experiencing an obnoxious adversity at point A, they almost always convince themselves of irrational beliefs (B), such as "I *can't stand* adversity! It is *awful* that it

exists! It *shouldn't exist!* I am a *worthless person* for not being able to get rid of it!" This set of beliefs is irrational for several reasons:

1. People *can* stand obnoxious adversities, even though they may never like them.
2. Adversities are hardly awful, because *awful* is an essentially indefinable term, with surplus meaning and little empirical referent. By calling the noxious events awful, the disturbed individual means they are (a) highly inconvenient and (b) totally inconvenient, disadvantageous, and unbeneficial. But what noxious stimuli can, in point of fact, be totally inconvenient, disadvantageous, and unbeneficial? Or as bad as it could be?
3. By holding that the unfortunate happenings in their lives *absolutely should not* exist, people really imply that they have godly power and that whatever they *want* not to exist *must* not. This hypothesis is, to say the least, highly dubious!
4. By contending that they are *worthless persons* because they have not been able to ward off unfortunate events, people hold that they should be able to control the universe and that because they are not succeeding in doing what they cannot do, they are obviously worthless. (What drivel!)

The basic tenet of REBT is that emotional *upsets,* as distinguished from feelings of sorrow, regret, annoyance, and frustration, largely stem from irrational beliefs. These beliefs are irrational because they magically insist that something in the universe *should, ought,* or *must* be different from the way it is. Although these irrational beliefs are ostensibly connected with reality (the adversity at point A), they are dogmatic ideas beyond the realm of empiricism. They generally take the form of the statement "Because I want something, it is not only desirable and preferable that it exists, but it absolutely should, and it is awful when it doesn't!" No such proposition, obviously, can be substantiated. Yet such propositions are devoutly held, every day, by literally billions of humans. That is how incredibly disturbance prone most people are!

Once people become emotionally upset—or, rather, upset themselves!—a peculiar thing frequently occurs. Most of the time, they know they feel anxious, depressed, or otherwise agitated, and they also know their symptoms are undesirable and (in our culture) socially disapproved. For who approves or respects highly agitated or "crazy" people? They therefore make their emotional consequence (C) or symptom into another activating event or adversity (A) and create a secondary symptom (C2) about this new A!

Thus, if you originally start with something like (A): "I did poorly on my job today" and (B): "Isn't that horrible!" you may wind up with (C): feelings of anxiety, worthlessness, and depression. You may now start all over with (A2): "I feel anxious and depressed, and worthless!" Then you proceed to (B2): "Isn't *that* horrible!" Now you end up with (C2): even greater feelings of anxiety, worthlessness, and depression. In other words, once you become anxious, you frequently make yourself anxious about *being* anxious; once you become depressed, you make yourself depressed about *being* depressed; and so on. You now have two consequences or symptoms for the price of one, and you often go around and around, in a vicious cycle of (1) condemning yourself for doing poorly at some task, (2) feeling guilty or depressed because of this self-condemnation, (3) condemning yourself for your feelings of guilt and depression, (4) condemning yourself for condemning yourself, (5) condemning yourself for seeing your disturbances and still not eliminating them, (6) condemning yourself for going for psychotherapeutic help and still not getting better, (7) condemning yourself for being more disturbed than other individuals, (8) concluding that you are without question hopelessly disturbed and that nothing can be done about it; and so on, in an endless spiral.

No matter what your original self-condemnation is about—and it hardly matters what it was, because your adversity (A) is often not that important—you eventually

tend to end up with a chain of disturbed reactions only obliquely related to the original "traumatic events" of your life. That is why dramatic psychotherapies are often misleading—they overemphasize "traumatic events" rather than self-condemnatory attitudes *about* these events—and that is why these therapies fail to help with any secondary disturbance, such as being anxious about being anxious. Most major psychotherapies also concentrate either on A, the adversities, or on C, the emotional consequences, and rarely consider B, the belief system, which is a vital factor in creating self-disturbance.

Even assuming, moreover, that adversities and emotional consequences are important, as in posttraumatic stress disorder (PTSD), for instance, there is not too much we can do by concentrating our therapeutic attention on them. The adversities belong to the past. There is nothing that anyone can do to *change* the past.

As for clients' present feelings, the more we focus on them, the worse they are likely to feel. If we keep talking about their anxiety and getting clients to reexperience this feeling, they can become still more anxious. The best way to interrupt their disturbed process is usually to help them to focus on their anxiety-creating belief system—point B—because that is the main (though not the only) cause of their disturbance.

If, for example, say a male client feels anxious during a therapy session and the therapist reassures him that there is nothing for him to be anxious about, he may achieve a palliative "solution" to his problem by thinking, "I am afraid that I will act foolishly right here and now, and wouldn't that be awful! No, it really wouldn't be awful, because *this* therapist will accept me, anyway." He may thereby temporarily decrease his anxiety.

Or the therapist can concentrate on the past adversities in the client's life that are presumably making him anxious—by, for instance, showing him that his mother used to point out his deficiencies, that he was always afraid of speaking to authority figures who might disapprove of him, and that, *therefore,* because of all his prior and present fears, in situations A1, A2, A3 . . . A11, he is *now* anxious with the therapist. Whereupon the client might convince himself, "Ah! Now I see that I am generally anxious when I am faced with authority figures. No wonder I am anxious even with my own therapist!" In which case, he might feel better and temporarily lose his anxiety.

It would be better, however, for the therapist to show this client that he was anxious as a child and is still anxious with authority figures because he has always believed, and still believes, that he *must* be approved, that it is *awful* when an authority figure disapproves of him. Then the anxious client would tend to become diverted from concentrating on A (criticism by an authority figure) and from C (his feelings of anxiety) to a consideration of B (his irrational belief system). This diversion would help him become immediately nonanxious—for when he is focusing on "What am I telling myself (at B) to *make myself* anxious?" he cannot focus on the self-defeating, useless thought "Wouldn't it be terrible if I said something stupid to my therapist and if even he disapproved of me!" He would begin actively to dispute (at point D) his irrational beliefs, and not only could he then temporarily change them (by convincing himself, "It would be *unfortunate* if I said something stupid to my therapist and he disapproved of me, but it would hardly be *terrible* or *catastrophic!*"), but he would also tend to have a much weaker allegiance to these self-defeating beliefs the next time. Thus he would obtain, by the therapist's helping him to focus primarily on B rather than on A and C, curative and preventive, rather than merely palliative, results in connection with his anxiety.

This is the basic personality theory of REBT: Humans largely create their own emotional consequences. They appear to be born with a distinct proneness to do so, and they learn, through social conditioning, to exaggerate (rather than to minimize) that proneness. They nonetheless have considerable ability to understand what they foolishly believe to cause their distress (because they have a unique talent for thinking about their

thinking) and to train themselves to change their self-sabotaging beliefs (because they also have a unique capacity for self-discipline or self-reconditioning). If they *think* and *work* hard at understanding and contradicting their *must*urbatory belief systems, they can make amazing curative and preventive changes. And if they are helped to zero in on their crooked thinking and unhealthy emoting and behaving by a highly active–directive homework-assigning therapist, they are more likely to change their beliefs than if they work with a dynamically oriented, client-centered, conventional existential therapist or with a classical therapist who emphasizes behavior modification.

Although REBT is mainly a theory of personality change, it is also a personality theory in its own right (Ellis, 1994, 2001b, 2002).

Variety of Concepts

Ellis largely agrees with Sigmund Freud that the pleasure principle (or short-range hedonism) tends to run most people's lives; with Karen Horney and Erich Fromm that cultural influences as well as early family influences tend to play a significant part in bolstering people's irrational thinking; with Alfred Adler that fictitious goals tend to order and run human lives; with Gordon Allport that when individuals begin to think and act in a certain manner, they find it very difficult to think or act differently, even when they want very much to do so; with Ivan Pavlov that our species's large cerebral cortex provides humans with a secondary signaling system through which they often become cognitively conditioned; with Jerome Frank that people are exceptionally prone to the influence of suggestion; with Jean Piaget that active learning is much more effective than passive learning; with Anna Freud that people frequently refuse to acknowledge their mistakes and resort to defenses and rationalizations to cover up underlying feelings of shame and self-deprecation; and with Abraham Maslow and Carl Rogers that humans, however disturbed they may be, have great untapped capacity for growth.

On the other hand, REBT has serious differences with certain aspects of many popular personality theories.

1. It opposes the Freudian concept that people have clear-cut libidinous instincts, which if thwarted must lead to emotional disturbances. It also objects to the view of William Glasser and many other therapists that all humans *need* to be approved and to succeed—and that if these needs are blocked, they cannot possibly accept themselves or be happy. REBT, instead, posits strong human *desires,* which become needs or necessities only when people foolishly define them as such.

2. REBT places the Oedipus complex as a relatively minor subheading under people's major irrational belief that they absolutely have to receive the approval of their parents (and others), that they *must not* fail (at lusting or almost anything else), and that when they are disapproved of and when they fail, they are worthless. Many so-called sexual problems—such as sexual inadequacy, severe inhibition, and obsessive–compulsive behavior—partly result from people's irrational beliefs that they *need* approval, success, and immediate gratification.

3. REBT holds that people's environment, particularly their childhood parental environment, *reaffirms* but does not always *create* strong tendencies to think irrationally and to be disturbed. Parents and culture teach children standards and values, but they do not always teach them "musts" about these values. People naturally and *easily* add rigid commands to socially inhibited standards.

4. REBT looks skeptically at anything mystical, devout, transpersonal, or magical when these terms are used in the strict sense. It maintains that reason itself is limited, ungodlike, and absolute (Ellis, 1962, 1994). It holds that humans may in some ways transcend themselves or experience altered states of consciousness—for example, hypnosis—that

may enhance their ability to know themselves and the world and to solve some of their problems; but it does not believe that people can transcend their humanness and become superhuman. They can become more adept and competent, but they still remain fallible and in no way godly. REBT holds that minimal disturbance goes with people's surrendering all pretensions to superhumanness and accepting, while still disliking, their own and the world's limitations.

5. For REBT, no part of a human is to be reified into an entity called the unconscious, although it holds that people have many thoughts, feelings, and even acts of which they are unaware. These "unconscious" or tacit thoughts and feelings are, for the most part, slightly below the level of consciousness, are not often deeply repressed, and can usually be brought to consciousness by brief, incisive probing. Thus, suppose a wife is angrier with her husband than she is aware of and that her anger is motivated by the unconscious grandiose thought, "After all I've done for him he *absolutely should* be having sex with me more frequently!" A rational emotive behavior therapist (who suspects that she has these unconscious feelings and thoughts) can usually induce her to (a) hypothesize that she is angry with her husband and look for some evidence with which to test that hypothesis and (b) check herself for grandiose thinking whenever she feels angry. In the majority of instances, without resorting to free association, dream analysis, analyzing the transference relationship, hypnosis, or other presumably "depth-centered" techniques for revealing unconscious thoughts and feelings, REBT practitioners can reveal these in short order—sometimes in a matter of minutes. They show the client her unconsciously held attitudes, beliefs, and values and, in addition, teach the client how to bring her self-defeating, hidden ideas to consciousness and actively dispute them.

People often see how REBT differs significantly from psychoanalysis, Rogerianism, gestalt therapy, and orthodox behavior therapy but have difficulty seeing how it differs from more closely related schools, such as Adler's Individual Psychology. REBT agrees with nearly all of Adlerian theory but has a more hardheaded and behavior-oriented practice (Ellis, 1994; Ellis & Dryden, 1997; Ellis & MacLaren, 1998). It also ignores most of the Adlerian emphasis on early-childhood memories and the importance of birth order. But the basic mistakes that Adlerians emphasize are similar to the irrational beliefs of REBT.

REBT overlaps with Beck's cognitive therapy (CT) in several ways, but it also differs in significant ways: (1) It usually disputes clients' irrational beliefs more actively, directly, quickly, and forcefully than does CT. (2) It emphasizes absolutist *musts* more than CT and holds that most major irrationalities implicitly stem from dogmatic *shoulds* and *musts*. (3) It uses psychoeducational approaches—such as books, pamphlets, audiovisual materials, talks, and workshops—as intrinsic elements and stresses their use more than CT does. (4) It clearly distinguishes between healthy negative feelings (e.g., sadness and frustration) and unhealthy negative feelings (e.g., depression and hostility). (5) REBT emphasizes several emotive-evocative methods—such as shame-attacking exercises, rational emotive imagery, and *strong* self-statements and self-dialogues—that CT often neglects. (6) REBT favors *in vivo* desensitization, preferably done implosively, more than CT does. (7) REBT often uses penalties as well as reinforcements to help people do their homework (Ellis, 2001b, 2002, 2003a). (8) It emphasizes profound philosophical and *unconditional* acceptance of oneself, other people, and the world more than CT does (Ellis, 2005).

REBT is humanistic and to some degree existentialist. It first tries to help people minimize their emotional and behavioral disturbances, but it also encourages them to make themselves happier than they normally are and to strive for more self-actualization and human growth (Ellis, 1994). It is closer in some respects to Rogers's (1961)

person-centered approach than to other therapies in that it mainly emphasizes unconditional self-acceptance (USA) as well as unconditional other-acceptance (UOA) no matter how well or how badly people may perform (Ellis, 2001a, 2002, 2003a, 2005; Ellis & Blau, 1998; Ellis & Harper, 1997; Hauck, 1992).

PSYCHOTHERAPY

Theory of Psychotherapy

According to the theory of REBT, neurotic disturbance occurs when individuals demand that their wishes be satisfied, that they succeed and be approved, that others treat them fairly, and that the universe be more pleasant. When people's demandingness (and not their desirousness) gets them into emotional trouble, they tend to alleviate their pain in both inelegant and elegant ways.

Distraction

Just as a whining child can be temporarily diverted by receiving a piece of candy, so can adult demanders be transitorily sidetracked by distraction. Thus, a therapist who sees someone who is afraid of being rejected (that is, one who demands that significant others accept him) can try to divert him into activities such as sports, aesthetic creation, a political cause, yoga exercises, meditation, or preoccupation with the events of his childhood. While the individual is so diverted, he will not be so inclined to demand acceptance by others and to make himself anxious. Distraction techniques are mainly palliative, given that distracted people are still demanders and that, as soon as they are not diverted, they will probably return to their destructive commanding.

Satisfaction of Demands

If a client's insistences are always catered to, she or he will tend to feel better (but will not necessarily get better). To arrange this kind of "solution," a therapist can give her or his love and approval, provide pleasurable sensations (for example, put the client in an encounter group to be hugged or massaged), teach methods of having demands met, or give reassurance that the client eventually will be gratified. Many clients will feel immensely better when accorded this kind of treatment, but they may well have their demandingness reinforced rather than minimized.

Magic and Mysticism

A boy who demands may be assuaged by magic—for example, by his parents saying that a fairy godmother will soon satisfy his demands. Similarly, adolescent and adult demanders can be led to believe (by a therapist or someone else) that their therapist is a kind of magician who will take away their troubles merely by listening to what bothers them. These magical solutions sometimes work beautifully by getting true believers to feel better and give up disturbed symptoms, but they rarely work for any length of time and frequently lead to eventual disillusionment.

Minimization of Demandingness

The most elegant solution to the problems resulting from irrational demandingness is to help individuals to become less demanding. As children mature, they normally become

less childish and less insistent that their desires be immediately gratified. REBT encourages clients to achieve minimal demandingness and maximum tolerance.

REBT practitioners may, at times, use temporary "solutions," such as distraction, satisfying the client's "needs," and even (on rare occasions) "magic." But they realize that these are low-level, inelegant, palliative solutions, mainly to be used with clients who refuse to accept a more elegant and permanent resolution. The therapist prefers to strive for the highest-order solution: minimizing *must*urbation, perfectionism, grandiosity, and low frustration tolerance.

In REBT, therapists help clients to minimize their absolutistic core philosophies by using cognitive, emotive, and behavioristic procedures.

1. REBT cognitively attempts to show clients that giving up perfectionism can help them lead happier, less anxiety-ridden lives. It teaches them how to recognize their *shoulds, oughts,* and *musts;* how to separate rational (preferential) from irrational (absolutistic) beliefs; how to be logical and pragmatic about their own problems; and how to accept reality, even when it is pretty grim. REBT is oriented toward helping disturbed people philosophize more effectively and thereby uncreate the needless problems they have constructed. Not only does it employ a one-to-one Socratic-type dialogue between the client and the therapist, but it also, in group therapy, encourages other members of the group to discuss, explain, and reason with other ineffectually thinking clients. It teaches logical and semantic precision—that a man's being rejected does not mean that he will always be rejected and that a woman's failure does not mean she cannot succeed. It helps clients to keep asking themselves whether the worst things that could happen would really be as bad as they melodramatically fantasize they would be.

2. REBT emotively employs various means of dramatizing preferences and *musts* so that clients can clearly distinguish between the two. Thus, the therapist may employ *role playing* to show clients how to adopt different ideas; *humor* to reduce disturbance-creating ideas to absurdity; *unconditional acceptance* to demonstrate that clients are acceptable, even with their unfortunate traits; and *strong disputing* to persuade people to give up some of their "crazy thinking" and replace it with more efficient notions. The therapist may also encourage clients, either in individual or group counseling, to take risks (for example, telling another group member what they really think of him or her) that will prove to be not that risky; to reveal themselves (for example, by sharing the details of their sexual problems); to convince themselves that others can accept them with their failings; and to get in touch with their "shameful" feelings (such as hostility) so that they can zero in on exactly what they are telling themselves to create these feelings. Experiential exercises are used to help clients overcome denial of their feelings and then work at REBT's ABCDs (the D refers to disputation) to change their self-defeating emotions. The therapist may also use pleasure-giving techniques, not merely to satisfy clients' unreasonable demands for immediate gratification but also to show them they are capable of doing many pleasant acts that they think, wrongly, they cannot do, and that they can seek pleasure for its own sake, even though others may frown upon them for doing so.

3. *Behavior therapy* is employed in REBT not only to help clients to become habituated to more effective ways of performing but also to help change their cognitions. Thus, their demandingness that they perform beautifully may be whittled away by their agreeing to do risk-taking assignments, such as asking a desired person for a date, deliberately failing at some task (for example, making a real attempt to speak badly in public), imagining themselves in failing situations, and throwing themselves into unusual activities that they consider especially dangerous. Clients' demandingness that others treat them fairly and that the world be kind may be challenged by the therapist's encouraging them to stay in poor circumstances and teach themselves, at least temporarily, to accept them; to take

on hard tasks (such as enrolling in college); to imagine themselves having a rough time at something and making themselves not feel terribly upset or having to "cop out" of it; to allow themselves to do a pleasant thing, such as go to a movie or see their friends, only after they have done unpleasant but desirable tasks, such as studying French or finishing a report for their boss; and so on. REBT often employs operant conditioning to reinforce people's efforts to change undesirable behavior (e.g., smoking or overeating) or to change irrational thinking (e.g., condemning themselves when they smoke or overeat).

REBT accepts that there are many kinds of psychological treatment and that most of them work to some degree. An elegant system of therapy includes (a) economy of time and effort, (b) rapid symptom reduction, (c) effectiveness with a large percentage of different kinds of clients, (d) depth of solution of the presenting problems, and (e) lastingness of the therapeutic results. Philosophically, REBT combats absoluteness and ruthlessly persists at undermining childish demandingness—the main element of much neurotic disturbance (Ellis, 1962, 1994, 2002). It theorizes that if people learn to only strongly prefer, instead of grandiosely insisting, that their desires be fulfilled, they can make themselves remarkably less disturbed and less disturb*able* (Ellis, 1999, 2001a, 2001b, 2002).

Process of Psychotherapy

REBT helps clients acquire a more realistic, tolerant philosophy of life. Because some of its methods are similar to methods used by other therapists, they are not detailed in this section. Most of the space here is devoted to the cognitive–persuasive aspects of REBT, one of its most distinguishing characteristics.

REBT practitioners generally do not spend a great deal of time listening to the client's history, encouraging long tales of woe, sympathetically getting in tune with emotionalizing, or carefully and incisively reflecting feelings. They may use all these methods, but they generally keep them short because they consider most long-winded dialogues a form of indulgence therapy, in which the client may be helped to *feel* better but rarely to *get* better. Even when these methods work, they are often inefficient and sidetracking (Ellis, 2001a).

Similarly, the rational emotive behavior therapist makes little use of free association, dream analysis, interpretations of the transference relationship, explanations of the client's present symptoms in terms of past experiences, disclosure, analysis of the so-called Oedipus complex, and other dynamically directed interpretations or explanations. When they are employed at all, they are used to help clients see some of their basic irrational ideas.

Thus, if a male therapist notes that a female client rebels against him just as she previously rebelled against her father during childhood, he will not interpret the present rebelliousness as stemming from the prior pattern but, instead, will probably say something like this:

> It looks like you frequently hated your father because he kept forcing you to follow certain rules you considered arbitrary and because you kept convincing yourself, "My father isn't being considerate of me and he *ought* to be! I'll get even with him!" I think you are now telling yourself approximately the same thing about me. But your angry rebelliousness against your father was senseless because (a) he was not a *total bastard* for perpetrating a bastardly act; (b) there was no reason why he *ought* to have been considerate of you (although there were several reasons why it *would have been preferable* if he had been); and (c) your getting angry at him and trying to "get even with him" would not, probably, encourage him to act more kindly but would actually induce him to be more cruel.

You consequently confused—as most children will—being displeased with your father's behavior with being "righteously" angry at him, and you needlessly made yourself upset about his real or imagined unfair treatment of you. In my case, too, you may be doing much the same thing. You may be taking the risks that I encourage you to take and insisting that they are too onerous (when in fact, they are only onerous), and after assuming that I am wrong in suggesting them (which I indeed may be), you are condemning me for my supposedly wrong deeds. Moreover, you are quite possibly assuming that I am "wrong" and a "louse" for being wrong because I resemble, in some ways, your "wrong" and "lousy" father.

But this is another illogical conclusion (that I resemble him in all ways) and an irrational premise (that I, like your father, am a *bad person* if I do a wrong act). So you are not only *inventing* a false connection between me and your father, but you are creating today, as you have done for many years now, a renewed *demand* that the world be an easy place for you and that everyone *ought* to treat you fairly. Now, how can you challenge these irrational premises and illogical deductions?

REBT practitioners often employ a rapid-fire active–directive–persuasive–philosophical methodology. In most instances, they quickly pin clients down to a few basic dysfunctional beliefs. They challenge them to try to defend these ideas; show that they contain illogical premises that cannot be substantiated logically; analyze these ideas and actively dispute them; vigorously show why they cannot work and why they will almost inevitably lead to more disturbance; reduce these ideas to absurdity, sometimes in a humorous manner; explain how they can be replaced with more rational philosophies; and teach clients how to think scientifically so that they can observe, logically parse, and minimize any subsequent irrational ideas and illogical deductions that lead to self-defeating feelings and behaviors.

When working with certain clients who have suffered extreme traumas (such as incest, rape, child abuse, or other violent situations), REBT practitioners may well be quite empathic and go more slowly before doing any vigorous disputing of clients' dysfunctional beliefs about these traumatic events or about anything else in their lives.

To show how REBT is sometimes, but hardly always, actively–directively done, here is a verbatim transcript of a session with a 25-year-old single woman, Sara, who worked as the head of a computer programming section of a firm and who, without any traumatic or violent history, was very insecure and self-denigrating.

T-1: What would you want to start on first?
C-1: I don't know. I'm petrified at the moment!
T-2: You're petrified—of what?
C-2: Of you!
T-3: No, surely not of me—perhaps of yourself!
C-3: [Laughs nervously.]
T-4: Because of what I am going to do to you?
C-4: Right! You are threatening me, I guess.
T-5: But how? What am I doing? Obviously, I'm not going to take a knife and stab you. Now, in what way am I threatening you?
C-5: I guess I'm afraid, perhaps, of what I'm going to find out—about me.
T-6: Well, so let's suppose you find out something dreadful about you—that you're thinking foolishly or something. Now why would that be awful?
C-6: Because I, I guess I'm the most important thing to me at the moment.

T-7: No, I don't think that's the answer. It's, I believe, the opposite! You're really the least important thing to you. You are prepared to beat yourself over the head if I tell you that you're acting foolishly. If you were not a self-blamer, then you wouldn't care what I said. It would be important to you—but you'd just go around correcting it. But if I tell you something really negative about you, you're going to beat yourself mercilessly. Aren't you?

C-7: Yes, I generally do.

T-8: All right. So perhaps that's what you're really afraid of. You're not afraid of me. You're afraid of your own self-criticism.

C-8: [Sighs.] All right.

T-9: So why do you have to criticize yourself? Suppose I find you're the worst person I ever met? Let's just suppose that. All right, now *why* would you have to criticize yourself?

C-9: [Pause.] I'd have to. I don't know any other behavior pattern, I guess, in this point of time. I always do. I guess I think I'm just a shit.

T-10: Yeah. But that, that isn't so. If you don't know how to ski or swim, you could learn. You can also learn not to condemn yourself, no matter what you do.

C-10: I don't know.

T-11: Well, the answer is: You don't know how.

C-11: Perhaps.

T-12: I get the impression you're saying, "I *have* to berate myself if I do something wrong." Because isn't that where your depression comes from?

C-12: Yes, I guess so. [Silence.]

T-13: Now, what are you *mainly* putting yourself down for right now?

C-13: I don't seem quite able, in this point of time, to break it down very neatly. The form [that our clinic gets clients to fill out before their sessions] gave me a great deal of trouble. Because my tendency is to say *everything,* I want to change everything; I'm depressed about everything, etc.

T-14: Give me a couple of things, for example.

C-14: What I'm depressed about? I, uh, don't know that I have any purpose in life. I don't know what I—what I am. And I don't know in what direction I'm going.

T-15: Yeah, but that's—so you're saying, "I'm ignorant!" [Client nods.] Well, what's so awful about being ignorant? It's too bad you're ignorant. It would be nicer if you weren't—if you *had* a purpose and *knew* where you were going. But just let's suppose the worst: for the rest of your life you didn't have a purpose and you stayed this way. Let's suppose that. Now, why would *you* be so bad?

C-15: Because everyone *should* have a purpose!

T-16: Where did you get the *should?*

C-16: 'Cause it's what I believe in. [Silence.]

T-17: I know. But think about it for a minute. You're obviously a bright woman. Now, where did that *should* come from?

C-17: I, I don't know! I'm not thinking clearly at the moment. I'm too nervous! I'm sorry.

T-18: Well, but you *can* think clearly. Are you now saying, "Oh, it's hopeless! I can't think clearly. What a shit I am for not thinking clearly!" You see: you're blaming yourself for *that.*

[From C-18 to C-26 the client upsets herself about not reacting well to the session, but the therapist shows her that this is not overly important and calms her down.]

C-27: I can't imagine existing, uh, or that there would be any reason for existing without a purpose!
T-28: No, but the vast majority of human beings don't have much purpose.
C-28: [Angrily.] All right, then, I should not feel bad about it.
T-29: No, no, no! Wait a minute, now. You just *jumped.* [Laughs.] You jumped from one extreme to another! You see, you said a sane sentence and an *insane* sentence. Now, if we could get you to separate the two—which you're perfectly able to do—you would solve the problem. What you really mean is "It *would be better* if I had a purpose. Because I'd be happier." Right?
C-29: Yes.
T-30: But then you magically jump to "Therefore I *should!*" Now do you see the difference between "It *would be better* if I had a purpose" and "I *should,* I *must,* I've *got to*"?
C-30: Yes, I do.
T-31: Well, what's the difference?
C-31: [Laughs.] I just said that to agree with you!
T-32: Yes! See, that won't be any good. We could go on that way forever, and you'll agree with me, and I'll say, "Oh, what a great woman! She agrees with me." And then you'll go out of here as nutty as you were before!
C-32: [Laughs, this time with genuine appreciation and good humor.]
T-33: You're perfectly able, as I said, to think—to stop giving up. That's what you've done most of your life. That's why you're disturbed. Because you refuse to think. And let's go over it again: "It would be better if I had a purpose in life; if I weren't depressed, etc., etc. If I had a good, nice, enjoyable purpose." We could give reasons why it would be better. "It's fairly obvious why it would be better!" Now, why is that a magical statement, that "I *should* do what would be better"?
C-33: You mean, why do I feel that way?
T-34: No, no. It's a belief. You feel that way because you believe that way.
C-34: Yes.
T-35: If you believed you were a kangaroo, you'd be hopping around and you'd *feel* like a kangaroo. Whatever you *believe,* you feel. Feelings largely come from your beliefs. Now, I'm temporarily forgetting about your feelings, because we really can't change feelings without changing beliefs. So I'm showing you; you have two beliefs—or two feelings, if you want to call them that. One, "It would be better if I had a purpose in life." Do you agree? [Client nods.] Now that's perfectly reasonable. That's quite true. We could prove it. Two, "Therefore I *should* do what would be better." Now those are two different statements. They may seem the same, but they're vastly different. Now, the first one, as I said, is sane. Because we could prove it. It's related to reality. We can list the advantages of having a purpose—for almost anybody, not just for you.
C-35: [Calm now, and listening intently to T's explanation.] Uh-huh.
T-36: But the second one, "Therefore I *should* do what would be better," is crazy. Now, why is it crazy?
C-36: I can't accept it as a crazy statement.
T-37: Because who said you *should?*
C-37: I don't know where it all began! Somebody said it.
T-38: I know, but I say whoever said it was screwy!
C-38: [Laughs.] All right.
T-39: How could the world possibly have a *should?*
C-39: Well, it does.

T-40: But it *doesn't!* You see, that's what emotional disturbance is: believing in *shoulds, oughts,* and *musts* instead of *it would be betters.* That's exactly what makes people neurotic! Suppose you said to yourself, "I wish I had a dollar in my pocket right now," and you had only 90 cents. How would you feel?

C-40: Not particularly upset.

T-41: Yes, you'd be a little disappointed. It would be better to have a dollar. But now suppose you said, "I should, I must have a dollar in my pocket at all times," and you found you had only 90 cents. Now, how would you feel?

C-41: Then I would be terribly upset, following your line of reasoning.

T-42: But not because you had only 90 cents.

C-42: Because I thought I should have a dollar.

T-43: THAT'S RIGHT! The should. And what's more, let's just go one step further. Suppose you said, "I must have a dollar in my pocket at all times." And you found you had a dollar and 10 cents. Now how would you feel?

C-43: Superb, I guess!

T-44: No—anxious!

C-44: [Laughs.] You mean I'd be guilty: "What was I doing with the extra money?"

T-45: No.

C-45: I'm sorry, I'm not following you. I—

T-46: Because you're not thinking. Think for a minute. Why, if you said, "I must have a dollar, I should have a dollar," and you had a dollar and 10 cents, would you still be anxious? Anybody would be. Now why would anybody be anxious if they were saying, "I've got to have a dollar!" and they found they had a dollar and 10 cents?

C-46: Because it violated their should. It violated their rule of what they thought was right, I guess.

T-47: Well, not at the moment. But they could easily lose 20 cents.

C-47: Oh! Well.

T-48: Yeah! They'd still be anxious. You see, because must means, "At all times I must—"

C-48: Oh, I see what you mean! All right. I see what you mean. They could easily lose some of the money and would therefore feel insecure.

T-49: Yeah. Most anxiety comes from musts.

C-49: [Long silence.] Why do you create such an anxiety-ridden situation initially for someone?

T-50: I don't think I do. I see hundreds of people and you're one of the few who makes this so anxiety-provoking for yourself. The others may do it mildly, but you're making it very anxiety-provoking. Which just shows that you may carry must into everything, including this situation. Most people come in here very relieved. They finally get to talk to somebody who knows how to help them, and they're very happy that I stop the horseshit, and stop asking about their childhood, and don't talk about the weather, etc. And I get *right away* to what bothers them. I tell them in 5 minutes. I've just explained to you the secret of most emotional disturbance. If you really followed what I said, and used it, you'd never be disturbed about practically anything for the rest of your life!

C-50: Uh-huh.

T-51: Because practically every time you're disturbed, you're changing it would be better to a must! That's all neurosis is! Very, very simple. Now, why should I waste your time and not explain this—and talk about irrelevant things?

C-51: Because perhaps I would have followed your explanation a little better if I hadn't been so threatened initially.

T-52: But then, if I pat you on the head and hold back, etc., then you'll think for the rest of your life you have to be patted on the head! You're a bright woman!

C-52: All right—

T-53: That's another should. "He should pat me on the head and take it slowly—then a shit like me can understand! But if he goes fast and makes me think, oh my God I'll make an error—and that is awful!" More horseshit! You don't have to believe that horseshit! You're perfectly able to follow what I say—if you stop worrying, "I should do perfectly well!" For that's what you're basically thinking, sitting there. Well, why should you do perfectly well? Suppose we had to go over it 20 times before you got it?

C-53: I don't *like* to appear stupid!

T-54: No. See. Now you're lying to yourself! Because again you said a sane thing—and then you added an insane thing. The sane thing was, "I don't like to appear stupid, because it's *better* to appear bright." But then you immediately jumped over to the insane thing: "And it's *awful* if I appear stupid—"

C-54: [Laughs appreciatively, almost joyously.]

T-55: "—I *should* appear bright!" You see?

C-55: [With conviction.] Yes.

T-56: The same crap! It's always the same crap. Now if you would look at the crap—instead of "Oh, how stupid I am! He hates me! I think I'll kill myself!"—then you'd be on the road to getting better fairly quickly.

C-56: You've been listening! [Laughs.]

T-57: Listening to what?

C-57: [Laughs.] Those wild statements in my mind, like that, that I make.

T-58: That's right! Because I know that you have to make those statements—because I have a good *theory.* And according to my theory, people wouldn't usually get upset *unless* they made those nutty statements to themselves.

C-58: I haven't the faintest idea why I've been so upset—

T-59: But you *do* have the faintest idea. I just told you.

C-59: All right, I know!

T-60: Why are you upset? Report it to me.

C-60: I'm upset because I know, I—the role that I envisioned myself being in when I walked in here and what I [Laughs, almost joyously] and what I would do and should do—

T-61: Yeah?

C-61: And therefore you forced me to violate that. And I don't like it.

T-62: "And isn't it *awful* that I didn't come out greatly! If I had violated that needed role *beautifully,* and I gave him the *right* answers immediately, and he beamed, and said, 'Boy, what a bright woman, this!' then it would have been all right."

C-62: [Laughing good-humoredly.] Certainly!

T-63: Horseshit! You would have been exactly as disturbed as you are now! It wouldn't have helped you a bit! In fact, you would have gotten nuttier! Because then you would have gone out of here with the same philosophy you came in here with: "That when I act well and people pat me on the head and say, 'What a great woman I am!' then everything is rosy!" It's a nutty philosophy! Because even if I loved you madly, the next person you talk to is likely to hate you. So I like brown eyes and he likes blue eyes or something else. So you're then dead! Because you really think: "I've got to be *accepted!* I've got to act intelligently!" Well, why?

C-63: [Very soberly and reflectively.] True.

T-64: You see?
C-64: Yes.
T-65: Now, if you will learn that lesson, then you've had a very valuable session. Because you *don't* have to upset yourself. As I said before, if I thought you were the worst shit who ever existed, well, that's my *opinion.* And I'm entitled to it. But does it make you a turd?
C-65: [Reflective silence.]
T-66: *Does* it?
C-66: No.
T-67: *What* makes you a turd?
C-67: *Thinking* that you are.
T-68: That's right! Your *belief* that you are. That's the only thing that could ever do it. And you never have to believe that. See? You control your thinking. I control *my* thinking—*my* belief about you. But you don't have to be affected by that. You *always* control what you think. And you believe you don't. So let's get back to that depression. The depression, as I said before, stems from self-castigation. That's where it comes from. Now what are you castigating yourself for?
C-68: Because I can't live up to it—there's a basic conflict in what people appear to think I am and what I think I am.
T-69: Right.
C-69: And perhaps it's not fair to blame other people. Perhaps I thrust myself into a leader's role. But, anyway, my feeling right now is that all my life I've been forced to be something that I'm not, and the older I get, the more difficult this *façade,* huh, this *appearance,* uh—that the veneer is becoming thinner and thinner and thinner, until I just can't do it anymore.
T-70: Well, but really, yeah, I'm afraid you're a little wrong. Because oddly enough, almost the opposite is happening. You are thrust into this role. That's right: the role of something of a leader. Is that correct?
C-70: Yes.
T-71: And *they* think you're filling it.
C-71: Everyone usually does.
T-72: And it just so happens they're *right.*
C-72: But it's taking more and more out of me.
T-73: Because you're not doing something else. You see, you are fulfilling *their* expectations of you. Because, obviously, they wouldn't think you are a leader, they'd think you were nothing if you *were* acting like a nonleader. So you are fulfilling their expectations. But you're not fulfilling your own idealistic and impractical expectations of leadership.
C-73: [Verging on tears.] No, I guess I'm not.
T-74: You see, that's the issue. So therefore you *are* doing O.K. by them—by your job. But you're not being an angel, you're not being *perfect!* And you *should* be, to be a real *leader.* And therefore you're a *sham!* You see? Now, if you give up those nutty expectations of yourself and go back to their expectations, you're in no trouble at all. Because obviously you're doing all right by them and *their* expectations.
C-74: Well, I haven't been. I had to, to give up one very successful situation. And, uh, when I left, they thought it was still successful. But I just couldn't go on—
T-75: "Because I must, I must *really* be a leader in *my* eyes, be pretty *perfect.*" You see, "If I satisfy the world, but I know I did badly, or less than I *should,* then I'm a slob! And they haven't found me out, so that makes me a *double* slob. Because I'm pretending to them to be a nonslob when I really am one!"
C-75: [Laughs in agreement, then grows sober.] True.

T-76: But it's all your silly *expectations.* It's not *them.* And oddly enough, you are—even with your *handicap,* which is depression, self-deprecation, etc.—you're doing remarkably well. Imagine what you might do *without* this nutty handicap! You see, you're satisfying them while you're spending most of your time and energy flagellating yourself. Imagine what you might do *without* the self-flagellation! Can you see that?

C-76: [Stopped in her self-blaming tracks, at least temporarily convinced, speaks very meaningfully.] Yes.

Mechanisms of Psychotherapy

From the foregoing partial protocol (which consumed about 15 minutes of the first session with the client), it can be seen that the therapist tries to do several things:

1. No matter what *feelings* the client brings out, the therapist tries to get back to her main irrational *ideas* that probably lie behind these feelings—especially her ideas that it would be *awful* if someone, including him, disliked her.

2. The therapist does not hesitate to contradict the client, using evidence from the client's own life and from his knowledge of people in general.

3. He usually is one step *ahead* of her—tells her, for example, that she is a self-blamer before she has said that she is. Knowing, on the basis of REBT theory, that she has *shoulds, oughts,* and *musts* in her thinking if she becomes anxious, depressed, and guilty, he helps her to admit these *shoulds* and then dispute them (T-16, T-17).

4. He uses the strongest philosophical approach he can think of: "Suppose," he keeps saying to her, "the *worst* thing happened and you really did do badly and others hated you, would you *still* be so bad?" (T-15). He assumes that if he can convince her that *none* of her behavior, no matter how execrable, denigrates *her,* he has helped her to make a *deep* attitudinal change.

5. He is not thrown by her distress (C-17), is not too sympathetic about these feelings, but *uses* them to try to prove to her that, right now, she still believes in foolish ideas and thereby upsets herself. He does not dwell on her "transference" feelings. He interprets the *ideas* behind these feelings, shows her why they are self-defeating, and indicates why his acting sympathetically would probably reinforce her demanding philosophy instead of helping her change it.

6. He is fairly stern with her but also shows full acceptance and demonstrates confidence in her abilities, especially her constructive ability to change herself.

7. Instead of merely *telling* her that her ideas are irrational, he keeps trying to get her to see this for herself (T-36). He wants her not merely to accept or parrot *his* rational philosophies but to think them through. He does, however, explain some relevant psychological processes, such as the way the client's feelings largely derive from her thinking (T-35, T-68).

8. He deliberately, on several occasions, uses strong language (T-18, T-50). This is done (a) to help loosen up the client, (b) to show that he, the therapist, is a down-to-earth human being, and (c) to give her an emotive jolt or shock so his words may have a more dramatic effect. Note that in this case, the client first calls herself a "shit" (C-9).

9. Although hardly sympathetic to her ideas, he is really quite empathic. Rational emotive behavior therapists are usually attuned to the client's unexpressed thoughts (her negative ideas about herself and the world), rather than to her superficial feelings (her perceptions that she is doing poorly or that others are abusing her). They empathize with the client's *feelings* and with the *beliefs* that underlie these feelings. This is a two-pronged form of empathy that many therapies miss out on.

10. The therapist keeps checking the client's ostensible understanding of what he is teaching her (T-65, T-66, T-67).

11. The therapist—as is common in early sessions of REBT—does most of the talking and explaining. He gives the client plenty of opportunity to express herself but uses her responses as points of departure for further teaching. He tries to make each "lecture" brief and trenchant and to relate it specifically to her problems and feelings. Also, at times he stops to let ideas sink in.

As can be seen from the first part of this initial REBT session, the client does not receive feelings of love and warmth from the therapist. Transference and countertransference spontaneously occur, but they are quickly analyzed, the philosophies behind them are revealed, and they tend to evaporate in the process. The client's deep feelings (shame, self-pity, weeping, anger) clearly exist, but the client is not given too much chance to revel in these feelings or to abreact strongly about them. As the therapist points out and attacks the ideologies that underlie these feelings, they swiftly change and are sometimes almost miraculously transformed into other, contradictory feelings (such as humor, joy, and reflective contemplation). The therapist's "coolness," philosophizing, and encouraging insistence that the client can feel something besides anxiety and depression help change her destructiveness into constructive feelings. That is why REBT is a constructivist rather than a purely rationalist kind of therapy (Ellis, 1994, 1999, 2001a, 2001b, 2002).

What the client does seem to experience, as the session proceeds, is (1) full acceptance of herself, in spite of her poor behavior; (2) renewed confidence that she can do certain things, such as think for herself; (3) the belief that it is her own perfectionistic *shoulds* that are upsetting her and not the attitudes of others (including the therapist); (4) reality testing, in her starting to see that even though she performs inefficiently (with the therapist and with some of the people she works with), she can still recover, try again, and probably do better in the future; and (5) reduction of some of her defenses, in that she can stop blaming others (such as her therapist) for her anxiety and can start to admit that she is doing something herself to cause it.

In these 15 minutes the client is getting only *glimmerings* of these constructive thoughts and feelings. The REBT intent, however, is that she will *keep* getting insights—that is, *philosophical* rather than merely *psychodynamic* insights—into the self-causation of her disturbed symptoms; that she will use these insights to change some of her most enduring and deep-seated ways of thinking about herself, about others, and about the world; and that she will thereby eventually become ideationally, emotionally, and behaviorally less self-defeating. Unless she finally makes an *attitudinal* (as well as symptom-reducing) change, although she may be helped to some degree, she will still be far from the ideal REBT goal of making a basic and lasting personality change.

APPLICATIONS

Who Can We Help?

It is easier to state what kinds of problems are *not* handled than what kinds *are* handled in REBT. Individuals who are out of contact with reality, in a highly manic state, seriously autistic or brain-injured, or in the lower ranges of mental deficiency are not normally treated by REBT therapists (or by most other practitioners). They are referred for medical treatment, for custodial or institutional care, or for behavior therapy along operant conditioning lines.

In particular, REBT therapists try to show clients how to (1) minimize anxiety, guilt, and depression by unconditionally accepting themselves, (2) alleviate their anger, hostility, and violence by unconditionally accepting other people, and (3) reduce their low frustration tolerance and inertia by learning to accept life unconditionally even when it is grim (Ellis, 2001a; Ellis & Blau, 1998; Ellis & Dryden, 1997; Ellis & MacLaren, 1998).

Group Therapy

REBT is particularly applicable to group therapy. Because group members are taught to apply REBT procedures to one another, they can help others learn the procedures and get practice (under the direct supervision of the group leader) in applying them. In group work, moreover, there is usually more opportunity for the members to agree on homework assignments (some of which are to be carried out in the group itself), to get assertiveness training, to engage in role playing, to interact with other people, to take verbal and nonverbal risks, to learn from the experiences of others, to interact therapeutically and socially with each other in after-group sessions, and to have their behavior directly observed by the therapist and other group members (Ellis, 2001b; Ellis & Dryden, 1997).

REBT Workshops, Rational Encounter Marathons and Intensives

REBT has successfully used marathon encounter groups and large-scale one-day intensive workshops that include many verbal and nonverbal exercises, dramatic risk-taking procedures, evocative lectures, personal encounters, homework assignments, and other emotive and behavioral methods. Research studies have shown that these workshops, marathons, and intensive workshops have beneficial, immediate, and lasting effects (Ellis & Dryden, 1997; Ellis & Joffe, 2002).

Brief Therapy

REBT is naturally designed for brief therapy. It is preferable that individuals with severe disturbances come to individual and/or group sessions for at least 6 months. But for individuals who are going to stay in therapy for only a short while, REBT can teach them, in 1 to 10 sessions, the A–B–C method of understanding emotional problems, seeing their main philosophical source, and beginning to change fundamental disturbance-creating attitudes (Ellis, 2001b).

This is particularly true for the person who has a specific problem—such as hostility toward a boss or sexual inadequacy—and who is not too *generally* disturbed. Such an individual can, with the help of REBT, be almost completely "cured" in a few sessions. But even clients with long-standing difficulties may be significantly helped as a result of brief therapy.

Two special devices often employed in REBT can help speed the therapeutic process. The first is to tape the entire session. These recordings are then listened to, usually several times, by the clients in their own home, car, or office, so that they can more clearly see their problems and the rational emotive behavioral way of handling them. Many clients who have difficulty "hearing" what goes on during the face-to-face sessions (because they are too intent on talking themselves, are easily distracted, or are too anxious) are able to get more from listening to a recording of these sessions than from the original encounter.

Second, an REBT Self-Help Form is frequently used with clients to help teach them how to use the method when they encounter emotional problems between therapy sessions or after therapy has ended. This form is reproduced on pages 211–212.

Marriage and Family Therapy

From its beginning, REBT has been used extensively in marriage and family counseling (Ellis, 1962, 2001b; Ellis & Dryden, 1997; Ellis & Harper, 1997, 2003). Usually, marital or love partners are seen together. REBT therapists listen to their complaints about each other and then try to show that even if the complaints are justified, making themselves unduly upset is not. Work is done with either or both participants to minimize anxiety, depression, guilt, and (especially) hostility. As they begin to learn and apply the REBT principles, they usually become much less disturbed, often within a few sessions, and then are much better able to minimize their incompatibilities and maximize their compatibilities.

Sometimes, of course, they decide that they would be better off separated or divorced, but usually they decide to work at their problems to achieve a happier marital arrangement. They are frequently taught contracting, compromising, communication, and other relating skills. The therapist is concerned with both of them as individuals who can be helped emotionally, whether or not they decide to stay together. But the more they work at helping themselves, the better their relationship tends to become (Ellis, 2001b; Ellis & Crawford, 2000; Ellis & Harper, 2003).

In family therapy, REBT practitioners sometimes see all members of the same family together, see the children in one session and the parents in another, or see them all individually. Several joint sessions are usually held to observe the interactions among family members. Whether together or separately, parents are frequently shown how to accept their children and to stop condemning them, and children are similarly shown that they can accept their parents and their siblings. The general REBT principles of unconditionally accepting oneself and others are repeatedly taught. As is common with other REBT procedures, bibliotherapy supplements counseling with REBT materials such as *A Guide to Rational Living* (Ellis & Harper, 1997), *A Rational Counseling Primer* (Young, 1974), *How to Make Yourself Happy and Remarkably Less Disturbable* (Ellis, 1999), and *Feeling Better, Getting Better, Staying Better* (Ellis, 2001a), and *The Myth of Self-Esteem* (Ellis, 2005).

The *setting* of REBT sessions is much like that for other types of therapy. Most individual sessions take place in an office, but there may well be no desk between the therapist and the client, and REBT therapists tend to be informally dressed and to use simple language. They tend to be more open, authentic, and less "professional" than the average therapist. The main special equipment used is a tape recorder. The client is likely to be encouraged to make a recording of the session to take home for replaying.

REBT therapists are highly active, give their own views without hesitation, usually answer direct questions about their personal lives, are quite energetic and often directive in group therapy, and do a good deal of speaking, particularly during early sessions. At the same time, they unconditionally accept clients. They may engage in considerable explaining, interpreting, and "lecturing" and may easily work with clients they personally do not like. Because they tend to have complete tolerance for all individuals, REBT therapists are often seen as warm and caring by their clients.

Resistance is usually handled by showing clients that they resist changing because they would like to find a magical, easy solution rather than work at changing themselves. Resistance is not usually interpreted as their particular feelings about the therapist. If a client tries to seduce a therapist, this is usually explained not in terms of "transference" but in terms of (1) the client's need for love, (2) normal attraction to a helpful person, and (3) the natural sex urges of two people who have intimate mental–emotional contact. If the therapist is attracted to the client, he or she usually admits the attraction but explains why it is unethical to have sexual or personal relations with a client (Ellis, 2002).

Evidence

REBT has directly or indirectly inspired scores of experiments to test its theories, and there are now hundreds of research studies that tend to validate its major theoretical hypotheses (Ellis & Whiteley, 1979). More than 200 outcome studies have been published showing that REBT is effective in changing the thoughts, feelings, and behaviors of groups of individuals with various kinds of disturbances (DiGiuseppe, Terjesen, Rose, Doyle, & Vadalakis, 1998). These studies tend to show that REBT disputing and other methods usually work better than no therapy and are often more effective than other forms of psychotherapy (DiGiuseppe, Miller, & Trexler, 1979; Engels, Garnefski, & Diekstra, 1993; Haaga & Davison, 1993; Hajzler & Bernard, 1991; Jorn, 1989; Lyons & Woods, 1991; McGovern & Silverman, 1984; Silverman et al., 1992).

Applications of REBT to special kinds of clients have also been shown to be effective. It has yielded particularly good results with individuals who have anger disorders (Ellis, 2003a), with religious clients (Nielsen, Johnson, & Ellis, 2001), and with schoolchildren (Seligman, Revich, Jaycox, & Gillham, 1995).

In addition, hundreds of other outcome studies done by cognitive therapists—particularly by Aaron Beck (Alford & Beck, 1997) and his associates—also support the clinical hypothesis of REBT. Finally, more than 1,000 other investigations have shown that the irrationality scales derived from Ellis's original list of irrational beliefs significantly correlate with the diagnostic disorders with which these scales have been tested (Hollon & Beck, 1994; Woods, 1992). Although much has yet to be learned about the effectiveness of REBT and other cognitive–behavior therapies, the research results so far are impressive.

Individual Evaluations

REBT therapists may use various diagnostic instruments and psychological tests, and they especially employ tests of irrationality, such as the Jones Irrational Beliefs Test, the Beck Depression Inventory, and the Dysfunctional Attitude Scale. Many of these tests have been shown to have considerable reliability and validity in controlled experiments.

Psychotherapy in a Multicultural World

It is important for all therapists to appreciate the multicultural aspects of psychotherapy, since this is a vital issue (Sue & Sue, 2003). REBT has always taken a multicultural position and promotes flexibility and open-mindedness so that practitioners who use it can deal with clients who follow different family, religious, and cultural customs. This is because it practically never gets people to dispute or discard their cultural goals, values, and ideals but only their grandiose insistences that these goals *absolutely must* be achieved.

Suppose a client lives in an American city populated largely by middle-class white Protestant citizens, and she is a relatively poor, dark-skinned, Pakistani-born Muslim. She will naturally have some real differences with her neighbors and coworkers and may upset herself about these differences. Her REBT therapist would give her unconditional acceptance, even though the therapist was a member of the majority group in the client's region and viewed some of her views and leanings as "peculiar." Her cultural and religious values would be respected as being legitimate and good for her, in spite of her differences with her community's values.

This client would be supported in following her goals and purposes—as long as she was willing to accept the consequences of displeasing some of the townspeople by sticking to them. She could be shown, with REBT, how to refuse to put herself down

REBT Self-Help Form

A (ACTIVATING EVENTS OR ADVERSITIES)

- Briefly summarize the situation you are disturbed about (what would a camera see?)
- An A can be *internal* or *external, real* or *imagined.*
- An A can be an event in the *past, present,* or *future.*

IBs (IRRATIONAL BELIEFS)

To identify IBs, look for

- Dogmatic Demands (musts, absolutes, shoulds)
- Awfulizing (It's awful, terrible, horrible)
- Low Frustration Tolerance (I can't stand it)
- Self/Other Rating (I'm/he is/she is bad, worthless)

D (DISPUTING IBs)

To dispute, ask yourself:

- Where is holding this belief getting me? Is it *helpful* or *self-defeating?*
- Where is the evidence to support the existence of my irrational belief? Is it *consistent with social reality?*
- Is my belief *logical?* Does it follow from my preferences?
- Is it really *awful* (as bad as it could be)?
- Can I really not *stand* it?

REBT Self-Help Form *(continued)*

C (CONSEQUENCES)

Major unhealthy negative **emotions:**

Major self-defeating **behaviors:**

Unhealthy negative emotions include

- Anxiety
- Depression
- Rage
- Low Frustration Tolerance
- Shame/Embarrassment
- Hurt
- Jealousy
- Guilt

E (EFFECTIVE NEW PHILOSOPHIES)

To think more rationally, strive for:

- Non-Dogmatic Preferences (wishes, wants, desires)
- Evaluating Badness (it's bad, unfortunate)
- High Frustration Tolerance (I don't like it, but I can stand it)
- Not Globally Rating Self or Others (I—and others—are fallible human beings)

E (EFFECTIVE EMOTIONS & BEHAVIORS)

New healthy **negative emotions:**

New constructive **behaviors:**

Healthy negative emotions include:

- Disappointment
- Concern
- Annoyance
- Sadness
- Regret
- Frustration

if she suffered from community criticism, and her "peculiar" cultural and religious ways would be questioned only if they were so rigidly held that they interfered with her basic aims.

Thus, if she flouted the social–sexual mores of her own religion and culture and concluded that she was worthless for not following them perfectly, she would be shown that it was her rigid demand that she *absolutely must* inflexibly adhere to them that was leading to her feelings of worthlessness and depression. If she changed her *must* to a *preference,* she could choose to follow or not to follow these cultural rules and not feel worthless and depressed.

REBT, then, has three main principles relevant to cross-cultural psychotherapy:

> (1) Clients can unconditionally accept themselves and other individuals and can achieve high frustration tolerance when faced with life adversities. (2) If the therapist follows these rules and encourages her or his clients to follow them and to lead a flexible life, multicultural problems may sometimes exist but can be resolved with minimum intercultural and intracultural prejudice. (3) Most multicultural issues involve bias and intolerance, which REBT particularly works against (see *The Road to Tolerance*, Ellis, 2004).

Client Problems

No matter what the presenting problem may be, REBT therapists first help clients to express their disturbed emotional and behavioral reactions to their practical difficulties and to see and tackle the basic ideas or philosophies that underlie these reactions. This is apparent in the course of workshops for executives. In these workshops, the executives constantly bring up business, management, organizational, personal, and other problems. But they are shown that these practical problems often are tied to their self-defeating belief systems, and it is *this* problem that REBT mainly helps them resolve (Ellis, Gordon, Neenan, & Palmer, 1998).

Some individuals, however, may be so inhibited or defensive that they do not permit themselves to feel and therefore may not even be aware of some of their underlying emotional problems. Thus, the successful executive who comes for psychological help only because his wife insists they have a poor relationship and who claims that nothing really bothers him other than his wife's complaints may have to be jolted out of his complacency by direct confrontation. REBT group therapy may be particularly helpful for such an individual so that he finally expresses underlying anxieties and resentments and begins to acknowledge that he has emotional problems.

Extreme emotionalism in the course of REBT sessions—such as crying, psychotic behavior, and violent expressions of suicidal or homicidal intent—are naturally difficult to handle. But therapists handle these problems by their own, presumably rational philosophy of life and therapy, which includes these ideas: (1) Client outbursts make things difficult, but they are hardly *awful, terrible,* or *catastrophic.* (2) Behind each outburst is some irrational idea. Now, what is this idea? How can it be brought to the client's attention and what can be done to help change it? (3) No therapist can possibly help every client all the time. If this particular client cannot be helped and has to be referred elsewhere or lost to therapy, this is unfortunate. But it does not mean that the therapist is a failure.

REBT therapists usually handle clients' profound depressions by showing them, as quickly, directly, and vigorously as possible, that they are probably creating or exacerbating their depression by (1) blaming themselves for what they have done or not done, (2) castigating themselves for being depressed and inert, and (3) bemoaning their fate

because of the hassles and harshness of environmental conditions. Their self-condemnation is not only revealed but firmly disputed, and in the meantime, the therapist may give clients reassurance and support, may refer them for supplementary medication, may speak to their relatives or friends to enlist their aid, and may recommend temporary withdrawal from some activities. Through an immediate and direct disputing of clients' extreme self-deprecation and self-pity, the therapist often helps deeply depressed and suicidal people in a short period.

The most difficult clients are usually the chronic avoiders or shirkers who keep looking for magical solutions. These individuals are shown that no such magic exists; that if they do not want to work hard to get better, it is their privilege to keep suffering; and that they are not *terrible persons* for goofing off but could live much more enjoyably if they worked at helping themselves. To help them get going, a form of people-involved therapy, such as group therapy, is frequently a method of choice. Results with unresponsive clients are still relatively poor in REBT (and in virtually all other therapies), but persistence and vigor on the part of the therapist often eventually overcome this kind of resistance (Ellis, 1994, 2002; Ellis & Tafrate, 1998).

CASE EXAMPLE

This section is relatively brief because it concerns the 25-year-old computer programmer whose initial session was presented in this chapter (pp. 214–220). Other case material on this client follows.

Background

Sara came from an Orthodox Jewish family. Her mother died in childbirth when Sara was 2 years of age, so Sara was raised by a loving but strict and somewhat remote father and a dominating paternal grandmother. She did well in school but had few friends up to and through college. Although fairly attractive, she was always ashamed of her body, did little dating, and occupied herself mainly with her work. At the age of 25, she was head of a section in a data processing firm. She was highly sexed and masturbated several times a week, but she had had intercourse with a man only once, when she was too drunk to know what she was doing. She had been overeating and overdrinking steadily since her college days. She had had 3 years of classical psychoanalysis. She thought her analyst was "a very kind and helpful man," but she had not really been helped by the process. She was quite disillusioned about therapy as a result of this experience and returned to it only because the president of her company, who liked her a great deal, told her that he would no longer put up with her constant drinking and insisted that she come to see the author of this chapter.

Treatment

Treatment continued for six sessions along the same lines indicated in the transcript included previously in this chapter. This was followed by 24 weeks of REBT group therapy and a weekend-long rational encounter marathon.

Cognitively, the client was shown repeatedly that her central problem was that she devoutly believed she *had* to be almost perfect and that she *must not* be criticized in any major way by significant others. She was persistently shown, instead, how to refrain from rating her *self* but only to measure her *performances;* to see that she could never be, except by arbitrary definition, a "worm" even if she never succeeded in overcoming her

overeating, compulsive drinking, and foolish symptoms; to see that it was highly desirable but not necessary that she relate intimately to a man and win the approval of her peers and her bosses at work; and first to accept herself *with* her hostility and then to give up her childish *demands* on others that led her to be so hostile to them. Although she devoutly believed in the "fact" that she and others *should* be extremely efficient and follow strict disciplinary rules, and although time and again she resisted the therapist's and the group members' assaults against her moralistic *shoulds,* she was finally induced to replace them, in her vocabulary as well as in her internalized beliefs, with *it would be betters.* She claimed to have completely overthrown her original religious orthodoxy, but she was shown that she had merely replaced it with an inordinate demand for certainty in her personal life and in world affairs, and she was finally induced to give this up, too (Ellis, 2003b).

Emotively, Sara was fully accepted by the therapist *as a person,* even though he strongly assailed many of her *ideas* and sometimes humorously reduced them to absurdity. She was assertively confronted by some of the group members, who helped her see how she was angrily condemning other group members for their stupidities and their shirking, and she was encouraged to accept these "bad" group members (as well as people outside the group) in spite of their inadequacies. The therapist, and some of the others in her group and in the marathon weekend of rational encounter in which she participated, used vigorous, down-to-earth language with her. This initially horrified Sara, but she later began to loosen up and to use similar language. When she went on a drinking bout for a few weeks and felt utterly depressed and hopeless, two group members brought out their own previous difficulties with alcohol and drugs and showed how they had managed to get through that almost impossible period in their lives. Another member gave her steady support through many phone calls and visits. At times when she clammed up and sulked, the therapist and other group members pushed her to open up and voice her real feelings. Then they went after her defenses, revealed her foolish ideas (especially the idea that she had to be terribly hurt if others rejected her), and showed how these could be uprooted. During the marathon, she was able, for the first time in her life, to let herself be really touched emotionally by a man who, up to that time, was a perfect stranger to her, and this showed her that she could afford to let down her long-held barriers to intimacy and allow herself to love.

Behaviorally, Sara was given homework assignments that included talking to attractive men in public places and thereby overcoming her fears of being rejected. She was shown how to stay on a long-term diet (which she had never done before) by allowing herself rewarding experiences (such as listening to classical music) only when she had first maintained her diet for a certain number of hours. Through role playing with the therapist and other group members, she was given training in being assertive with people at work and in her social life without being aggressive (Ellis, 2003a; Wolfe, 1992).

Resolution

Sara progressed in several ways: (1) She stopped drinking completely, lost 25 pounds, and appeared to be maintaining both her sobriety and her weight loss. (2) She became considerably less condemnatory of both herself and others and began to make some close friends. (3) She had satisfactory sexual relations with three different men and began to date one of them steadily. (4) She only rarely made herself guilty or depressed, accepted herself with her failings, and began to focus much more on enjoying than on rating herself.

Follow-Up

Sara had REBT individual and group sessions for 6 months and occasional follow-up sessions the next year. She married her steady boyfriend about a year after she had originally begun treatment, after having two premarital counseling sessions with him following their engagement. Two and a half years after the close of therapy, she and her husband reported that everything was going well in their marriage, at her job, and in their social life. Her husband seemed particularly appreciative of the use she was making of REBT principles and noted, "she still works hard at what she learned with you and the group and, frankly, I think that she keeps improving, because of this work, all the time." She smilingly and enthusiastically agreed.

SUMMARY

Rational emotive behavior therapy (REBT) is a comprehensive system of personality change that incorporates cognitive, emotive, and behavior therapy methods. It is based on a clear-cut theory of emotional health and disturbance, and the many techniques it employs are usually related to that theory. Its major hypotheses also apply to childrearing, education, social and political affairs, the extension of people's intellectual and emotional frontiers, and support of their unique potential for growth. REBT psychology is hardheaded, empirically oriented, rational, and nonmagical. It fosters the use of reason, science, and technology. It is humanistic, existentialist, and hedonistic. It aims for reduced emotional disturbance as well as increased growth and self-actualization in people's intrapersonal and interpersonal lives.

REBT theory holds that people are biologically and culturally predisposed to choose, create, and enjoy, but that they are also strongly predisposed to overconform, be suggestible, hate, and foolishly block their enjoying. Although they have remarkable capacities to observe, reason, imaginatively enhance their experiencing, and transcend some of their own essential limitations, they also have strong tendencies to ignore social reality, misuse reason, and invent absolutist *musts* that frequently sabotage their health and happiness. Because of their refusals to accept social reality, their continual *must*urbation, and their absorption in deifying and devilifying themselves and others, people frequently wind up with emotional disturbances.

When noxious stimuli occur in people's lives at point A (their adversities), they usually observe these events objectively and conclude, at point rB (their rational belief), that this event is unfortunate, inconvenient, and disadvantageous and that they wish it would change. Then they healthily feel, at point C (the consequence), sad, regretful, frustrated, or annoyed. These healthy negative feelings usually help them to try to do something about their adversities to improve or change them. Their inborn and acquired hedonism and constructivism encourage them to have, in regard to adversities, rational thoughts ("I don't like this; let's see what I can do to change it") and healthy negative feelings (sorrow and annoyance) that enable them to reorder their environment and to live more enjoyably.

Very often, however, when similar adversities occur in people's lives, they observe these events intolerantly and grandiosely and conclude, at point iB (their irrational beliefs), that these events are awful, horrible, and catastrophic; that they *must* not exist; and that they absolutely cannot stand them. They then self-defeatingly feel the consequence, at point C, of worthlessness, guilt, anxiety, depression, rage, and inertia. Their disturbed feelings usually interfere with their doing something constructive about the adversities, and they tend to condemn themselves for their unconstructiveness and to experience more feelings of shame, inferiority, and hopelessness. Their inborn and

acquired self-critical, antihumanistic, and deifying and devilifying philosophies encourage them to have, in regard to unfortunate activating events, foolish thoughts ("How awful this is and I am! There's nothing I can do about it!") and dysfunctional feelings (hatred of themselves, of others, and of the world) that encourage them to whine and rant and live less enjoyably.

REBT is a cognitive–emotive–behavioristic method of psychotherapy uniquely designed to enable people to observe, understand, and persistently dispute their irrational, grandiose, perfectionistic *shoulds, oughts,* and *musts* and their *awfulizing.* It employs the logico-empirical method of science to encourage people to surrender magic, absolutes, and damnation; to acknowledge that nothing is sacred or all-important (although many things are exceptionally unpleasant and inconvenient); and to gradually teach themselves and to practice the philosophy of desiring rather than demanding and of working at changing what they can change and gracefully accepting what they cannot change about themselves, about others, and about the world (Ellis, 1994, 2002; Ellis & Blau, 1998; Ellis & Dryden, 1997; Ellis & MacLaren, 1998).

In conclusion, rational emotive behavior therapy is a method of personality change that quickly and efficiently helps people resist their tendencies to be too conforming, suggestible, and anhedonic. It actively and didactically, as well as emotively and behaviorally, shows people how to abet and enhance one side of their humanness while simultaneously changing and living more happily with (and not repressing or squelching) another side. It is thus realistic and practical as well as idealistic and future oriented. It helps individuals to more fully actualize, experience, and enjoy the here and now, but it also espouses long-range hedonism, which includes planning for their own (and others') future. It is what its name implies: rational *and* emotive *and* behavioral, realistic *and* visionary, empirical *and* humanistic. As, in all their complexity, are humans.

ANNOTATED BIBLIOGRAPHY

Web sites

Dr. Debbie Joffe Ellis, www.debbiejoffeellis.com
Friends of Albert Ellis, www.albert-ellis-friends.net
REBT Network, www.rebtnetwork.org

Books

Ellis, A. (2004). *Rational emotive behavior therapy—it works for me—it can work for you.* Amherst, NY: Prometheus Books.
This autobiographical book presents an excellent overview of the life and work of Albert Ellis.

Ellis, A. (2004). *The road to tolerance: The philosophy of rational emotive behavior therapy.* Amherst, NY: Prometheus Books.
This book reviews the theoretical underpinnings of REBT and advocates tolerance for and patience with the all-too-common shortcomings of human beings.

Ellis, A. (2005). *The myth of self-esteem.* New York: Prometheus Books.
The book provides an overview of Ellis's approach to life and psychotherapy and REBT's emphasis on unconditional acceptance, and it gives some insight into the breadth of his intellect. Separate chapters deal with Jean-Paul Sartre, Martin Heidegger, Martin Buber, D. T. Suzuki, and Zen Buddhism.

Ellis, A. (2010). *All out! An autobiography.* Amherst, NY: Prometheus Books.
Albert Ellis's last work, this fascinating, candid, and substantial autobiography includes memorable episodes, descriptions of the important people in his life, the way he coped with difficulties, his developing of REBT, his love life, and personal reflections.

Ellis, A., & Dryden, W. (1997). *The practice of rational emotive behavior therapy.* New York: Springer.
This book presents the general theory and basic practice of rational emotive behavior therapy (REBT), with special chapters on how it is used in individual, couples, family, group, and sex therapy. It brings the original seminal book on REBT, *Reason and Emotion in Psychotherapy* (Ellis, 1962) up to date and gives many details about REBT therapy procedures.

Ellis, A., & Harper, R. A. (1997). *A guide to rational living.* North Hollywood, CA: Wilshire Books.
This completely revised and rewritten version of the REBT self-help classic is one of the most widely read self-help books ever published, and it is often recommended by cognitive–behavior therapists to their clients. It is a succinct, straightforward approach to REBT based on self-questioning and homework and shows how readers can help themselves with various emotional problems.

CASE READINGS

Ellis, A. (1971). A twenty-three-year-old woman, guilty about not following her parents' rules. In A. Ellis, *Growth through reason: Verbatim cases in rational-emotive therapy* (pp. 223–286). Hollywood: Wilshire Books. [Reprinted in D. Wedding & R. J. Corsini (Eds.). (2011). *Case studies in psychotherapy.* Belmont, CA: Brooks/Cole.]

Ellis presents a verbatim protocol of the first, second, and fourth sessions with a woman who comes for help because she is self-punishing, impulsive and compulsive, and afraid of males, has no goals in life, and is guilty about her relations with her parents. The therapist quickly zeroes in on her main problems and shows her that she need not feel guilty about doing what she wants to do in life, even if her parents keep upsetting themselves about her beliefs and actions.

Ellis, A. (1977). Verbatim psychotherapy session with a procrastinator. In A. Ellis & W. J. Knaus, *Overcoming procrastination* (pp. 152–167). New York: New American Library.

Ellis presents a single verbatim session with a procrastinator who was failing to finish her doctoral thesis in sociology. He deals with her problems in a direct, no-nonsense manner typical of rational emotive behavior therapy, and she later reports that as a result of a single session, she finished her thesis, although she had previously been procrastinating on it for a number of years.

Ellis, A., & Dryden, W. (1996). Transcript of a demonstration session, with comments on the session by Windy Dryden and Albert Ellis. In W. Dryden, *Practical skills in rational emotive behavior therapy* (pp. 91–117). London: Whurr.

Ellis presents a verbatim protocol with a therapist who volunteers to bring up problems of feeling inadequate as a therapist and as a person. Albert Ellis shows her some core beliefs leading to her self-downing and how to actively dispute and surrender these beliefs. Ellis and Windy Dryden then review the protocol to analyze its REBT aspects.