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.