2

Basic Tenets of REBT/CBT

While there have been some arguments against applying the concept of placebo to psychotherapy (Herbert & Gaudiano, 2005; Kirsch, 2005; Lambert, 2005), Lambert concluded that it would be better to focus on such causal mechanisms as expectation for improvement as a common factor. But how does REBT/CBT purport to enhance the client's expectations that she or he might be able to make changes? I argue that for the REBT/CBT counselor, it is part and parcel of the approach. This chapter focuses on some of the specific aspects of REBT/CBT that enhance expectations as well as promote the therapeutic alliance.

Generally, REBT and broad-based CBT may be considered synonymous, although there are some initial differences that might be considered. Ellis's (1993) primary emphasis was somewhat more philosophically based, while Beck was initially focused on searching for empirical evidence for a theory of depression (Alford & Beck, 1997; Beck & Alford, 2009; Beck, Rush, Shaw, & Emery, 1979; Padesky & Beck, 2003; Rush & Beck, 1978). Ellis subsequently made some distinctions in what he called *specialized* or *preferential* REBT versus CBT.

Still, and interestingly, both Albert Ellis and Aaron Beck were trained in psychoanalysis and began their careers as psychoanalysts. These two giants independently began to question the efficacy of psychoanalysis and turned instead to examining the role of cognitive processes in emotional disturbances. While their origins are distinct, there is a fundamental agreement between REBT and CBT that (a) our cognitions may affect our behavior, (b) our cognitions may be changed, and (c) our behaviors and emotions may change as a result of our changes in cognitions. In this chapter I provide

a description of the basic tenets of REBT and CBT suggesting similarities and differences and show how this approach to psychotherapy has been demonstrably effective.

REBT in a Nutshell

Philosophically, Ellis was strongly influenced by the writings of Stoic philosophers such as Epictetus and Marcus Aurelius (Dryden & Ellis, 2001; Ellis, 1977b, 2007; Ellis & Grieger, 1977). He has often been noted to quote Epictetus: "People are disturbed not by things but by their view of things." In other words, "It is not the things themselves that worry us, but the opinions that we have about those things" (Wessler & Wessler, 1980, p. 238).

Likewise, Ellis (1977b) elaborated on the importance of self-acceptance and clearly distinguished self-acceptance from self-evaluation. In making this distinction, Ellis (1977b) also made direct reference to the work of philosopher Bertrand Russell, who espoused that self-centered passions including self-pity and self-admiration shut one's self in a personal prison. Wessler and Wessler (1980) characterized REBT as the "applied philosophy of Russell" (p. 3).

Although Ellis was familiar with the work of Alfred Adler, it was not until Ellis gave his first public paper on rational-emotive therapy in 1956 that others pointed out to him the significant overlap in the two approaches (Ellis, 1962). Adler emphasized the importance of life's goals and Ellis (1962) explained that, similar to his own emphasis on beliefs and attitudes, life's goals are a form of thought. Ellis (1962) also noted that Adlerians tried to help individuals learn that inferiority resulted from self-devaluation, similar to REBT counselors who explain inadequacy in terms of irrational self-beliefs.

Emotional Disturbance

Ellis (1993) proposed a biopsychosocial explanation of human emotions. He posited that humans are born with a tendency toward growth and also learn goals and preferences from environmental influences including family and society. Ellis (1962) proposed that individuals are propagandized by parents and society to hold certain values such as the need to be loved but then "repropagandize" (p. 191) themselves to blindly accept these notions. He described this as a "triple-headed propagandistic broadside" (p. 192).

Foremost in Ellis's theory, however, is the role of cognitions in the influence on emotions and behaviors (Ellis, 1962, 1971a, 1977a, 1989b, 2004).

He recognized that humans have an innate tendency to mentally construct absolute demands about their goals and preferences. He described these demands as self-defeating and irrational. Emotional disturbance comes about by irrational beliefs about one's goals and preferences.

ABCs of REBT

In training future counselors, I often begin by asking students the question: "What pushes your buttons?" There have been a wide variety of answers: "driving behind a slow driver on a main highway," "pop quizzes," "rude people," "waiting in line." I then proceed to explain that the students really push their own buttons. Ask yourself this question and keep your answer in mind.

As a prospective counselor, to introduce you to the tenets of REBT, I invite you to reflect on this scenario. Close your eyes and imagine yourself alone in New York City. This is your very first visit to New York. You need to travel on the subway to meet your friend. You have never been on the subway system. It is 10:30 at night, and you are supposed to travel to the SoHo district (South of Houston) from Penn Station. You are alone and on the subway platform. You are a bit nervous to begin with. Your friends have advised against this trip. There have been recent reports of women being raped and/or robbed on the subway. Suddenly you feel something like an elbow punch to your rib cage. It hurts and you begin to lose your balance. How are you feeling? What are your emotions? What is your reaction? On a scale of 1 to 10 (1 being very comfortable, 10 being extremely upset) where are you emotionally? Scared? Angry? Frustrated? Open your eyes and write the number down. (I have used this in class and many students expressed a variety of emotions including extreme fear and anger.)

Close your eyes again. Get back to the subway platform. You experience the pain of having your ribs being elbowed. You look around. You notice that there is a man standing next to you with a cane. He is blind. He inadvertently bumped against you. What are your emotions? What is your reaction? Is it the same?

Note that the event itself had not changed. You were still on the subway platform. You still received the elbow to your rib cage. What was different?

With his philosophical understanding that it is not so much the uninvited life events that cause a person to become disturbed, Ellis developed the ABCs of REBT. REBT proposes that people have basic goals such as striving for happiness, self-actualization, and desires for happiness, comfort, and approval. At times, something happens that interferes with achieving these goals. Ellis defined this as an *Activating Event* or

Adversity (A). This activating event is any experience or event that may occur on a daily basis such as failure or rejection (Ellis, 1977b, 2007; Ellis & Lange, 1994).

Ellis (1977b) would explain, for example, that a person might lose her or his job (A). Suppose that this person moped around the house for weeks instead of trying to get another job. This person might say she or he is depressed due to losing the job. The depression and inertia are emotional and behavioral *Consequences* (C).

Ellis would argue that the depression is not the direct result of the lost job. **A** does not cause **C**. Rather, Ellis would argue that it is the individual's *Beliefs* about the event (B) that cause the disturbance. An individual might feel disappointed or regretful (C) about losing a job (A) if her or his belief was one of wishing that she or he had not been fired but basically evaluating the job loss as unfortunate or sad. This disappointment is not a disturbed emotion. The person may tell herself or himself that she or he still has ways to enjoy life. However, regret does not make one's self miserable. On the other hand, when the individual believes and internally demands that she or he MUST have the job or judges herself or himself as worthless because he or she can't get meaningful employment and must rely on unemployment (B), these beliefs are characterized as demanding and self-defeating, or irrational. Would losing a job make you feel utterly devastated? Would it outright destroy you?

From the REBT perspective, emotions are not neatly categorized as positive or negative. Rather, they are seen on a continuum. Experiencing sadness (C) when I lose a job (A) or grief (C) when my spouse dies (A) are healthy emotions. Emotions become disturbed when they result from disturbed thinking (Ellis, 1962).

Ellis (1977b) distinguished rational beliefs (rBs) from irrational beliefs (iBs). If a belief is rational (rB), it will be based on objective reality and lead to individual happiness and survival (Ellis, 2007; Wessler & Wessler, 1980). A rational belief is based on notions such as preferences or wishes, and, when the preference is thwarted, a person may become frustrated or disappointed. On the other hand, an underlying an irrational belief is a faulty *appraisal*. It is based on notions of dogmatic absolutistic demands and musts. When thwarted, a person may become damning of oneself or others. Ellis (2007) referred to this as "I-can't-stand-it-itis" (p. 303). A client comes into therapy emotionally upset and proclaims, "My father does not love me." This statement may or may not be true. The primary focus of REBT is not on the veracity of a particular statement but on how the statement is appraised. Irrational beliefs lead to self-defeating and self-destructive consequences (Ellis, 1977b). This would be rational to believe: "It would be preferable for my father to love me." However, this would be irrational

to believe: "My father MUST love me." Irrational beliefs are marked by a combination of *awfulizing*, *demandingness*, and evaluation of one's self or others (Wessler & Wessler, 1980). Ellis has categorized the core iBs of REBT in a number of listings (Ellis & Grieger, 1977; Ellis & Harper, 1975; Ellis & Lange, 1994).

1. You MUST have love and approval by all of the significant people in your life.
2. You MUST NOT fail. You MUST be thoroughly competent, adequate, and achieving if you are to be considered worthwhile.
3. People MUST NOT act in a bad, wicked, or villainous way, and if they do they MUST be blamed or damned and considered as bad and/or villainous people.
4. If you are treated unfairly and things do not go the way you want them to be, it MUST awful and catastrophic.
5. Since you have little or no ability to control your happiness, you MUST be seriously disturbed and miserable when you experience externally caused disturbances or events that are difficult.
6. There MUST be a perfect solution to every problem, and I MUST be able to find it.
7. If something is or may be dangerous or fearsome, you MUST obsess about it and frantically look for ways to avoid even the possibility of it occurring.
8. You MUST be able to avoid certain difficulties and responsibilities and still have a fulfilling life.
9. You MUST have something or someone stronger or greater than yourself to rely on.
10. Because something terrible happened in your past, these past experiences MUST be all important determiners of your present behavior and feelings.
11. You MUST be able to achieve human happiness even if you don't do anything.
12. You MUST be able to be disturbed and upset by others' problems and disturbances since you don't have control over your emotions.

These iBs have been subsumed into three *musturbatory* notions:

1. I absolutely must do well and win the approval of my significant others or else rate myself as worthless or rotten.
2. Significant others must absolutely treat me kindly and fairly in the exact way that I want them to treat me or else they need to be blamed or damned for their inconsiderateness.
3. The conditions under which I live in this world must be arranged in such a way that I can get almost everything that I want quickly and easily and must not get anything that I do not want. (Ellis, 1977b; Ellis & Grieger, 1977)

The D-Es in REBT

The challenge for the REBT counselor is to help the client detect her or his iBs and learn techniques to *Dispute* them (D) (Ellis, 1971a, 1977b, 2004). Often disputation is done through debating. Take the above client who is angry and upset because his father doesn't love him. An *inelegant* solution would be to dispute by using some kind of reframing. Perhaps the father is overwhelmed by his job and feeling financial burdens. Maybe the house is in foreclosure. A more elegant solution is to help the client discover his irrational beliefs and dispute them through Socratic questioning. Where is the evidence that all fathers must love their children? Is there evidence that some fathers do not? A client is also taught to discriminate between wants and needs and desires and demands. A client is helped to see that it is desirable for her or his father to love her or him but demanding the love is self-defeating. Ellis (1977b) explained that after this process of disputation, a client might be led to surrender her or his irrational beliefs and acquire a new *Effect* (E).

Following is an excerpt from a therapy session that Ellis had with a client who had graduated from college, had a good job, and had a steady girlfriend. Still, he had a terrible fear that he might become a homosexual. Ellis (1971a) is disputing and trying to get the client to recognize the difference between preferring and demanding.

T. Now what?

C. I'll always be anxious (*inaudible*).

T. As long as you have necessities, demands, got-to's.

C. (*Inaudible*)

T. Because as soon as you say, "I've *got* to have *x*"—such as be straight—and there's the slightest possibility that you won't, then you'll say "Wouldn't it be *awful* if I were not what I've *got* to be?" While if you're sticking to "It's *desirable* to be straight, but I'm not or might not be," you'll say, "Well, tough shit! So I'd be gay! I wouldn't *like* it. And I'd work against it if I were gay. But what's so goddamned *horrible* about having an undesirable trait?" You see?

C. But that undesirable trait scares me.

T. No! "I scare me, with me got-to's! It isn't the undesirable trait that scares me. Since I *must* be straight, then the mere thought of being gay scares me. But if I *want* to be straight, and right now I'm not, I'd be *concerned* but not *scared*." Do you see the difference? (pp. 112–113)

However, besides the Socratic questioning, there are other techniques that are used to dispute iBs.

Techniques of REBT

While practitioners of REBT might employ a number of cognitive techniques, each is built on the fundamental goal of having a client recognize the need for unconditional self-acceptance (USA). As mentioned in the chapter before, the counselor likewise gives the client unconditional acceptance, though the counselor may be most interactive and challenging. Included below are some of the more common techniques used in REBT. Later in this chapter you will see that many of the practices of CBT are very similar.

Psychoeducational Emphasis. One of the most significant elements that distinguishes REBT is its emphasis on instructing the clients on the basic philosophy and tenets of REBT (Ellis, 1993). Clients are taught that change can happen and should be expected. In the initial sessions in REBT, the counselor specifically teaches a client the relationship between her or his emotional disturbance and the underlying thinking. The client is then taught to dispute the irrational beliefs. Ellis clearly believed that psychotherapy should focus much more on living a happy and self-fulfilled life. He stressed that it was crucial to "teach their clients how to choose more functional solutions to their lives" (Ellis, 2002).

In addition to teaching the basic A-B-C-D-Es of REBT, counselors often use other educational materials. These might include bibliotherapy and/or audiotherapy. Clients are taught problem-solving skills and are invited to attend workshops and lectures.

Ellis was known for his famous free Friday night demonstrations at the Albert Ellis Institute in New York. I recall my last visit to the Institute with a colleague prior to Ellis's death. We witnessed how this 90-year-old legend was still discussing and disputing iBs. He used rational-emotive imagery and invited everyone in the audience to join in singing his rational humorous songs.

Rational-Emotive Imagery. Rational-emotive imagery (REI) was originally developed by Maxie Maultsby and is now one of the main interventions used in REBT (Ellis, 1977a). This technique is designed to help clients learn the rational habits of thinking that are usually the opposite of what they normally experience. An REBT counselor might ask a client to complete an A-B-C-D analysis of the specific event that sparked a disturbing emotional response. For example, a client might come into therapy because of a fear of public speaking. Recently the client was embarrassed because of a blunder that was made when the client gave a report to his coworkers at a regional meeting. His girlfriend was attending the meeting.

The counselor would give a set of instructions to the client to help him or her relax.

1. Take a deep breath. Breathe in and out a slow but continuous motion, take a deep breath and force it out, saying to yourself, "Relax."
2. Now hold your breath for ten seconds, counting "one-thousand one, one-thousand two, one-thousand three," and so on.
3. Do this for a few minutes until you feel relaxed.

After the client is relaxed, he or she is directed to imagine the original disturbing emotion from the A-B-C-D analysis. The client is instructed to picture himself or herself only with the rational thoughts at the D section.

Ellis made some adaptations of REI (Wessler & Wessler, 1980). For example, the client is asked to close his eyes and imagine the presenting situation as exaggeratedly a *worst case scenario*. In the case of the blundering public speaker, coworkers might laugh out loud or even leave the room. The client loses the contract. His girlfriend cancels their dinner date.

As described above, the counselor gives the client sufficient time to get in touch with his feelings. The counselor instructs the client to raise his hand when he is experiencing the emotional distress at point C. The counselor then asks the client to experience his feelings. The client responds that he is feeling awful and depressed and utterly worthless. Next, the counselor asks the client to keep the same image of being in the auditorium making the same blunder but to change his feelings from an unhealthy feeling of awful and depressed and worthless to a healthy negative feeling of "not depressed and worthless, ONLY disappointed" (Ellis, 1977b, p. 202). The client is then asked what he thought about to change the feeling. REI becomes a form of deconditioning in which a client learns rational self-talk.

Shame Attacking Exercises. In an effort to help a client become more self-accepting and less dependent on the opinion of others, another technique often used in REBT is the *shame attack* (Ellis, 2004). In this exercise a client is invited to do something in public that might appear to be humiliating or even mortifying. Because each client might experience shame or embarrassment in different situations, these exercises are individualized (Wessler & Wessler, 1980). A client is asked what might be shameful or embarrassing. The client is then asked to put himself or herself in that situation. One client might be asked to dress in a silly manner such as a male wearing his tie around his forehead while going into a fancy restaurant. Another client may be asked to loudly call out stops on a bus or subway. These exercises are designed to help the client experience and practice changing her or his beliefs about the emotional consequences of another's perception. The client is asked to report back what she or he said to herself or himself to make the situation bearable.

In an interview with Jeffrey Mishlove, Ellis offered an example that he might suggest such as stopping someone "on the street and say, 'I just got out of the loony bin. What month is it?' and not feel ashamed when they look in horror at you and think you're off your rocker" (Mishlove & Ellis, 1995, p. 45).

I invite you as a prospective counselor to put yourself in a situation that is breaking some socially accepted norm. I have had students do this and report back. One student got into the elevator, faced the rear while everyone else was facing front, and talked out loud. Another example was a student who went into a computer lab class, took off her boots and socks, and walked around the room barefoot. However, I remind you and them not to do anything that might lead to you getting arrested or being fired from a job. The important part of this exercise is to ask yourself, "What did you say to yourself that made the exercise maybe somewhat embarrassing but bearable?"

Humor. As I pointed out in the previous chapter, REBT counselors understand that humor is a way of establishing the therapeutic alliance. It also is a way to help clients dispute their irrational beliefs. Ellis explained that in REBT, counselors use humor intentionally. Ellis (1989b) recalled the example of a woman who came to him with serious suicidal ideation. "Humorously again, I convinced her that even if she killed herself, she would not be a fool or a worm but only a person who was acting foolishly and wormly (that is, against her own interest)" (p. 78). One of her homework assignments was to sing one of his Rational Humorous songs at least three times each day. She left the session laughing and replied to Ellis, "It was a pleasure talking to you" (p. 80).

Ellis explained that "when you're unhumorous, you take things too seriously. . . . We never laugh at you, only the way you think and act and feel, and we show you how to laugh at yourself and not take yourself too seriously, which is what emotional disturbance, again, is" (Mishlove & Ellis, 1995, p. 45).

Ellis's humor can also often be seen in his use of peppery language. He might ask a client something like "Just because you acted in a shitty way, does that make you a shithead?" One of his most recognized coined words is *musterbation*. In REBT, counselors are taught to listen for when a client tells herself or himself that "I must do well," "She must do . . . ," or "The world must. . . ." In principle, if a person doesn't *musterbate*, then she or he wouldn't awfulize and catastrophize and disturb herself or himself. Ellis (1977a) believed that "*musterbation* (is) a form of behavior infinitely more pernicious than masturbation" (p. 263).

Homework. As mentioned in the previous chapter, homework assignments are integral to REBT as well as CBT and the completion of these assignments are indicative that a therapeutic alliance is being built (Garfield, 1989, 1995). But what might be suggested for an REBT assignment? While the assignments might include actual in vivo experiences, such as a person who has a fear of riding elevators might be required to ride an elevator up and down for 10 minutes every day for a week or practicing doing a rational emotive imagery every day for a week, Ellis (1971b) recommended incorporating behavioral self-management procedures into the assignments to help the client condition herself or himself to develop a consistent habit.

For example, after engaging the client in a rational emotive imagery exercise, an REBT counselor might ask a client, "Are you willing to do this every day until we meet for our next session?" After the client agrees, the counselor would add, "What is something that you really dislike doing?" The client might reply, "Dusting the things in my house." The counselor then asks the client, "What is something that you really enjoy doing every day?" The client might reply, "Playing a video game." The counselor then might instruct the client by saying, "Before you play the video game, you will practice this imagery. If you do not practice it, you must dust everything in your house." In his Friday night sessions, Ellis often exaggerated humorously and might have said something like, "And if you don't, you must also go dust everything in your mother's house."

Table 2.1 REBT Summary

A	Activating Event
B	Rational or Irrational Beliefs about the event
C	Emotional or Behavioral Consequence
D	Dispute the Irrational Belief
E	Effect of new Emotion

CBT in a Nutshell

Beck's theory initially focused on experimental testing and clinical observations of persons diagnosed with depression (Alford & Beck, 1997; Beck & Alford, 2009; Beck et al., 1979; Padesky & Beck, 2003; Rush & Beck, 1978). He was originally testing Freud's theory and found it to be lacking. This led to his formulation of what was originally termed the *cognitive theory of depression.*

Basic to Beck's cognitive model are three specific notions: (1) *the cognitive triad*, (2) *schemas*, and (3) *cognitive errors*. There is an underlying assumption that experiences are active processes that lead to *automatic thoughts* that are linked to *schemas* (Beck & Alford, 2009; Rush & Beck, 1978).

Cognitive Triad

According to Beck (1963; 1964), the role of cognitive processing is essential to understanding depression. There are three cognitive patterns that are seen to underlie depression (see Figure 2.1).

The first component centers on how a person views herself or himself. Persons with depression will have a *negative view of themselves*. They will see themselves as worthless, somehow defective and inadequate. They do not believe that they possess the qualities necessary for happiness. Persons who are mildly depressed may report being disappointed in themselves, whereas the more severely depressed might consider themselves despicable and unworthy of living. For example, a person in a situation when a coworker receives recognition for a job well done will automatically think something like "I'm no good" or "I'm a loser" (Beck & Alford, 2009; Rush & Beck, 1978).

The second component involves how a person construes his or her environment. Persons with depression have a *negative view of their experiences in the world*. Their world is devoid of meaning. The environment places too many unreasonable demands on them. Even when evidence is presented that there are alternative interpretations of a situation, depressed persons continue to tailor facts to fit into their negative conclusions. For example, a student who doesn't get the grade he thinks he deserves may

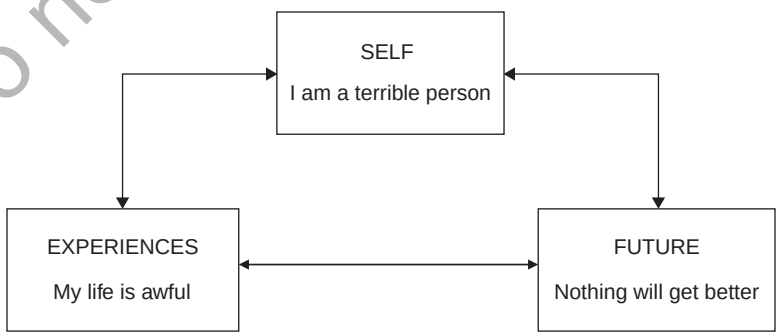

Figure 2.1 Cognitive Triad of Negative Views Leading to Depression

automatically think to himself, "It isn't fair, the teacher plays favorites," even though it was clear that the student didn't follow the rubric that was given.

The third component focuses on how a person views the future. Persons with depression have a *negative view of the future*. They believe that things will never get better. If they have a task to accomplish, they automatically think that it will result in failure. These negative expectations can take the form of fantasies. Even though a person might ordinarily have enjoyed skiing when she was not depressed, she might now fantasize that she probably would fall and break her leg.

With this negative cognitive triad, persons with depression will exhibit certain regressive motivational patterns. There may be a certain *paralysis of the will*. They often are not able to mobilize themselves to perform even the simplest tasks. They may know what they need to do, such as get up and go to work, but often can't do it.

Another motivational pattern that persons with depression often exhibit is *avoidance or escape wishes*. A student may know that a paper is due but can't muster enough energy to do it. In class, that student may daydream rather than pay attention to the professor. A more severely depressed individual might not want to be friends and may even drop out of his or her social circle.

A person with depression will often have *suicidal wishes*. In their research, Beck and Alford (2009) reported that suicidal ideation was reported by 74% of their patients. It took the form of overt expressions such as "I wish I were dead" to more indirect verbalizations like "My family would be better off without me" (pp. 30–31).

These negative self-statements are closely related to Ellis's irrational beliefs—motivations are interdependent and may often lead a person to feelings of dependency and wanting to be helped (Beck & Alford, 2009).

Schemas

A schema is a stable cognitive framework that a person uses to organize and interpret events from a "kaleidoscopic array of stimuli" (Beck, 1964; Rush & Beck 1978). Although different persons may react to situations in different ways, individuals tend to extract aspects that become a coherent pattern that becomes a more or less permanent reaction. While not directly observable, schemas can often be inferred by negative thought patterns. For example, a person may have the schema that he or she must do everything perfectly to avoid being a failure (similar to Ellis's iBs). That person goes to the pool and jumps in for a swim. He or she may begin to think, "I don't swim as well as everyone else."

Cognitive Errors

As a person's depression becomes worse, she or he is less able to see that the schemas are erroneous. This leads to a distortion of the person's thinking. There are a number of cognitive errors in logic that Beck put forth (Beck, 1963; Beck & Alford, 2009; Rush & Beck, 1978).

- *Arbitrary inference* refers to an erroneous conclusion that is made about a situation without supporting evidence or contrary to the evidence that is at hand. There is often an unwillingness to consider alternatives. A person goes into the drug store to get a prescription filled. The druggist isn't smiling. The person may think to himself or herself, "The druggist doesn't care about me." Is there proof? Could the druggist have a headache?
- *Selective abstraction* refers to an erroneous conclusion that is made on the basis of a small detail taken out of context while neglecting the more relevant aspects of the situation. A student may receive a paper with minor corrections on it. The student may say to herself or himself, "The teacher probably thinks that I don't even care about my work."
- *Overgeneralization* refers to an erroneous conclusion based on one single incident. An employee has a project that is due to his boss but he missed the deadline. That employee says to himself, "I'm such a failure, I never do things the way I should."
- *Magnification and minimization* refers to an erroneous conclusion such that negative information is extremely distorted and/or positive information is grossly trivialized. Jim is on a date with his girlfriend. He spills coffee on his shirt. He thinks to himself, "This is a disaster. I'm sure she will never want to see me again." This is magnification. In contrast, Carol's friend's father died and she is at the funeral after baking a cake and taking it to Carol's house. Still, she thinks to herself, "Even this doesn't make up for when I forgot to send her a birthday card last month." This is minimization.
- *Personalization* refers to an erroneous conclusion that a person makes about her or his responsibility for an external event when it is not her or his fault. Dottie's chore is to walk the family dog. When she didn't do it, her mother thought to herself, "I must not be a very good mother since my daughter didn't take her responsibility seriously."

Just as in REBT, the focus of CBT is on helping clients examine their core beliefs and test their accuracy. However, Beck's emphasis is not so much on the *irrationality* of a person's beliefs but rather on the *functionality* of those core beliefs (Padesky & Beck, 2003). Consider the example of a person who holds the belief that "God will protect me." If this belief brings a person spiritual comfort, it would be considered functional. On the other hand, if it leads the person to drive recklessly on the turnpike, it would be quite dysfunctional (Padesky & Beck, 2003). In Beck's cognitive model, *core beliefs* influence a person's attitudes or self-expectations (*intermediate beliefs*), and these give rise to automatic thoughts that influence his or her emotions and behaviors (Beck, 1963).

Techniques in CBT

Similar to REBT, a CBT counselor will question the client, help the client identify illogical thinking patterns, help the client search for alternative solutions, and use many similar cognitive and behavioral interventions. These may include assigning homework, bibliotherapy, using an activity schedule to help the client overcome lack of motivation, cognitive rehearsal, and role playing. Some are more specific to CBT (Beck et al., 1979).

The CBT record is a worksheet to help clients identify automatic and negative thought patterns. Beck et al. (1979) also suggested the use of a modified wrist golf counter as a helpful way for a client become more aware of his or her automatic negative thoughts.

Effectiveness of REBT/CBT

There is sufficient evidence that CBT is an effective treatment for a wide range of conditions (see Hollon & Beck, 1994). While this is not to say that REBT is at all less effective, from its inception, the initial emphasis in CBT was specifically aimed at finding empirical data to support Beck's theory of depression. In comparing CBT and REBT, Padesky and Beck (2003) argued that CBT was more empirically based and REBT was more philosophical. While Ellis (2005) agreed with many of the points that Padesky and Beck made, he disagreed with the criticism that REBT lacked outcome studies. He commented, "Actually, over 200 outcome studies on REBT have been published, but many of them have not been as rigorously done as CT studies" (Ellis, 2005, p. 181).

Depression

Over the years, CBT and psychopharmacology have been called the "gold standard" for the treatment of persons diagnosed with a major depressive disorder (Hollon et al., 2005). CBT has been found to be at least as effective as medication and the effects possibly longer lasting (Hollon & Beck, 1994).

In a meta-analysis review, Dobson (1989) analyzed 28 studies of clients diagnosed with depression who had been treated with (a) CBT, (b) clients who were treated with medications, (c) clients who received behavior or other therapies, and (d) clients who were on the wait list or no treatment control group. Results showed that clients who received CBT showed a greater degree of change.

On the other hand, Siddique, Chung, Brown, and Miranda (2012) found that moderately depressed women who received medication were less depressed after 6 months than those who received CBT, but after 1 year

there was no difference. There were no significant differences with women who were severely depressed, but after 1 year those who received CBT were less depressed than those on medication.

Szentagotai, David, Lupu, and Cosman (2008) compared standard CBT, REBT, and medication in the treatment of depression and on changes in thoughts and beliefs. These authors examined the effects of each on measures of (a) irrational beliefs (REBT), (b) intermediate and core beliefs, and (c) automatic thoughts. All three treatments showed changes in the three types of cognitions. In a 6-month follow up, both REBT and CBT participants showed improvement on a measure of depression.

Other Applications

Again, in addition to treating a person with depression, Beck and his colleagues have applied the principles of CBT to a wide scope of disorders (Hollon & Beck, 1994). Books have been published with manuals describing how CBT can be used to treat panic and anxiety disorders (Clark & Beck, 2010) and each of the personality disorders (Beck, Freeman, & Davis, 2004).

Counselors who are interested in working in a school setting will also find REBT/CBT very helpful. Many strategies have also been developed to address the needs of children in the educational setting. Some examples include suggestions for adolescents with eating disorders (Mennuti, Bloomgarden, Mathison, & Gabriel, 2012), developing substance abuse prevention programs in schools (Forman & Sharp, 2012), and implementing bullying prevention interventions (Doll et al., 2012). Interventions for children diagnosed with autism (Bolton, McPoyle-Callahan, & Christner, 2012) and attention deficit hyperactivity disorder are also based on REBT/CBT. Interventions used for the treatment for anxiety are suggested for use with students who are selectively mute (Mulligan & Christner, 2012) and for lesbian, gay, bisexual, transgendered, and questioning (LGBTQ) (Weiler-Timmins, 2012).

Kendall and Hedtke (2006b) developed *The Coping Cat Workbook* for treating anxiety in children. This workbook has been used in the school setting as well in the clinical setting (Gosh, Flannery-Schroeder, & Brecher, 2012).

Common Factors and Challenges of the Medical Model

Focusing on diagnosis might raise a concern from the common factors perspective. Because he contended that psychotherapy is an interpersonal process and not a medical procedure, Elkins (2009) made strong arguments against continuing to use the medical model framework in psychotherapy. I agree

that this is a particular challenge for REBT/CBT counselors since there are ample empirically validated studies showing the effectiveness of REBT/CBT.

There has also been concern that overreliance on manualized treatments actually may decrease the therapeutic alliance (Addis, Wade, & Hatgis, 1999). The question then remains: Is the effectiveness of CBT dependent on its use of manualized treatments so results can more easily be controlled?

Beck reminded novice counselors to be wary of "slighting the therapeutic relationship" (Beck et al., 1979). Likewise, even though research supports the effectiveness of both REBT/CBT, Ellis himself never had a manual and would never be constricted to following sessions that might be prescribed. His Friday night sessions were anything but manualized.

Ellis (1989a) himself encouraged variability and commented that "I do . . . considerably vary both my style and content in using RET with radically different clients; and I strongly recommend that other counselors do so" (p. 221). I believe that if REBT/CBT counselors become too wedded to the medical model, Ellis himself might poke fun at this when "presumably intelligent men and women, with hell knows how many academic degrees behind them (which we may unhumorously refer to as degrees of restriction rather than degrees of freedom), consistently take themselves too seriously" (Ellis, 1977a, p. 262).

"Love Me, Love Me, Only Me!"
(To the tune of "Yankee Doodle")

Love me, love me, only me
Or I'll die without you!
Make your love a guarantee,
So I can never doubt you!
Love me, love me, totally
Really, really try dear.
But if you demand love, too,
I'll hate you till I die dear!
Love me, love me all the time,
Thoroughly and wholly!
Life turns into slushy slime
Less you love me soley!
Love me with great tenderness,
With no ifs or buts dear.
If you love me somewhat less,
I'll hate your goddamned guts, dear![1]

[1] Ellis, A. (Speaker). (1971c). A garland of rational humorous songs [Cassette recording]. New York: Institute for Rational-Emotive Therapy. Printed with permission.

Summary

- Although REBT developed from a more philosophical stance and CBT from a more empirical base, both agree that cognitions have an effect on emotions.
- Both REBT and CBT have an educational component where clients are specifically taught the basic tenets of each respectively.
- The language of REBT is in the ABCs. The activating event (A) does not cause the emotional consequence (C). Rather, it the irrational beliefs (B) about the event that cause the disturbance. The beliefs that are irrational are disputed (D) through a variety of methods. A new more healthy emotion (E) results.
- CBT uses the language of a *cognitive triad*. A negative view of (a) one's self, (b) of one's world, and (c) one's future underlies the development of depression.
- There are many empirical studies that demonstrate the effectiveness of REBT and CBT.