Rational Emotive Behavior Therapy:

The Journey Toward the Development and Application of My Theoretical Orientation

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As an early career psychologist it is imperative that I recognize why and how I conduct therapy. The delivery of therapeutic services has to emerge from a theoretical grounding in conjunction with the core values of the therapist. A variety of experiences have enhanced my understanding of my core values and influenced my perspective on what may influence thoughts and behaviors. I have found it is important to challenge clients in session helping them identify barriers that prevent them from living optimally. Developing my own theoretical orientation has been an evolving process. The process began by understanding my core values, philosophy of science orientation, research paradigm, and how they are connected to my preferred theoretical orientation.

The first section of the current paper will discuss my core values and philosophy of science orientation. Next, the section will focus on the evolution of my theoretical orientation and how I embraced different approaches to therapy before eventually finding what style works best for me. The section will conclude with an explanation and rationale as to what my current theoretical orientation is and why it seems to be my best fit.

Core Values and Philosophy of Science Orientation

My core values include accepting the self as a worthy, confident, and moral person. I believe that self-acceptance emerges from the beliefs we have about ourselves to help predict how we feel about ourselves. Understanding that we can take ownership of our behaviors, emotions, and cognitions can influence how much we value ourselves in both research and practice.
In my philosophy of science, understanding the individual, their behaviors, thoughts, emotions, and patterns in the moment are fundamental. From a constructivist-interpretivist research paradigm, it is essential to understand how my core values impact clients. Therefore, when conducting therapy, I feel there are different realities; each one constructed by the individual who helps inform and direct therapeutic outcome and research. A key component to my philosophy of science is to verbalize therapeutic techniques in an interactive, subjective, and personalized manner. To best understand individuals seeking therapy, I want to comprehend their personal narratives without categorizing or generalizing their experiences. Therefore, in the process of understanding individuals my theoretical orientation has evolved numerous times.

Behavioral Therapy

Throughout my professional development my theoretical orientation has shifted repeatedly. During my undergraduate degree and a portion of my master’s program I immersed myself within the context of Applied Behavioral Analysis (ABA) while working with autistic children. The implementation of the ABA approach has shown to be effective with children suffering from autism (Baer & Risley, 1987; Birnbrauer & Leach, 1993; DeMeyer, Hingtgen, & Jackson, 1981, Jensen & Sinclair, 2002; Fenske, Zalenski, Krantz, & McClannahan, 1985; Lovaas, 1987; Simpson, 2001). The premise of ABA is to engage children in a variety of structured behavioral trials conditioning them to learn tasks that are intended to become routine (i.e. mastered). I found that the behavioral interventions were beneficial for the children I was working with. The experience helped me believe that similar ideas could naturally be applied to anyone experiencing some form of physical, cognitive or emotional dysfunction. Therefore, at the start of my master’s program, I embraced the theoretical orientation of Behavioral Therapy (BT).
Much of my early work during my master’s program was with adolescents. Adolescents wanted to see immediate results and thus we focused on present problems rather than past behaviors. I wanted to involve clients in the process of therapy by actively engaging them in specific activities allowing them to see the change transpire. I believe that clients have the ability to make the appropriate changes within their own environment. Therefore, any interventions that were implemented could be practiced both in session and outside of session. It was my hope that clients could eventually generalize, evaluate, and conduct their own therapy. However, while conducting therapy much of the process focused on building rapport with the clients.

According to Cormier & Cormier (1998), BT has a strong focus on the relationship between client and therapist. The collaborative process of developing a treatment plan -setting goals, assessing the advantages and disadvantages of the goals, and the nature of goal implementation and attainment- reaffirmed my attraction to BT. I believe that if individuals took a moment to attend to their maladaptive behaviors and recognized an alternative, they could condition themselves to learn another response. However, the further I immersed myself in the professional role of a therapist, the more I became focused on the individual person rather than any interventions I could implement into practice. Therefore, I began to evolve from BT to more of a person-centered Rogerian approach.

**Client-Centered Therapy**

Rogerian Client-Centered Therapy (Rogers, 1951) became interesting to me because of the concept of self-actualization and working from the client’s belief system. I felt the need to diminish my solution-focused tendency of attending to immediate behavior change and direct more of my energy to empowering the client. I wanted clients to recognize that they have the tools and ability to create a desired change. Additionally, it was important for me to take more of
a passive role and be comfortable with clients leading the session. Adhering to a Rogerian style of therapy, I was able to provide more space to collaboratively achieve therapeutic understanding (Ward, 1994).

Rogerian techniques that focused on empowering clients and having them see how they could become more psychologically balanced were important to me. By attending to the core of the clients’ issues I would indirectly understand their destructive behaviors and how these behaviors could be modified. What seemed to be most intriguing to me was physical and emotional presence with clients. I felt one of my core values was to be optimally present with each interaction and understand each individual within their own context.

As I further developed professionally, I began to understand that Rogerian Client-Centered therapy had its deficiencies. The most common pitfall was that Rogerian therapy assumes clients have the resources to make the changes outside of session. Additionally, being present is crucial, can help build rapport, and strengthen the therapeutic relationship (Asay & Lambert, 2002), but that did not seem sufficient to help clients change long-term. I began to understand that if clients cannot think about why their distortions exist, then rapport and basic microcounseling skills are insufficient.

I started to process the importance of the here and now utilizing Gestalt psychology when focusing on the needs of clients. I felt aspects of Rogerian therapy were necessary, but it was essential to be actively engaged in the process using some techniques and not just a certain attitude toward therapy. I understand the importance of historical exploration comparable to a Psychoanalytic approach (Morgan & MacMillan, 1999). However, as my population of interest became older adolescents and college-aged individuals, I noticed they needed to see immediate and direct action and intervention to determine effectiveness.
The more therapy I conducted, the more I realized how much my personality and core values factored into my theoretical orientation. I understood the benefits of BT in which goal-setting and an action-oriented collaborative approach to therapy can be effective. Additionally, I understood the necessity of having sessions focus on the client with Rogerian therapy, and the importance of the here and now with Gestalt therapy. However, I recognized that to be optimally present with clients, I felt most comfortable in session providing techniques they can utilize. Thus, I felt my clients were not receiving as much as they could from my personal and professional abilities in session. I internally processed that shaping my personality to a certain therapeutic style was less effective than staying true to my core self and associated values.

My foundational core value is that above all it is essential we accept ourselves as worthy individuals regardless of the events that transpire in our lives. Additionally, embracing discomfort, taking risks, and experiencing failure are to be seen as opportunities for growth rather than a reason to engage in self-destructive thoughts. It was necessary for me to still find value in being present and empathic with clients, having them continuously check-in with themselves while taking ownership of their thoughts. Consequently, integrating my experiences with my core values led me to adhere to my current theoretical orientation: Rational Emotive Behavior Therapy.

My Current Theoretical Orientation and Its Practical Application

*Rational Emotive Behavior Therapy (REBT)*

Similar to the foundation of Rational Emotive Behavioral Therapy (REBT), it is my belief that all humans are innately born with the rational ability to think sensibly if given the opportunity and space. However, I am also aware that people may be as likely to have irrational negative thought processes that can contribute to cyclic procrastination of functional actions.
Therefore, after much thought, reflection, and experience, my current theoretical orientation is REBT for two main reasons. Firstly, using REBT in therapy allows me to focus on the thought process of the client, confront them, and question their irrationality and destructive fixed thinking. Secondly, REBT can be implemented effectively in a brief therapy setting (Mas-Baga, 2000) comparable to a high school or college counseling center, which meshes with my desired population and setting of interest.

As I have gained more insight into REBT, I realized that I can still use aspects of the various theoretical orientations, such as BT (Foa, 1996), Gestalt (Clance, Thompson, Simerly, & Weiss, 1994; Greenberg, Rice, & Elliot, 1993; Greenberg, Elliot, & Lietaer, 1994) and Rogerian (Tuesch, Bohme, & Gastpar, 1997), while still practicing REBT. For instance, focusing on the here and now of clients’ thoughts, how those thoughts are impacting their behaviors, and challenging their irrationalities while building empathy encompass all of the aforementioned modalities.

Additionally, I found that not only can I naturally integrate the techniques of REBT into session, but also integrate my own personality with those techniques. I acknowledge the efficacy and effectiveness of the aforementioned theoretical orientations (Clance et al., 1994; Foa, 1996; Greenberg et al., 1993; Greenberg et al., 1994; Morgan & MacMillan, 1999; Tuesch et al., 1997) in a variety of settings. However, I feel that REBT provides an ideal integration of my core values, philosophy of science, and research orientation.

The current section will emphasize a brief historical overview and the core theoretical aspects that have shaped REBT. Then the focus will shift to outlining confirmatory evidence of the applicability of REBT in a therapeutic setting. The section will then emphasize how client change is noticeable, what initiates maladaptive behavior and how that can be addressed with
REBT. Next, I will discuss how REBT connects with multicultural counseling, including the strengths, limitations, and practical implications when working with diverse clients. Finally, I will review research on the effectiveness and efficaciousness of REBT and discuss how this research has informed my clinical work. The section and paper will conclude by detailing specific successful and unsuccessful case examples in my own clinical work illustrating the impact of REBT highlighting my approach to both assessment and interventions.

**History and Principles of REBT**

REBT was founded in 1955 by psychoanalyst Albert Ellis. As Ellis’ primary work focused on marriage therapy, he believed that for people to live healthily and happily together they had to first live happily with their own self (Ellis, 1962). The foundation of REBT was heavily influenced by Greek and Roman philosophies emphasizing that people are not disturbed by the incidents or events in their lives, but more so how they choose to perceive these events. Emerging from a postmodern viewpoint (Ellis, 1994), REBT embraces the Christian perspective of forgiving the sinner more than the sin itself, thus not disliking the person but instead disapproving of their action(s).

REBT was also influenced by the work of Alfred Adler such that it assigns intentional goals, values, and meaning to an individual’s thoughts (Ellis, Gordon, Neenan, & Palmer, 1997). Additionally, the initial intention of REBT was an active-directive approach, which stresses the importance of straightforward thinking about cognitions with direct involvement from the therapist in session. Originally, Ellis referred to the modality as Rational Psychotherapy (RT, Ellis, 1957), stressing that rational thinking aided in the effective outcome of psychoanalytic change. Emotions were then integrated into the techniques, further solidifying the tenets of the therapy and resulting in a name change to Rational Emotive Therapy (Ellis, 1962). By 1993, the
name had been changed again to Rational Emotive Behavior Therapy; Ellis acknowledged the importance of including behavior as a cornerstone of the theory because changing irrational beliefs (IBs) to rational beliefs (RBs) can lead to healthier behaviors.

The structure of REBT was referred to as the ABC framework of disputing IBs (Ellis, 1962). The ABC model was used to construct effective emotions and thinking patterns. The model progresses in a way that the client acknowledges an activating event (A) that creates distress. Then the client acknowledges the feelings that emerge as a result of the activating event, which Ellis referred to as the consequences (C). Finally, attending directly to the belief about the event (B) is the crux of the model. Clients are to communicate the activating event, the associated consequences, and the intermittent belief about the event that causes the feelings/emotions. There are a number of examples where humans engage in irrational thinking that fit with the ABC model.

For instance, I once worked with a female sophomore in college who was experiencing anxiety with public speaking. The event (A) was speaking in front of large audiences and the consequences (C) were the feelings of inadequacy, nervousness, and fear that she expressed. The IB (B) was “I think everyone thinks I am incompetent,” “I think they all want me to fail,” and “If I cannot do this, I am a failure.” Converting the IB to RB included constructing statements such as “What evidence exists that everyone in the room thinks I am incompetent?”, “What makes me think everyone wants me to fail?”, “If I fail at this one single event, does that really mean I am a complete failure?” As she began to understand that she did not have any evidence for any of her beliefs, she felt a sense of relief, more relaxed, and a sense satisfaction instead of fear, worry, and nervousness.
The ABC model of thinking is not used to replace negative thoughts with positive ones. The purpose of the model is to acknowledge the negative thoughts and alter the philosophy of thinking that can lead to constructive cognitions, emotions, and eventually behaviors. Therefore, REBT includes processing with clients that they have a choice in how their thoughts and consequential feelings emerge into action. For example, replacing “S/he makes me angry” with “In this one incident I feel angry, but s/he does not make me angry all the time” can lead to a more constructive and successful mode of thinking.

The notion of preference versus the absolute is another major principle of REBT. The idea is to change absolute “musts” to “preferences”. Therefore, adopting RBs of “preferring” may lead to goal achievement, while relying on “absolutes” (IBs) may lead to prevention of goal attainment. An example of an “absolute” or “must” statement is “I absolutely must pass my test otherwise I am a complete failure.” An example of a “preference” statement would be “I would prefer to pass my test, but if I do not that does not mean I am a complete failure.”

There are an excess of irrational beliefs that Ellis highlights as the focal point of REBT. Such IBs include awfulizing, frequent jumping to conclusions, focusing too much on the negative while disqualifying the positive, and personalizing negative events. All of the aforementioned include extreme negative thinking that lead to negative, defeating behaviors. The key is to know the difference between the presenting IBs and what the resulting feelings are.

Ellis and Dryden (1997) emphasized the importance of understanding the difference between the IB, the negative feelings that result from these beliefs, and the impact they can have on the resulting behavior. For example, “I must not fail at school, it’s awful when I do and it means I am a complete failure.” The consequential feelings emerging from thoughts of this nature may lead to anxiety, depression, and lowered self-confidence and self-worth. The
intention behind knowing the difference between IBs and RBs helps acknowledge the IBs and the consequential feelings both in session and out of session. Much of the application of REBT outside of session occurs through homework assignments.

Changing insight with homework and practice, the client(s) will feel better in the present and get better in the future (i.e. long-term). Although REBT is its own orientation, because of the heavy emphasis on cognitions, behaviors, and emotions, it tends to fall under both Cognitive Behavior Therapy and Cognitive Therapy (Beck, 1976; Beck, Rush, Shaw, & Emery, 1979). However, REBT differs from CBT because it is not manualized and the primary focus is on cognitions and not behaviors. The intention of REBT is to strive for success and comfort in thinking patterns changing musts to preferences to see that change is noticeable. Nevertheless, when working with clients it is important to focus on all three components: cognitions, behaviors, and emotions.

Analysis of Maladjustment and REBT

Maladjustment, according to REBT, involves two main underlying foundations: humans are naturally inclined to have IBs, and they place excessive demands on themselves to succeed (Ellis & Dryden, 1997). Consequently, these innate IBs and excessive demands can lead to psychological maladjustment creating more disturbed thinking (Ellis & McLaren, 2005). Thus, if clients can understand that much of their distress is rooted within their thoughts, they can alter IBs to RBs. If not, clients may further disturb themselves.

Additionally, irrational thinking stems from the biological emphasis that humans innately think irrationally. It is within the theoretical structure of REBT that humans have considerable demands of the self, others, and the universe. If and/or when one of the aforementioned demands interferes with flowing cognitions, destructive self-defeating thoughts, feelings, and behaviors
can occur. Humans are biologically programmed to embrace self-defeating tendencies versus self-enhancing tendencies because it is easier, even though it may be irrational. For example, it is easier to overeat than it is to maintain a diet of restrictive eating habits. An example of an IB that is related to overeating would be “I do not believe I can adhere to a strict diet, the last time I tried I failed. I always fail at dieting. I can’t do anything about it. It’s just easier for me because I have always been this way.” The intention of REBT is to acknowledge these tendencies, IBs and convert them to RBs.

**Actualization and Conceptualization of REBT with Clients in Practice**

REBT focuses primarily on client thinking patterns to overcome destructive beliefs. There are a number of ways to confirm the impact of REBT when working with clients. It is my belief that the main conceptualization of maladaptive behavior lies within the construction of an individual’s thoughts. Thus, if clients can see that they can think differently about their thoughts and the direct impact it has on the associated feelings, they may better understand that they are in control of their distress. So, what does it look like? Where is the proof for the therapist and the client that it does ‘work’? The proof REBT works exists both within and beyond the session.

For instance, when working with a client, I have them articulate one example of changing IBs to RBs and noticing that the associated consequential feelings tend to be preferable. By illustrating one example of effectiveness, the tendency is that the client becomes more motivated to generalize the same concepts to additional activating events. Integrating the ABC model directly into session with the client, in a safe and encouraging environment, may help them actualize their ability to rationally think about their cognitions.

Additionally, I usually have clients leave the session with an assignment of filling in an ABC chart (As, Bs and Cs of rational thinking) then returning the following week with a
completed chart of as many examples as they could create. The proof from the chart will confirm to the client that REBT works because they will have their own written evidence. Clients can use completed homework as a reference if/when relapse occurs. In my own clinical work, the clients who have embraced the homework assignments have found these assignments helped them recall successful interventions and provide them with the evidence that they can modify their perceptions. The goal is for clients to begin using REBT language both internally and externally. Converting IBs to RBs in an expedited, natural manner further confirms REBT is becoming naturally embedded within the client’s language, thoughts, and consequential actions. As part of the termination process, I have clients explain to me what REBT is, which tends to create a sense of empowerment for them.

From a cognitive perspective, engaging clients in disputing their irrational cognitions may help increase client self-efficacy. Secondly, it is essential to acknowledge with clients the difference between preferences of beliefs versus evidence the beliefs actually exist. Thus, if the client does not have any evidence, altering the debilitating thought to an idyllic preference can help them see how change is possible.

Engaging clients in philosophical exploration forces them to understand they can change their perspective. Philosophizing too much on one problem and catastrophizing life, clients may be ignoring all the positive events occurring. Disputing overgeneralizations, clients can see change. Using rational coping statements will help clients realize that if they fail at one event it does not mean they have to think they are a complete failure.

Another method that identifying change can occur is referred to as referenting (Ellis & McLaren, 2005). Having clients make a list of all the advantages and disadvantages of their method of thinking with specific scenarios can help them see the patterns of their thoughts.
Making this list, clients can see the advantages of their thoughts on paper and if there are more disadvantages use the appropriate REBT techniques to diminish them. Overall, cognitively reframing negative thinking to positive, constructive thinking can be helpful. Stopping the thought and monitoring the destructive belief will help the client notice evidence within themselves and their thoughts that they can change. However, cognitions are only a fraction of the foundation for clients as emotions have equal weight in the internal restructuring.

The core behind the emotional component of REBT is how clients feel about themselves. REBT emphasizes unconditional self acceptance (USA) and unconditional other acceptance (UOA). Thus, regardless of the activating events that occur in our lives, above all else it is important that we still accept ourselves as well as others as worthy and capable beings. REBT emphasizes USA and UOA to acknowledge that although distress will happen, how you feel about yourself and others will dictate how you respond and view consequential beliefs. Therefore, others may disappoint you, but if you can see and acknowledge your disappointment and recognize that these are isolated events, you can still accept the person.

Integrating an active directive approach to the therapeutic process which involves continuously challenging clients’ IBs will help build empathy. The approach is active because the therapist is just as much a part of the session as the client and it is directive because the therapist is intentionally instructive in the responses to the client. By using USA and UOA, the hope is clients will begin to conceptualize that negative events are going to happen but this does not have to define them as a whole. Furthermore, focusing on the past and primarily attending to thoughts in the present during session will further help build rapport by communicating the therapist’s presence. It is also important to understand that according to Ellis & McLaren
REBT does not have one absolute method for conducting REBT in session and thus it will vary based on the needs of each individual client.

Once clients start to realize the biological, social, and environmental connection they will begin to understand the impact their thoughts have on the world and how they view it. Understanding the difference between IBs and RBs will help clients see change is possible. The active-directive style is intended to have clients getting better in the moment with the intention of feeling better in the future. Regardless of their race, religion, and cultural background REBT can be adaptable.

REBT and Multicultural Counseling

The primary intention behind implementing REBT is to be people-and problem-specific, beginning with isolated incidents in people’s lives (Corey, 2001). Therefore, focusing on an emic perspective, REBT emphasizes the tendencies specific to each individual client. The issues can therefore range from religion, race, and socioeconomic status with respect to the individual. The applicability of REBT has many strengths when working with diverse clients, as the modality is primarily based on environmental influences, experience, perceptions of the world, and the individual’s history.

A strength of REBT is that it accounts for cultural background and is open to diverse cultures because each client is seen as an entity in and of themselves (Adomeh, 2006; Gregas, 2006). There is no standard format or number of sessions to REBT. Thus, opposing strict structured thinking, REBT is intended to help clients process how they’re thinking, acknowledging their preferences, and allowing themselves the space to be open and flexible to alternative thoughts. Additionally, REBT accounts for the differences in cultural practices but stresses that these practices are in fact preferences and do not need to be absolute.
Emphasizing the notion that irrational ideas exist within all humans regardless of culture, being inflexible and focusing on a structured number of sessions may decrease the purpose of therapy and create added stress for many clients. For example, a client may present an issue of discrimination that cannot be generalized to others. From my previous experience, in as few as two sessions, providing the clients with space to explore how they think of themselves regardless of what others may have said to them is the underlying premise of USA. The concept of USA can be implemented early in treatment to help modify client perspectives. Therefore, another strength of REBT when working with diverse clients is the focus it has on helping clients concentrate more on their perception of their self to help them realize how much control they have over how they feel. Focusing multicultural counseling on empowerment can be quite effective.

Another strength of REBT is its significant link with religion, as it is primarily based on religious beliefs (Nielsen, 1994). Much of REBT is synchronized with Christianity (Nielsen, Johnson, & Ridley, 2000). For instance, one view fundamental to Christianity is that all people are equal and worthwhile and sins can be forgiven. A strong precept to REBT is not accepting an action that may cause distress, but still accepting the person who performs the action. This connects well with the Christian beliefs (e.g., not forgiving the sin, but forgiving the sinner). For example, in cultures where suicide bombing or genocide directed by a single dictator occurs, REBT would not support immoral acts, but still accepts all humanity regardless of their actions. Thus, a suicide bomb may not necessarily be an acceptable act as it could claim the lives of innocent people. However, according to the REBT principles, an individual may not accept the act (i.e. the sin), but it is preferred that one can still accept the person (i.e. the sinner), their beliefs and see them as a worthy individual (i.e. UOA).
A plethora of religions share similar philosophies with REBT, such as the idea that people create their beliefs and resulting disturbances (Walen, DiGiuseppe, & Dryden, 1992). The common thread of free will in many religions is congruent with the notion that people are innately responsible for disturbing themselves (Nielsen et al., 2000). According to DiGiuseppe (1991), religion also frequently encompasses an educational component to its doctrine similar to that of the various disputations in REBT (e.g., philosophical, empirical, logical, and functional).

Although there are many strengths of the practical application and implications of REBT when working with diverse clients, there are also a variety of limitations of the orientation that could impede the progress of therapy. For example, REBT is active and directive. Some cultures and individuals from certain racial or ethnic backgrounds may be reluctant to explore their thoughts and feelings (e.g., Asian-Americans; Sue & Sue, 2008). Therefore, engaging in directive REBT may be too confrontational, intrusive, and counterproductive for certain clients.

Additionally, REBT tends to use confrontational language and can be intimidating for individuals who are not comfortable with this style of communication. Consequently, certain clients may become more detached and distant from the therapist and the session, inevitably diminishing any possible rapport. Thus, it is important to acknowledge with new clients the type of language that is commonly used with REBT, and disclose that not all clients connect with the terminology.

Although the language may be direct, it is important to inform clients that one of the core principles of REBT is to engage diverse clients in accepting their differences and embracing them instead of opposing them (e.g., race, religion, socioeconomic status, sexual orientation) to help contribute to their well-being. Moreover, by unconditionally self-accepting, clients may be more capable of thinking about their thoughts and not their destructive responses to negative
isolated experiences. Having the accessibility to tailor the session to the individual needs of the client and their background may influence the effectiveness of therapy for clients regardless of their culture.

In the years that I have been conducting therapy, I have worked with a number of clients from a variety of diverse backgrounds (e.g., religion, race, social class, gender, age). I have found that because the core component of REBT focuses on the individual, the techniques have led to successful therapeutic outcomes. My work has included clients from various religions (e.g., Christian, Jewish, and Muslim), social classes (upper, middle, and lower), and races (African-American, Asian-American, and Caucasian). I have embedded multicultural considerations into my assessment and interventions with my clients in a variety of ways, confirming many practical implications of engaging in REBT with diverse clients.

The strengths and limitations of REBT imply that it is important to always check-in with the client before delivering the therapy. For example, I will explain to them what REBT is and how it is delivered and if they are accepting of the style I will use it in session. If they are not accepting of the REBT style, I will present them with alternatives that may be more conducive to their preference (e.g., CBT, Psychodynamic). For example, when working with a Muslim client, I summarize and reflect what they have shared with me (e.g., the role of family pressure and the impact that it is having on their thoughts). Then I will articulate one style of therapy that helps explore an individual’s beliefs about certain events that can impact their feelings. The direct approach seems to have worked with the few Muslim clients as it addresses their most immediate concern. The practical implication of REBT suggests that the theory and affiliated techniques account for religious sensitivity.
Another example includes my work with a Jewish client who informed me that he wants to hear the most honest and direct response in our work together. Therefore, this type of feedback creates the space for optimal REBT type techniques. The same held true for an African-American client, who mentioned that he functions best when the people he seeks to confide in are upfront with him. Thus, another practical implication of REBT suggests the uniqueness of tailoring the treatment to the individual can have lasting effects. In both scenarios the active-directive confrontational style of therapy was embraced and led to successful therapy.

Another example of the practical implication of REBT with diverse clients is the influence of USA. Unconditionally accepting the self as a worthy individual regardless of what others may think of you is a central aspect to REBT. An example of how values intertwine with USA occurred when I worked with a 30-year old female client of a middle-class background. She mentioned that she wanted to connect her thoughts to her feelings, but too many people in her life did not feel she was emotionally strong enough to hear more direct feedback, so her issues remained unresolved. She also mentioned that part of her family values included remaining nonconfrontational. In the opening session, I presented the A-B-C chart to show her how she could see the connection between her thoughts and feelings and emphasized the importance of USA. After we wrote out two examples, I checked-in with her to see if she was “okay.” She responded by saying “No one has ever put my thoughts into perspective like we did. Of course I am okay. I am starting to see why I have been reacting the way I have and the choice is more within my control than I realized.”

Although the aforementioned examples are uplifting, there have been incidents when I have approached diverse clients and had to modify the REBT language to a less confrontational and more embracing style to ensure the client would respond. Therefore, one of the weaknesses
of REBT is that therapists may have to modify the language for certain clients. For example, when I was working with an Asian-American client, he was reserved, hesitant, and scared to be in therapy. Although he mentioned that he was having too many negative thoughts about his own ability, the delivery of my REBT terminology was slightly lightened to ensure I remained empathic. The difference between the modified, less harsh REBT, and the more direct language when working with certain diverse clients is that I will not challenge them to build empathy. I will help build empathy and determine the degree of challenge based on the rapport that is developed.

There are a variety of practical implications of REBT that can be applied to the therapeutic sessions when working with diverse clients (e.g., the type of language used, the style of questioning, the timing of challenging questions, and types of responses employed). Regardless of whether or not modifications to REBT occur when working with diverse clients, the core component still remains the same: explore the clients’ beliefs about the events that lead to disturbances on an individual basis. Additionally, understanding that each client comes to therapy with a different set of values, skills, knowledge and awareness of themselves, the therapeutic process, and their role in society is a core principle when working with culturally diverse individuals. Therefore, although effective with diverse clients, using REBT can and will be different for each client and clinician. Nevertheless, as effective as I have found REBT to be with many types of clients, I feel there is a need for psychological interventions to have some concrete validation of their effectiveness.

*Empirically Supported Treatments and REBT*

Using a structured approach to research, Empirically Supported Treatments (ESTs) investigate large samples of the population to examine the efficacy of various therapeutic
interventions. Adhering to strict protocols, ESTs are intended to generate optimal therapeutic results. ESTs include wide ranging controlled trials of evidence in research, analyzing a variety of quantitative data, and strong scientific evidence for efficacy of psychotherapy (Wampold, Lichtenberg, & Waehler, 2005). However, restricting research to randomized controlled trials (RCTs) does not mesh well with REBT, as there are too many subjective variables that REBT therapists use.

Although REBT has been shown to be effective (Balter & Unger, 1997; Ellis, 1962, Ellis & Dryden, 1997; Ellis & McLaern, 2005; Engels, Garnefsky, & Diekstra, 1993; Lyons & Woods, 1991; Maes, 1987; Nicastro, Luskin, Raps, & Benisvich, 1999; Russell & Jarvis, 2003; Shannon & Allen, 1998; Silverman, McCarthy, & McGavern, 1992), psychology and therapy today emphasize the importance of ESTs to help validate the efficacy of the therapy. Given that many REBT practioners use a collaboration of behavioral, cognitive, and emotive components, it is difficult to guarantee or confirm that REBT can be an EST. With the unstructured presentation of REBT, consistency is difficult to assess and therefore can inhibit validation of the treatment and the use of RCTs (Wessler, 1986). REBT can be flexible and most therapeutic relationships are brief. Therefore, if a technique or intervention is not working, the therapist will most likely explore an alternative approach within the REBT framework. RCTs focus on whether or not the clients feel better as a result of an intervention. However, researchers tend to ignore how the client altered their cognitive processing and overall philosophy of life in approaching negative events. Therefore, research overlooks how individual clients (regardless of their ethnicity) actually get better in the long term (Ellis, 1999).

It has been suggested that racial differences and affiliated biases that clients and clinicians may hold can affect the therapeutic process (Sue & Sue, 2008). Thus, it is important to
acknowledge these differences and biases in session (Institute of Medicine, 2003). Most results from ESTs are intended to be generalized from empirical research, but by ignoring the participants’ demographics it seems inaccurate to apply the findings to a global population of individuals. REBT emphasizes the individual and how their specific environmental, social, and biological components relate to their cognitive functioning. Therefore, the focus of REBT accounts for demographic differences and resulting feelings more so than one single controlled standardized treatment.

Additionally, Lambert and Bergin (1994) suggest that there are many common aspects between the clinician, the client, and the process of therapy that cannot be ignored in determining an effective therapeutic outcome. REBT recognizes the importance of empathic qualities for the therapeutic process (e.g., conveying support, warmth, emotional experience, insight, and constructive feedback). Unfortunately, the aforementioned attributes are difficult to measure with ESTs.

Stricker and Trierweiler, (1995) believe clinical expertise includes evaluating clients’ clinical state, prioritizing treatment needs, and establishing and maintaining a therapeutic alliance. Clinical expertise also involves helping evaluate risks and benefits for the client while monitoring client progress effectively, adjusting treatment accordingly and creating an environment with open communication. However, ESTs do not encompass all of the aforementioned attributes limiting optimal therapy.

Nevertheless, ESTs research does exist for REBT. The few studies available help validate the efficacy of the therapy, especially for anxiety (Maes, 1987; Shannon & Allen, 1998; Warren, McLellarn, & PonzoHa, 1988) and depression (Balter & Unger, 1997). An example of REBT and ESTs includes a study conducted by Rieckert and Moller (2000). The study included an RCT in
adult victims of childhood sexual abuse. Participants were randomly assigned to a treatment group or a prolonged treatment group. The participants who engaged in the REBT treatment group, had 10 sessions of REBT and a follow-up assessment 8 weeks later. Improvements existed for the participants who had group REBT, diminishing their depression, trait and state anxiety at the end of the study, and were maintained after follow-up. However, what was not assessed was how the participants thought about their cognitions. Granted their symptoms decreased, but there was no evidence as to how they thought and whether group REBT actually had a direct impact on their method of thinking.

Another EST study reviewed the effects of REBT with survivors of childhood sexual abuse (Moller & Steel, 2002), assessing anxiety, depression, and anger. The study focused on recovery, with the intention that REBT would help decrease guilt and increase self-esteem. It was noted that although the participants were able to decrease mental dysfunction, REBT needed to continue if a high degree of guilt was still present. The guilt and acceptance affiliated with the incident(s) of sexual abuse needed to be addressed because a high percentage of childhood sexual abuse is perpetuated by a close family member and that person may always be in their lives. Therefore, research needs to focus on gaining access to more information by engaging in a more in-depth analysis on the thought process that REBT would factor into therapy.

The clinical assessment process is thorough as the clinician considers all possible options for the client and not just what the research suggests. Henry, Schacht, Strupp, Butler, and Binder (1993) believe it is important to be aware and flexible throughout the therapeutic process, tailoring the plan of action for the specific client as opposed to what research states is most effective. A strong component of REBT is flexibility, and ESTs inhibit that from occurring. Norcross (2002) places a strong emphasis on the importance of considering the clients’ personal
problems, strengths, personality characteristics, demographics, and cultural context and preferences beyond empirically supported data, which is similar to the philosophies of REBT.

Therefore, a more appropriate connection to REBT would be Evidence Based Practices in Psychology (EBPP). I feel that the using EBPPs are most appropriate for my theoretical orientation because of how much emphasis is placed on the individual versus a random sample of participants in a randomized controlled trial. The concept of EBPP integrates both research and practice along with individual characteristics, culture and client preference and circumstance (APA, 2006; Messer, 2004; Sue & Zane, 2006; Sue, Zane, & Young, 1994). The clinician can consider a combination of the client’s personal preferences, background, development, values, any religious principles, views and goals for therapy which may differ from those surveyed in the validated research. Understanding a client’s individual situation is as important if not more important than anything research can generate. Shifting the focus from a quantitative perspective to more of a qualitative approach suggests that the individual client situation can be explored (Kazdin, 2008). With a more qualitative approach, I tend to use EBPPs more often than relying on ESTs when practicing REBT with my clients.

A qualitative approach that may be more synchronized with the efficacy of REBT would be the use of what Geertz (1973) referred to as Hermeneutic Single-Case Efficacy Design (HSCED). The HSCED emphasizes a thorough description and interpretation of the specific influences of the processes involved in an individual client’s therapy. The clinician can literally see and hear directly from the client if they attribute their change directly to the therapeutic process, as opposed to relying on what the research suggests will happen. Using HSCED, the evidence of effective therapy emerges directly from the single client as opposed to randomized controlled trials of large groups of individuals. Additionally, the client can follow-up with the
clinician confirming or disconfirming that their thoughts have successfully been altered as a result of the work with REBT. To enhance the understanding and effectiveness of REBT it may be most helpful to explore a single case study. Although I tend to rely on EBPPs I occasionally consider HSCEDs when working with specific clients.

Assessment, Intervention, and Applicability of REBT with Specific Clients

As REBT is often used with anxiety and depression in brief therapy (Balter & Unger, 1997; Maes, 1987; Shannon & Allen, 1998; Warren et al., 1988) it would be fitting to explore the effects of REBT with clients who sought therapy with the aforementioned diagnoses. Thus, I have selected a variety of clients from my previous clinical experience that exemplify the applicability of interventions and assessments that have worked (and not worked) while using the theoretical foundation of REBT. Each example begins with the original diagnosis according to the DSM-IV-TR (2000), proceeds with the applicability of REBT type techniques including the course of treatment, and then concludes by explicating the result of using the active-directive style of therapy.

One client was a 24-year old single Caucasian male in his senior year of college. He was given a diagnosis of Major Depressive Disorder (296.31), recurrent, mild: Provisional; Panic Disorder with Agoraphobia (300.21), rule out. He also had problems with his primary support group, and psychosocial and environmental problems. The symptoms affiliated with depression included fatigue, loss of interest in academics and socializing, significant weight gain, insomnia, and diminished ability to think.

The course of treatment included eight sessions of REBT exploring his cognitions, which were often characterized by personalization, focusing on the negative, overgeneralization, and distressing and catastrophic thinking. The ABC model was used frequently and each week he
commented on how he saw slow but steady progress. When a lapse would occur and he opted out of social plans, he felt discouraged. We would then refer back to his ABC sheets and it reminded him how he can modify his perception of the distressing events. Additionally, we explored how he had the tendency to engage in catastrophizing small events and jumping to conclusions if certain situations did not work out as he had hoped. Consequently, we employed the use of rational coping statements to help him with his depressive symptoms. As the sessions continued, we explored how he would stop and monitor his thoughts and then naturally write down the rational belief. Once he was able to inherently understand the ABC model and saw the evidence work in session he was eager to try it in his classes, at home, and with friends.

Nearing the end of his therapy, he came into session with a different demeanor; relaxed, confident, and motivated. He said the words “It works. Whatever we did, it works. I have found myself changing my thoughts, and it is an incredible feeling.” He returned two weeks later for a follow-up appointment, shared similar sentiments, and shared his goals for the semester with me. It was REBT in its most authentic form.

Another example of when REBT worked was with a client who was diagnosed with Social Phobia (300.23). The client was a 19-year old female Caucasian college sophomore who had been dealing with social phobia for as long as she could remember. When in large crowds she would have difficulty breathing, increased heart rate, perspiration, and blushing. In public domains she believed that everyone was watching her and judging her.

My assessment of the case was such that her phobia was part of her thoughts and she was not only capable of being in public, but was an extraverted person as well. Thus, the course of therapy and implemented interventions included many elements of REBT that led to an effective therapeutic outcome. We explored the activating event (A) of being in large crowds, then the (C)
of feeling anxious, nervous, scared, and inadequate in large crowds. Finally, she listed all her beliefs about what she thought when in large crowds (e.g., “I don’t have anything interesting to say,” “My friends are all smarter than me,” “I know my fear is all in my head, but I have always been like this.”).

We spent three sessions disputing all of her irrational beliefs and modified them to become rational. By the fifth session she started to naturally use REBT language herself and explain it to me as the therapist. Her most pronounced statement was, “Every time I have those thoughts when in public, I have asked myself where the evidence is. It is amazing how effective that is.” Through the five sessions of therapy, the client had decreased her awfulizing tendencies and began to focus more on positive events rather than being consumed by negative events. Above all, though, she unconditionally accepted herself as a worthy member of society.

Another example involved an 18-year old Caucasian female freshman student who was diagnosed with Major Depressive Disorder (296.22), single episode, moderate. The symptoms she was experiencing included depressed mood most of the day, insomnia, loss of energy, feelings of worthlessness, and difficulty concentrating, especially within her occupational environment. The conceptualization of the case included REBT because she mentioned struggling with making sense of her beliefs about her academic performance and the pressure placed on her by her family members.

She attended therapy for nine sessions and struggled to make sense of her thoughts. We spent a majority of the first few sessions engaging in referenting (i.e. exploring the advantages and disadvantages of her thoughts). She was able to complete the task in session, but unable to do so outside of session. After four weeks of continuous referenting, ABC worksheets, shame
attacking exercises, and working on coping statements that lead to unconditionally accepting herself, she slowly began to understand it.

At one point in the fifth session she began to cry. She communicated that all the work she had been doing was starting to influence her daily life, functioning, and motivation to complete her daily tasks without engaging in episode of crying. She mentioned that having the challenging statements is what forced her to try harder and consequently appreciate her accomplished goals that much more.

One case where REBT was not effective was with an 18-year old Caucasian male freshman who was diagnosed with Major Depressive Disorder, Recurrent, severe without psychotic features (296.33). The client had experienced multiple symptoms of a depressive episode when high school ended and then the symptoms reemerged during the first month of college. His symptoms included a depressed mood most of the day, diminished interest in all of his activities, fatigue throughout the day, inappropriate guilt, and diminished ability to concentrate. He experienced a lot of difficulty with therapy and REBT did not make it any easier.

A significant barrier for this client was his thoughts that he was never going to have close friends in college like he did in high school. Consequently, I worked on rational coping statements to help him cope with his thoughts. We also worked on emphasizing the positives about college and de-emphasizing the negatives, diminishing his catastrophizing, and brief ABC worksheets. However, each time we began therapy or an activity he would engage in frequent and long-term episodes of crying throughout the sessions. He would want to try the activities, but could not physically complete them without crying. The treatment lasted three sessions before he terminated the therapy. Although I lightened the REBT language to meet the client at his level, he still found it difficult and too confrontational.
There have been countless examples where I have been able to implement REBT into many of my sessions, through assessment and interventions, and overall it seems to be successful. What is most interesting is the breadth of clinical issues it can be useful for. The individuals that I have used REBT with have had diagnoses ranging from eating disorders, depression, various phobias, and adjustment disorders. Although it has not worked all of the time, which has led me to modify the intervention, more often than not clients seem to return and succeed. It is also worth noting that my clients have all been within the ages of 18-30 and I have yet to experience REBT with an older adult or younger child. Nevertheless, using REBT as a framework has led me to whole heartedly embrace the assessments and interventions of my clients from a perspective that I personally and professionally connect with.

Conclusion

As noted by the client examples, unconditional self-acceptance, challenge, risk taking and taking ownership of thoughts help guide the cornerstones of REBT. However, it is worth noting that REBT may not work with all clients all the time. Nevertheless, synchronized with the idiographic scientific orientation and constructivist-interpretivist research orientation to a large degree, the focus of REBT emphasizes the individual and the individual experiences. Thus, it was important to acknowledge the effectiveness of other modalities to help better elucidate why REBT is my preferred theoretical orientation.

The BT approach emphasized the importance of developing a structured plan of implementing change into action. The shift to a more direct person-centered style created space for clients to direct the session. Acknowledging the importance of the here and now was a natural shift to focusing on the disturbances in the moment. However, the exquisiteness of REBT is that although it is in fact its own modality, one can borrow techniques from other therapies to
Further enhance the REBT process while still maintaining the major principles that spawned the theory.

Understanding that the main focus of REBT is rooted in the Greek and Roman idea that disturbance occurs because of how we choose to respond to negative events explicates the richness of the theory, connecting it to a deep rooted historical context. Additionally, the theory reiterates the importance of flexibility in how clients’ maladaptive tendencies are to be viewed which can impact clinical assessment and interventions. REBT emphasizes the importance of being adaptable to work with the individual client and as opposed to the general disturbance. Due to the individualized tailoring of REBT with each client, the theory meshes well when working with multicultural clients.

Although the theory emphasizes that humans are biologically programmed to have cognitive, emotive, and behavioral distortions, REBT emphasizes that those distortions in large part stem from thoughts and can be rectified, disputed and altered, if thinking about cognitions occurs within the clients. Additionally, a key conclusion to the theory and its practical implications emphasizes the notion that negative irrational beliefs are not be ignored, they are to be experienced, processed, understood, and disputed to lead more rationally self-enhancing lives.

To have more natural rational thinking patterns focuses on the individual and their own destructive beliefs. Thus, ESTs do not seem to fit well with REBT. ESTs have been shown to reveal a decrease in distressing symptoms with REBT. However, the main criticism is that ESTs do not assess how or what philosophical changes occur in the way individuals think about their thoughts as opposed to concluding that they just have diminished symptoms. Thus, EBPPs seem to be more appropriate as the focus is more on the culture of the client, the individuals, and their preferences (Sue et al., 1994). Additionally, an alternative to ESTs includes HSCED (Geertz,
1973), which focuses on the specific individual experience as a single client and can explicate exactly where change comes from. Using alternative study methods to further increase the validity of the theory may enhance its generalizability.

Nevertheless, as the case studies reiterated, the brief active–directive approach can work with various disorders, especially anxiety and depression. Additionally, if practiced accurately, clients will eventually become their own therapists. Thus, although it may have its drawbacks (e.g., too direct, too brief, unstructured), with REBT the therapist is directly involved in helping clients energetically construct an alternative philosophical approach to their thoughts in session to ensure they will eventually generalize in present and future events of distress. Furthermore, REBT will help clients become their own best source of artillery when battling maladaptive functioning, which will help prevent relapse, lead to empowerment, motivation and, above all, unconditional self acceptance.
References


