Introduction

In this book we will outline a view of psychotherapeutic change from the perspective of Rational Emotive Behaviour Therapy, an approach to cognitive-behaviour therapy that was originated in 1955 by Dr Albert Ellis, an American clinical psychologist. Ellis was previously a psychoanalyst who became disenchanted with the effectiveness and efficiency of psychoanalysis and psychoanalytic psychotherapy. After a brief experimental period with different therapeutic methods of the day, Ellis crystallised his ideas on therapy into an integrative approach which he named 'Rational Therapy'. This approach was based on a number of principles which still form the basis of REBT today, as outlined below.

Cognitions are important to an understanding of the way people feel and act

This principle has its roots in Stoic philosophy in general, and in particular the writings of Epictetus, who has been credited with this cognitive conceptualisation of psychological disturbance: 'Men are disturbed not by things, but by their views of things.' REBT's current position on this point can be summed up in the following version of Epictetus' saying: 'People are disturbed not by things, but by their rigid and extreme views of things.'

Cognitions, emotions and behaviours are not separate psychological processes, but often interact in complex ways

From the outset, Ellis adhered to the principle of psychological interactionism which states that cognitions, emotions and behaviours are interdependent processes. Ellis has, of late, acknowledged that it was a mistake to call his therapeutic approach 'Rational Therapy', for two reasons. First, the name suggested that the approach *only* focused on cognitions; and second, by not mentioning emotions and behaviours it did not prepare professionals who were new to the approach, or clients of the approach, for an integrative view of the latter's psychological problems. The current name of the approach, 'Rational Emotive Behaviour Therapy', corrects both of these mistakes.

Cognitive and emotive change is facilitated by behavioural change

From the beginning, Ellis held that if people act on their developing rational beliefs they are more likely to make appropriate cognitive and emotive changes, and if they do not act on these beliefs, they minimise the chances that such changes will be made. This position has remained the same ever since. In fact, REBT without a decided behavioural emphasis is like cognition without ignition.

Therapists in REBT serve their clients best by taking an active–directive approach to help de-propagandise the irrational ideas that they hold about themselves, other people and the world

At the outset, Ellis stressed that people make themselves disturbed by the irrational ideas (now beliefs) they hold about themselves, other people and the world. He also stressed that, when disturbed, people frequently cling on to these irrational beliefs. It follows, Ellis argued, that REBT therapists need to take an active–directive stance in helping their clients identify such irrational ideas and so help them de-propagandise these ideas. While the terminology of 'de-propagandise' is no longer used by Ellis or other REBT therapists, it does highlight the fact that Ellis encourages REBT therapists to actively help their client be strongly critical of their irrational beliefs.

The term 'propaganda' also suggests that the client has uncritically accepted one or more irrational ideas that lie at the core of his or her disturbed feelings. While most people think of propaganda as coming from outside the person (e.g. from one's parents, peers, the media, etc.) – and Ellis' early writing did stress these as the likely sources of such propaganda – it is possible to think of such propaganda as coming from within the person. Thus, Ellis' later writings place more emphasis on the person as the main source of his own irrational ideas and as actively propagandising himself with these ideas. Thus, while a person may learn from a variety of outside sources that approval is very desirable, he is the one who constructs an irrational idea about this desirable commodity and subsequently disturbs himself with the thought of not gaining approval ('Because it is desirable for me to gain approval, I absolutely must do so'). He is the one who creates such unhealthy propaganda for himself and keeps it alive in a number of ways. Even when the dogmatic propaganda comes from outside the person (such as when a teacher tells a pupil 'You must do well in your exams and it will be terrible if you don't'), it is only disturbing when he uncritically accepts such external dogmatic propaganda and makes it his own internal dogmatic propaganda ('Yes, you are right, I must do well in my exams and it will be terrible if I don't').

When other people encourage the person to think in dogmatic ways, he has the choice to reject this encouragement. Thus, in response to the example

above the person could say: 'You say that I must do well in my exams and it would be terrible if I don't. However, you are wrong. I don't have to do well in my exams, although it would be desirable if I do so. And while it would be disadvantageous if I don't do well it wouldn't be terrible.'

While this example demonstrates that it is possible for clients to be sceptical of external propaganda – and indeed of their own internal propaganda – they usually need quite a bit of help from their therapists to identify, challenge and change their irrational beliefs. The language of 'therapists helping clients to de-propagandise themselves against their irrational ideas' has been replaced by the language of 'therapists helping them to identify, challenge and change their irrational beliefs'. We will discuss this process more fully in Chapter 4.

While it is important that therapists empathise with their clients, show them respect and are congruent, these therapeutic conditions are neither necessary nor sufficient for therapeutic change to occur

All approaches to psychotherapy hold that the relationship between therapist and client is an important vehicle for client therapeutic change, although different approaches place differential weight on this relationship to promote such change. In 1959, Ellis published a response to Carl Rogers' (1957) seminal article in which the latter claimed that there were a number of therapeutic conditions necessary and sufficient for therapeutic change to occur. An up-to-date list of such conditions details empathy, unconditional positive regard and congruence. Ellis (1959) argued that while such conditions may well be useful in promoting therapeutic change, they are neither necessary nor sufficient for such change to occur. In part, this is consistent with Ellis' non-dogmatic view about any phenomena, but in the main it accords with his view that for therapeutic change to occur and be maintained, clients need to demonstrate an ongoing commitment to identifying, challenging and changing their irrational beliefs by using a variety of cognitive, emotive and behavioural techniques. It may well be that exposure to the aforementioned therapeutic conditions may encourage clients to make and act on this commitment, but it could also be that such exposure may *dis*courage clients from doing the hard work needed to promote and maintain therapeutic change. The client may feel better as a result of the experience of being understood and positively regarded by his therapist and therefore may not be motivated to get better by doing the hard work of change. The role that the therapeutic conditions have in promoting or discouraging client change in REBT awaits full empirical enquiry.

Current REBT theory draws upon working alliance theory to conceptualise the role that the therapeutic relationship has in fostering client change (Dryden, 1999). The therapeutic conditions put forward by Rogers and

reconceptualised by REBT therapists as empathy, unconditional acceptance and genuineness are generally seen as part of the bond domain of the working alliance (Bordin, 1979). We discuss the role of the working alliance in promoting client change in Chapter 4.

Clients need to adopt a protestant ethic approach to therapeutic change

From the inception of REBT, Ellis stressed that if clients are going to achieve lasting change they will have to work hard to achieve and maintain such change. This is what we refer to as the protestant ethic approach to change. As we discuss in Chapter 6, one of the biggest obstacles to client change is the reluctance to acknowledge and/or implement this clinical reality. Indeed, one of the most important skills that an REBT therapist needs to acquire and develop is helping clients to overcome their resistance towards working for lasting change.

Let us briefly summarise what we are going to cover in this book. In Chapter 1, we present REBT's ABC model of psychological disturbance and change. In particular, we discuss the differences between rational and irrational beliefs. In Chapter 2, we outline the REBT view that there are different – albeit overlapping – types of client change. We briefly outline these different types of change before concentrating on the one that is seen by REBT as the most far-reaching, yielding the greatest gains for the individual concerned, namely belief change. While our focus throughout this book is on client change within the therapeutic setting, much of what we have to say is relevant to personal change outside of this context, and in Chapter 3 we consider the REBT change sequence and outline in order the steps that clients need to take to promote psychological change. The steps in this sequence are not prescriptive, but rather are descriptive of an ideal change sequence. Then in Chapters 4 and 5 we consider the respective roles of therapist and client in promoting client change. Chapters 6, 7 and 8 focus on obstacles to client change from three perspectives. In Chapter 6 we consider in detail the major obstacles to client change within the client, while in Chapter 7 we consider the obstacles that reside in the therapist, and in Chapter 8 we consider the main obstacles to client change that arise from the interaction between client and therapist. In each of these three chapters we consider ways that therapists can deal with these obstacles. Finally, in Chapter 9, we close the book with a discussion of the process of change in REBT.