What you need to know about the theory of REBT to get started

Most books on counselling and psychotherapy begin by introducing you to the theory and practice of the approach in question. This is obviously a sensible way to start such a book because otherwise how are you to understand the practical techniques described by the author(s)? However, in my experience as a reader of such books, I am often given more information than I need about an approach to begin to practise it, at least in the context of a training setting. As I explained in the Introduction, my aim in this training handbook is to recreate the atmosphere of a beginning training seminar in REBT. In such seminars the emphasis is on the acquisition of practical skills and, consequently, theory is kept to a minimum. What I aim to do in such seminars and what I will do in this opening chapter is to introduce the information you will need to know about the theory of REBT so that you can begin to practise it in a training seminar setting. In the following chapter, I will cover what you need to know about the *practice* of REBT to get started.

Let me reiterate a point that I made in the Introduction. When learning any approach to counselling and psychotherapy, you will need to be trained by a competent trainer in the approach you are learning and supervised in your work with clients by a competent supervisor in that approach. To do otherwise is bad and, some would say, unethical practice. Certainly, when learning to practise REBT you will need to be trained and supervised by people competent not only in the practice of REBT but also in educating others how to use it (see Appendix III). A book such as this, then, is designed to supplement not to replace such training and supervision.

The situational *ABC* model of REBT

REBT is one of the cognitive-behavioural approaches to psychotherapy. This means that it pays particular attention to the role that cognitions and behaviour play in the development and maintenance of people's emotional problems. However, as I will presently show, REBT argues that at the core of emotional disturbance lies a set of rigid and extreme attitudes[1] that people hold towards themselves, other people and the world.

[1] As I explained in the Introduction, I prefer to use the word 'attitudes' to the word 'beliefs' and the terms 'rigid and extreme attitudes' and 'flexible and non-extreme attitudes' to the terms 'irrational beliefs' and 'rational beliefs'. Also, when specifically referring to the *B* in the *ABC* framework, I use the term 'basic attitudes', as suggested by my friend and colleague Dr Walter Matweychuk, since attitudes lie at the 'base' of the person's reactions at *C*. However, the rest of the time I use the word 'attitudes'.

Fundamentals of Rational Emotive Behaviour Therapy: A Training Handbook, Third Edition. Windy Dryden.

When assessing clients' psychological problems, REBT therapists employ a situational *ABC* framework, and I will now discuss each element of this framework in turn.

Situations

In this handbook, you will learn how to help your clients deal with their problems by working with specific examples of these problems. These specific examples occur in specific 'situations'. Such 'situations' are viewed in the 'situational *ABC*' model as *descriptions* of actual events about which you form inferences (see below). Briefly, inferences go beyond the data at hand and may be accurate or inaccurate.

'Situations' exist in time. Thus, they can describe past actual events (e.g., 'My boss asked me to see her at the end of the day'), present actual events (e.g., 'My boss is asking me to see her at the end of the day') or future events (e.g., 'My boss will ask me to see her at the end of the day'). Note that I have not referred to such future events as future actual events since it is not known that such events will occur (such future events may prove to be false). But if we look at such future 'situations', they are still descriptions of what may happen and do not add inferential meaning (see below).

'Situations' may refer to internal actual events (i.e., events that occur within ourselves, e.g., thoughts, feelings, bodily sensations, aches and pains, etc.) or to external actual events (i.e., events that occur outside ourselves, e.g., your boss asking to see you). Their defining characteristic is as before: they are descriptions of events and do not include inferential meaning.

As

*A*s are usually aspects of situations which your client is potentially able to discern and attend to and which can trigger their attitudes at *B*. While your client is potentially able to focus on different aspects of the situation at any moment, in an *ABC* episode what I refer to as *A* represents that actual or psychological event in their life which activates, at that moment, the attitudes that they hold (at *B*) and which lead to their emotional and behavioural responses (at *C*). The key ingredient of an *A* is that it activates or triggers attitudes. An *A* is usually an aspect of the situation that your client was in when they experienced an emotional response.

*A*s have several features that I will explain below.

As can be actual events

When actual events serve as attitude-triggering *A*s, they do not contain any inferences that your client adds to the event.

> While Susan was in therapy, her mother died. She felt very sad about this event and grieved appropriately. Using the *ABC* framework to understand this, we can say that the death of her mother represented an actual event at *A* which activated a set of attitudes that underpinned Susan's grief.

As can be inferred events

> When Wendy was in therapy, her mother died. Like Susan, she felt very sad about this and as such we can say that the death was an actual *A*, which triggered her sadness-related attitudes. However, unlike Susan, Wendy also felt guilty in relation to her mother's death. How can this be explained?

According to REBT, people make interpretations and inferences about the events in their lives. I regard interpretations and inferences as hunches about reality that go beyond observable data which may be correct or incorrect but need to be tested out. While most REBT therapists regard interpretations and inferences to be synonymous, I make the following distinction between them. Interpretations are hunches about reality that go beyond observable data but are not personally significant to the person making them. They are, thus, not implicated in the person's emotional experience. Inferences are also hunches about reality that go beyond the data at hand, but unlike interpretations they *are* personally significant to the person making them. They are, then, implicated in the person's emotional experience.

For example, imagine that I am standing with my face to a window and I ask you to describe what I am doing. If you say, 'You are looking out of the window', you are making an interpretation in that you are going beyond the data at hand (e.g., I could have my eyes closed) in an area that is probably insignificant to you (i.e., it probably doesn't matter to you whether I have my eyes open or not) and thus you will not have an emotional response while making the interpretation.

However, imagine that in response to my request for you to describe what I was doing in this example, you said, 'You are ridiculing me'. This, then, is an inference in that you are going beyond the data available to you in an area that is probably significant to you (i.e., it probably matters to you whether or not I am ridiculing you) and thus you will have an emotional response while making the inference. Whether this emotional response is healthy or not, however, depends on the type of attitude you hold about the inferred ridicule.

Returning to the example of Wendy who felt guilty about the death of her mother, I hope you can now see that she is guilty not about the death itself but about some inferred aspect of the death that is significant to her. In this case it emerged that Wendy felt guilty about hurting her mother's feelings when she was alive. This, then, is an inferred *A* – it points to something beyond the data available to Wendy; it is personally significant to her and it triggered her guilt-producing attitude.

As can be external or internal

So far, I have discussed *A*s that relate to events that have actually happened (e.g., the death of Susan's mother) or were deemed to have happened (e.g., Wendy's inference that she hurt her mother's feelings when she was alive). In REBT, these are known as external events in that they are external to the person concerned. Thus, the death of Susan's mother is an actual external *A* and Wendy's statement that she hurt her mother's feelings is an inferred external *A*.

However, *A*s can also refer to events that are *internal* to the person. Such events can actually occur, or their existence can be inferred.

An example of an actual internal event is when Bill experiences a pain in his throat. An example of an inferred internal event is when Bill thinks that this pain means that he has throat cancer. When Bill is anxious in this situation, the inferred internal event ('I have cancer') is more likely to trigger his rigid and extreme attitude than the actual internal event ('I have a pain in my throat'). As such, the inferred internal event is an *A*[2] and the actual internal event is not.

[2] In this book, I refer to an *A* that triggers rigid and extreme attitudes as an adversity.

As well as bodily sensations, internal *A*s can refer to such phenomena as a person's thoughts, images, fantasies, emotions and memories.

It is important to remember that, as with external *A*s, internal *A*s have their emotional impact by triggering attitudes at *B*.

*A*s can refer to past, present and future events

Just as *A*s can be actual or inferred and external or internal, they can also refer to past, present or future events. Before I discuss the time-dimensional nature of *A*s, remember that the *A* in an *ABC* episode, by definition, is that part of the person's total perceptual field which triggers their attitude at *B*.

When your client's *A* in an *ABC* episode is a past actual event, they do not bring any inferential meaning to this event. Thus, if their father died when they were a teenager, this very event can serve as an *A*. However, more frequently, particularly in therapy, you will find that your clients will bring inferential meaning to past events. Thus, your client may infer that their father's death meant that they were deprived in some way or they may infer that his passing away was a punishment for some misdeed that they were responsible for as a child. It is important to remember that it is the inferences your client makes now about a past event that triggers their attitudes at *B*. Such inferences may relate to the past, present and future.

An example of a future-related inference that your client might make about an actual past event is as follows:

> Because my father died when I was a teenager, I will continually look for a father figure to replace him.

I have already discussed present *A*s. However, I do want to stress that your clients can make past-, present- or future-related inferences about present events.

For example, if one of your clients has disturbed feelings about their son coming home late (present actual *A*), they may make the following time-related inferences about this event that trigger their disturbance-provoking attitudes:

1. Past-related inference: 'He reminds me of the rough kids at school who used to bully me when I was a teenager.'
2. Present-related inference: 'He is breaking our agreement.'
3. Future-related inference: 'If he does this now, he will turn into a criminal.'

The importance of assuming temporarily that A is true

As I will show in greater detail in Chapter 7, in order to assess a client's attitudes accurately you will need to do two things. First, you will need to help your client to identify the *A* which triggered these attitudes. Because there are many situational aspects that are in your client's perceptual field, it takes a lot of care and skill to do this accurately. Second, it is important that you encourage your client to assume temporarily that the *A* is true when it is an inferred *A*. The reason for doing this is to help your client to identify the

attitudes that the *A* triggered. You may well be tempted to help your client to challenge the inferred *A* if it is obviously distorted, but it is important for you to resist this temptation if you are to proceed to assess *B* accurately.

This is such an important point that we wish to emphasise it.

> Assume temporarily that your client's *A* is true when it is an inferred *A*

Bs

A major difference between REBT and other approaches to cognitive-behaviour therapy (CBT) is in the emphasis REBT gives to basic attitudes. In REBT, attitudes are at the base of clients' emotions and significant behaviours. Such basic attitudes are the only cognitions that constitute the *B* in the *ABC* framework in REBT. Thus, while other approaches which use an *ABC* framework classify all cognitive activity under *B*, REBT reserves *B* for basic attitudes and places inferences, for example, under *A*. It does so because it recognises that it is possible to hold two different types of basic attitudes at *B* about the same inferred *A*. It is the type of attitude that determines the nature of the person's emotional response at *C*.

Let me stress this point because it is very important that you fully grasp it.

> In REBT, basic attitudes are the only cognitions that constitute *B* in the *ABC* framework

Flexible and non-extreme attitudes

REBT keenly distinguishes between flexible and non-extreme attitudes and rigid and extreme attitudes. In this section, I will discuss flexible and non-extreme attitudes. These have four defining characteristics, as shown in Table 1.1.

People do not only proceed in life by making descriptions of what they perceive, nor do they just make interpretations and inferences of their perceptions. Rather, we engage in the fundamentally important activity of holding attitudes towards what we perceive and infer. REBT theory posits that people have four types of flexible and non-extreme attitudes, as shown in Table 1.2.

Table 1.1 Defining Characteristics of Flexible and Non-extreme Attitudes

- Consistent with reality
- Logical
- Largely functional in their emotional, behavioural and cognitive consequences
- Largely helpful to the individual in pursuing their basic goals and purposes

Table 1.2 Four Types of Flexible and Non-extreme Attitudes

- Flexible attitudes
- Non-awfulising attitudes
- Attitudes of bearability
- Unconditional self-acceptance/other-acceptance/life-acceptance attitudes

Flexible attitudes

As humans we have a range of preferences, wishes, desires, wants, etc. When we bring a flexible attitude to these preferences, etc., when they are not met then such flexible attitudes are at the base or core of psychological health.

Flexible attitudes are often expressed thus:

'I want to do well in my forthcoming test ('asserted preference' component), but I do not have to do so ('negated demand' component).'

If only the first part of this flexible attitude was expressed, which I call the 'asserted preference' component – 'I want to do well in my forthcoming test' – then your client could, implicitly, change this to a rigid attitude or demand – 'I want to do well in my forthcoming test. . . (and therefore I have to do so).' Such an attitude is at the base or core of psychological disturbance, as I will describe presently. So, it is important to help your client express fully their flexible attitude, and this involves helping them to include *both* the 'asserted preference' component (i.e., 'I want to do well in my forthcoming test') *and* the 'negated demand' component (i.e., 'but I do not have to do so').

In short, we have:

Flexible attitude =

- 'Asserted preference' component +
- 'Negated demand' component

This flexible attitude is healthy for the following reasons:

- It is flexible in that your client allows for the fact that they might not do well.
- It is consistent with reality in that (a) your client really does want to do well in the forthcoming test and (b) there is no law of the universe dictating that they have to do well.
- It is logical in that both the 'asserted preference' component and the 'negated demand' component are not rigid and thus the latter follows logically from the former.
- It will help your client to have immediate functional emotions, behaviours and cognitions and help them pursue their longer-term goals. Thus, the flexible attitude will motivate them to focus on what they are doing as opposed to how well or badly they are doing it.

According to Albert Ellis (1994), the originator of REBT, a flexible attitude is a primary attitude, and three other non-extreme attitudes are derived from it. These attitudes are non-awfulising attitudes, attitudes of bearability and unconditional self-, other- and life-acceptance attitudes, and I will deal with each in turn. In doing so, I will emphasise and illustrate the importance of negating the extreme component in formulating a non-extreme attitude in each of these derivatives.

Non-awfulising attitudes When your client does not get their preference met and holds a flexible attitude towards this adversity, then it is healthy for them to conclude that it is bad but not awful that they failed to get what they wanted. The more important their preference in this scenario, then the more unfortunate is their failure to get it. Evaluations of badness can be placed on a continuum from 0% to 99.99% badness. However, it is not possible to get to 100% badness. The words of the mother of pop

singer Smokey Robinson capture this concept quite nicely: 'From the day you are born till you ride in the hearse, there's nothing so bad that it couldn't be worse.' This should not be thought of as minimising the badness of a very negative event, rather as showing that 'nothing is truly awful in the universe'.

Taking my example of the client whose primary flexible attitude is 'I want to do well in my forthcoming test, but I do not have to do so,' their full non-awfulising attitude is:

'It will be bad if I fail to do well in my forthcoming test ('asserted badness' component), but it is not awful if I don't do well ('negated awfulising' component).'

If only the first part of this non-extreme attitude was expressed, which I call the 'asserted badness' component – 'It will be bad if I fail to do well in my forthcoming test' – then your client could, implicitly, change this to an awfulising attitude, which, as we shall see, REBT theory considers to lead to a disturbed response to the adversity – 'It will be bad if I fail to do well in my forthcoming test. . . (and therefore it will be awful if I don't do well).' So, it is important to help your client express fully their non-awfulising attitude, and this involves helping them to include *both* the 'asserted badness' component (i.e., 'It will be bad if I fail to do well in my forthcoming test') *and* the 'negated awfulising' component (i.e., 'but it is not awful if I don't do well').

In short, we have:

Non-awfulising attitude =

- 'Asserted badness' component +
- 'Negated awfulising' component

This non-awfulising attitude is healthy for the following reasons:

- It is non-extreme in that your client allows for the fact that there are things that can be worse than not doing well in the test.
- It is consistent with reality in that your client really can prove that it would be bad for them not to do well and that it wouldn't be awful.
- It is logical in that both the 'asserted badness' component and the 'negated awfulising' component are non-extreme and thus the latter follows logically from the former.
- It will help your client to have immediate functional emotions, behaviours and cognitions and help them pursue their longer-term goals. Thus, the non-awfulising attitude will again motivate them to focus on what they are doing as opposed to how well or badly they are doing it.

Attitudes of bearability When your client does not get their preference met and holds a flexible attitude towards this adversity, then it is healthy for them to conclude that:

1. It is difficult to bear this adversity.
2. It is not unbearable to do so and they can bear it.

3. It is worth tolerating (if it is).
4. They are worth bearing the adversity for.
5. They are willing to bear the adversity.
6. They commit themself to bear the adversity.
7. They behaviourally implement this commitment.

Adhering to an attitude of bearability enables your client to put up with the frustration of having their goals blocked, and in doing so they are more likely to deal with or circumvent these obstacles so that they can get back on track. REBT holds that the importance of developing an attitude of bearability is that it helps people to pursue their goals, not because bearing frustration is in itself good for people.

Applying this to my example, when your client holds the flexible attitude 'I want to do well in my forthcoming test, but I do not have to do so,' their attitude of bearability will be:

'If I don't do well in my forthcoming test, that will be difficult to bear ('asserted struggle' component), but I can stand it. It will not be unbearably intolerable ('negated unbearability' component), it is worth it for me to tolerate it ('worth bearing' component) and I am worth bearing it for ('I'm worth bearing it for' component). Furthermore, I am willing to bear my poor performance ('willingness to bear it' component) and I am going to bear it ('commitment to bear it' component). Then the person implements this commitment behaviourally ('behavioural implementation' component).'

If only the first part of this non-extreme attitude was expressed, which I call the 'asserted struggle' component – 'If I don't do well in my forthcoming test, that will be difficult to bear' – then your client could, implicitly, change this to an attitude of unbearability, which, as we shall see, REBT theory considers to lead to a disturbed response to the adversity – 'If I don't do well in my forthcoming test, that will be difficult to bear… (and therefore I can't stand it if I don't do well).' So, it is important to help your client express fully their attitude of bearability, and this involves helping them to include all seven components.

In short, we have:

Attitude of bearability =

- 'Asserted struggle' component +
- 'Negated unbearability' component +
- 'Worth bearing' component +
- 'I'm worth bearing it for' component +
- 'Willingness to bear it' component +
- 'Commitment to bear it' component +
- 'Behavioural implementation' component

This attitude of bearability is healthy for the following reasons:

- It is non-extreme in that the person allows for the fact that not doing well is bearable as opposed to the extreme position that it is unbearable.
- It is consistent with reality in that the person (a) recognises the struggle involved in bearing the adversity, (b) acknowledges the truth that they really can bear that which is difficult to bear, (c) sees the truth that it is in their interests to bear the adversity (if it is), (d) acknowledges the truth that they are worth bearing it for even if they don't have a strong conviction in this yet, (e) sees that they have a choice to being willing or, at least, prepared to bear the adversity, (f) sees the truth that being committed to bear the adversity is better than not being committed to do so and (g)
- It is logical in that the seven components are all non-extreme and are thus connected to one another logically.
- It will help your client to have immediate functional emotions, behaviours and thoughts and help them pursue their longer-term goals. Thus, it will help them to do well in the sense that it will lead them to focus on what they need to do to face the 'difficult to bear' situation of not doing well rather than on the 'intolerable' aspects of doing poorly.

Unconditional self-, other- and life-acceptance attitudes In this section, I will focus on unconditional self-acceptance attitudes. However, the same substantive points apply to unconditional other-acceptance attitudes and unconditional life-acceptance attitudes. When your client does not get their preference met, holds a flexible attitude towards this adversity and this failure can be attributed to themself, then it is healthy for them not to like their behaviour but to accept themselves unconditionally as a fallible human being who has acted poorly. Adopting an attitude of unconditional self-acceptance will encourage your client to focus on what needs to be done to correct their own behaviour.

In my example, if your client who holds the flexible attitude 'I want to do well in my forthcoming test, but I do not have to do so' fails to do well in this test because of their own failings, then their unconditional self-accepting attitude will be:

'I don't like the fact that I messed up in the test ('negatively evaluated aspect' component), but I am not unworthy for my poor performance ('negated global negative evaluation' component). Rather, I am a fallible human being too complex to be rated on the basis of my test performance ('asserted complexity/unrateability/fallibility' component).'

If only the first two parts of this non-extreme attitude were expressed, which we call the 'negatively evaluated aspect' component – 'I don't like the fact that I messed up in the test' – and the 'negated global negative evaluation' component – 'but I am not unworthy for my poor performance' – then the person could, implicitly, change this to a self-devaluation attitude, which (as will be shown later) REBT theory considers an extreme attitude – 'I don't like the fact that I messed up in the test, but I am not unworthy for my poor performance (but I would be worthier if I did well than if I did poorly).' So, it is important to help your client express fully their unconditional self-acceptance attitude, and this involves helping them to include all three components: the 'negatively evaluated aspect' component ('I don't like the fact that I messed up in the test'), the 'negated global negative evaluation' component ('but I am not

unworthy for my poor performance') and the 'asserted complexity/unrateability/fallibility' component ('Rather, I am a fallible human being too complex to be rated on the basis of my test performance').

In short, we have:

Unconditional acceptance attitude =

- 'Negatively evaluated aspect' component +
- 'Negated global negative evaluation' component +
- 'Asserted complex/unrateability/fallibility' component.

This unconditional self-acceptance attitude is healthy for the following reasons:

- It is non-extreme in that the person sees that they are able to perform well and also poorly.
- It is consistent with reality in that while the person can prove that they did not do well in the test (remember that at this point we have assumed temporarily that their inferred *A* is true), they can also prove that they are a fallible human being and that they are not unworthy as a person.
- It is logical in that the person is not making the part–whole error. They are clear in asserting that the whole of themself is not defined by a part of themself.
- It will lead to immediate functional emotions, behaviours and thoughts and help them pursue their longer-term goals. For example, it will help them to do well in the future in the sense that they will be motivated to learn from their previous errors and translate this learning to plan what they need to do to improve their performance in the next test rather than dwell unfruitfully on their past poor performance.

Once again let me state that the same points can be made for unconditional other-acceptance attitudes and unconditional life-acceptance attitudes.

Rigid and extreme attitudes

As I mentioned above, REBT keenly distinguishes between flexible and non-extreme attitudes and rigid and extreme attitudes. Having discussed flexible and non-extreme attitudes, I will now turn my attention to rigid and extreme attitudes, which lie, according to REBT theory, at the base or core of psychological problems. Rigid and extreme attitudes have four defining characteristics, as shown in Table 1.3.

Table 1.3 Defining Characteristics of Rigid and Extreme Attitudes

Rigid and extreme attitudes are:
▪ Inconsistent with reality
▪ Illogical
▪ Largely dysfunctional in their emotional, behavioural and cognitive consequences
▪ Largely detrimental to the individual in pursuing their basic goals and purposes

Table 1.4 Four Types of Rigid and Extreme Attitudes

- Rigid attitudes
- Awfulising attitudes
- Attitudes of unbearability
- Self-devaluation/Other-devaluation/Life-devaluation attitudes

I explained earlier in this chapter that people can have four types of flexible and non-extreme attitudes. According to REBT theory, people easily transmute or change these flexible and non-extreme attitudes into four types of rigid and extreme attitudes (see Table 1.4).

Rigid attitudes

As humans we often express rigid attitudes in the form of musts, absolute shoulds, demands, have to's, got to's, etc. According to REBT, our rigid attitudes are at the core of psychological disturbance.

Taking the example which I introduced above, the rigid attitude is expressed thus: 'I want to do well in my forthcoming test and therefore I must do so.'

(This is often expressed in everyday life as 'I must do well in my forthcoming test.')

Rigid attitudes, like flexible attitudes, are often based on asserted preferences. I have written elsewhere (Dryden, 2021a) that it is difficult for human beings only to think flexibly when their desires are strong. Thus, in my example, if your client's asserted preference is strong it is easy for them to change it into a rigid attitude: 'Because I really want to do well in my forthcoming test, therefore I absolutely have to do so.' As you can see, this attitude has two components: an 'asserted preference' component (i.e., 'I really want to do well in my forthcoming test') and an 'asserted demand' component ('. . . therefore I absolutely have to do so'). In practice, in a rigid attitude, the 'asserted preference' component is rarely articulated and therefore is held to be implicit. Thus, rigid attitudes are most often only shown with the 'asserted demand' component made explicit (e.g., 'I must do well in my forthcoming test'). I will show both cases below.

In short, we have:

Demand = 'Asserted demand' component

Demand =

- 'Asserted preference' component +
- 'Asserted demand' component

This rigid attitude is unhealthy for the following reasons:

- It is rigid in that your client does not allow for the fact that they might not do well.
- It is inconsistent with reality in that if there was a law of the universe that decreed that your client must do well in their forthcoming test, then there could be no possibility that they would not perform well in it. Obviously, no such law exists.
- It is illogical in that there is no logical connection between their 'asserted preference' component, which is not rigid, and their 'asserted demand' component, which is rigid. In logic, something rigid cannot logically follow from something that is not rigid.
- It will lead to immediate dysfunctional emotions, behaviours and thoughts and interfere with them pursuing their longer-term goals. It will interfere with them doing well in the sense that the rigid attitude will draw them to focus on how poorly they are doing rather than on what they are doing.

A note on language. The rigid attitudes targeted for change in REBT are absolute unconditional musts, as described above. Your clients will often express their rigid attitudes using terms such as 'must', 'should', 'got to', 'have to' and so on. As an REBT therapist it is important to be able to distinguish between unconditional rigid attitudes or demands that underpin emotional disturbance and conditional musts and shoulds, which do not. In the course of normal conversation your client is likely to use non-absolute shoulds regularly. At this point in your training, it is a good idea to familiarise yourself with the different ways of using words like 'should' so you can better assess your client's rigid attitudes. Encouraging your client to place the pertinent descriptor before the word 'should' or 'must' can help you both to make a clear distinction between absolute and non-absolute shoulds. Below is a list of different ways of using the word 'should'.

- *Recommendatory should*: This 'should' specifies a recommendation for self or other: 'You should read this book' translates to 'I recommend that you read this book,' or 'I really should go to bed early tonight' means 'It's in my best interest to go to bed early tonight.'
- *Predictive should:* This use of 'should' indicates predictions about the future: 'I should be on time for my flight' is interpreted as 'I predict that I will be on time for my flight.'
- *Ideal should:* This 'should' describes ideal conditions. For example, 'People should not litter' expresses the viewpoint 'Ideally, people should not litter.' Another way of phrasing this 'should' is to say 'In an ideal world *x, y* and *z* conditions would exist.'
- *Empirical should:* This 'should' points to the existence of reality. It encapsulates the idea that when all conditions are in place for a given event to occur then that event *should* occur. For example, 'Because the car is old and in ill repair it *should* have broken down' or 'Because of laws of gravity you *should* have fallen when you stepped off the ladder.'
- *Preferential should:* This 'should' indicates a desire or preference for a given condition to exist: 'My husband preferably should remember my anniversary,' for example, carries an implicit additional meaning: 'It would be good if he remembered but he does not have to.'
- *Conditional should/must:* This 'should' denotes that in order for one condition to exist another primary condition must be met. Examples include 'I *should* eat healthily in order to become slimmer' and 'I *must* pass the interview in order to be accepted onto the course.'
- *Absolute should:* This term obviously refers to disturbance-creating rigid attitudes or demands at *B* in the *ABC* model of REBT. 'I *absolutely should* visit my aunt in hospital' and 'I absolutely *must* tend to my aunt at all times and under any conditions' are examples of absolute shoulds.

Given the fact that the word 'should' has many meanings in English, I recommend that you use the qualifier 'absolute' when using the disturbance-creating 'should' with your clients.

According to Albert Ellis, a rigid attitude is a primary attitude, and three other extreme attitudes are derived from it. These are awfulising attitudes, attitudes of unbearability and self-, other- and life-devaluation attitudes. I will deal with each in turn.

Awfulising attitudes When your client holds a rigid attitude towards an adversity (e.g., not getting what they want), then they will tend to conclude that it is awful that they have failed to get what they consider essential. Awfulising, according to REBT theory, can be placed on a continuum from 101% to infinity and means worse than it absolutely should be.

Taking your client whose primary rigid attitude is 'Because I really want to do well in my forthcoming test, therefore I absolutely have to do so,' their full awfulising attitude is:

'Not only will it be bad if I fail to do well in my forthcoming test ('asserted badness' component), but it would also be awful if I fail ('asserted awfulising' component).'

More frequently, this is abbreviated as:

'It would be awful if I fail to do well in my forthcoming test.'

In practice, in an awfulising attitude, the 'asserted badness' component is rarely articulated and therefore is held to be implicit. Thus, awfulising attitudes are most often only shown with the 'asserted awfulising' component made explicit (e.g., 'It would be awful if I do not do well in my forthcoming test'). I will show both cases below.

In short, we have:

Awfulising attitude = 'Asserted awfulising' component

Awfulising attitude =

- 'Asserted badness' component +
- 'Asserted awfulising' component

The awfulising attitude (i.e., 'It would be awful if I fail to do well in my forthcoming test') is unhealthy for the following reasons:

- It is extreme in that your client does not allow for the fact that there are things that can be worse than not doing well in the test.
- It is inconsistent with reality in that your client really cannot prove that it would be awful if they do not do well. While there is evidence that it would be bad for them not to do well, there is no evidence that it would be more than 100% bad.
- It is illogical in the sense that the idea that it would be awful if they do not do well ('asserted awfulising' component) does not logically follow from the idea that it would be bad if this occurred ('asserted badness' component). The former is extreme and does not follow logically from the latter, which is non-extreme.

- It will lead to immediate dysfunctional emotions, behaviours and thoughts and interfere with the person pursuing their longer-term goals. It will not help them to do well in that it will discourage them from focusing on what they need to do in order to perform well in the test; rather, it will draw them to focus on how poorly they are doing while they are doing it.

Attitudes of unbearability When your client holds a rigid attitude towards an adversity (e.g., not getting what they want), then they will tend to conclude that they can't bear the adversity. In REBT theory 'I can't bear it' either means that the person will disintegrate or that they will never experience any happiness again if the adversity occurs. Adhering to an attitude of unbearability discourages your client from bearing the frustration of having their goals blocked and thus they will tend to back away from dealing with these obstacles.

Applying this to my example, when your client holds the rigid attitude 'Because I really want to do well in my forthcoming test, therefore I absolutely have to do so,' their attitude of unbearability will be:

'Because it would be difficult for me to bear not doing well in my forthcoming test ('asserted struggle' component) it would be unbearable if I fail ('asserted unbearability' component).'

More frequently this is abbreviated as:

'If I don't do well in my forthcoming test, it will be intolerable.'

In practice, in an attitude of unbearability, the 'asserted struggle' component is rarely articulated and therefore is held to be implicit. Thus, attitudes of unbearability are most often only shown with the 'asserted unbearability' component made explicit (e.g., 'It would be unbearable if I do not do well in my forthcoming test'). I will show both cases below.

In short, we have:

Attitude of unbearability = 'Asserted unbearability' component

Attitude of unbearability =

- 'Asserted struggle' component +
- 'Asserted unbearability' component

This attitude of unbearability (i.e., 'If I don't do well in my forthcoming test, it would be intolerable') is unhealthy for the following reasons:

- It is extreme in that your client does not allow for the fact that not doing well is bearable.
- It is inconsistent with reality in that if there was a law of the universe which stated that your client couldn't bear not doing well, then they couldn't bear it no matter what attitude they held. This means that they would literally disintegrate or would never experience any happiness again if they failed to do well in the test. Hardly likely!
- It is illogical in that the idea that not doing well on a test is unbearable ('asserted unbearability' component) does not logically follow from the idea that it is difficult to bear ('asserted struggle' component). The former is extreme and does not logically follow from the latter, which is non-extreme.

- It will lead to immediate dysfunctional emotions, behaviours and thoughts and interfere with the person pursuing their longer-term goals. It will interfere with them doing well in the sense that it will lead them to focus on the 'unbearable' aspects of doing poorly rather than on what they need to do to circumvent the obstacles in their way.

For a detailed discussion of different categories of attitudes of unbearability see Chapter 5 of Neenan and Dryden (1999).

Self-, other- and life-devaluation attitudes In this section, I will focus on self-devaluation attitudes. However, the same substantive points apply to other-devaluation attitudes and life-devaluation attitudes. When your client holds a rigid attitude towards an adversity (e.g., not getting what they want) and attributes this failure to themselves, then they will tend to dislike themselves as well as their own poor behaviour. Adopting an attitude of self-devaluation, for example, will discourage your client from focusing on what they need to do to correct their behaviour.

In my example, if your client who holds the rigid attitude 'Because I really want to do well in my forthcoming test, therefore I absolutely have to do so' fails to do well because of their own failings, then their self-devaluation attitude will be:

'Because I failed to do well in the test and that is bad ('negatively evaluated aspect' component), therefore I am a failure ('asserted global negative evaluation' component).

Or more frequently: 'I am a failure for not doing well in the test' (see below).'

In practice, in a self-devaluation attitude, the 'negatively evaluated aspect' component is rarely articulated and therefore is held to be implicit. Thus, self-devaluation attitudes are most often only shown with the 'asserted global negative evaluation' component made explicit (e.g., 'I am a failure for not doing well in the test'). I will show both cases below.

In short, we have:

Self-devaluation attitude = 'Asserted global negative evaluation' component

Self-devaluation attitude =

- 'Negatively evaluated aspect' component +
- 'Asserted global negative evaluation' component

The self-devaluation attitude (i.e., 'I would be a failure if I fail to do well in the forthcoming test') is unhealthy for the following reasons:

- It is extreme in that the person only sees themself as a reflection of their behaviour, rather than as a complex person with many different facets.
- It is inconsistent with reality in that while the person can prove that they did not do well in the test (remember that at this point we have assumed temporarily that their inferred *A* is true), they cannot

prove that they are a failure. Indeed, if the person was a failure, then they could only ever fail in life. Again, this is hardly likely!

- It is illogical, in that the person's conclusion that they are a failure does not logically follow from the observation that they did poorly in the test. They are making a part–whole error of logic.
- It will lead to immediate dysfunctional emotions, behaviours and thoughts and interfere with the person pursuing their longer-term goals. It will interfere with them doing well in the sense that the attitude will motivate them to focus on their negatively evaluated self rather than on helping them to deal with their negatively evaluated behaviour.

Similar points can be made about other- and life-devaluation attitudes.

Cs

In REBT theory *C* stands for consequences of holding basic attitudes (at *B*) towards adversities (at *A*). These consequences can be emotional, behavioural and thinking in nature. I will deal with each set of consequences in turn.

Emotional consequences of attitudes

The REBT theory of emotions is distinctive both in the field of psychotherapy and even within the tradition of CBT. It is a qualitative theory of emotions rather than a quantitative theory in that it distinguishes between healthy negative emotions and unhealthy negative emotions. For example, anxiety (unhealthy negative emotion) is deemed to be qualitatively different from concern (healthy negative emotion) rather than quantitatively different. I will discuss this issue more fully in Chapter 4.

Healthy negative emotions and unhealthy negative emotions As I will discuss in detail in Chapter 4, REBT theory holds that your clients experience *healthy* negative emotions when their preferences are not met, and that they hold a set of flexible and non-extreme attitudes towards this adversity. While negative emotions (which are listed in Table 1.5) are negative in feeling tone, they are healthy because they encourage your clients to change what can be changed or make a constructive adjustment when the situations that they face cannot be changed.

Alternatively, your clients experience *unhealthy* negative emotions when their preferences are not met, and this time they hold a set of rigid and extreme attitudes towards this adversity. These negative emotions (which are also listed in Table 1.5) are again negative in feeling tone, but they are unhealthy in that they tend to discourage your clients from changing what can be changed and from adjusting constructively when they cannot change the situations that they encounter. In short, healthy negative emotions

Table 1.5 Types of Healthy and Unhealthy Negative Emotions

Healthy negative emotions	Unhealthy negative emotions
Concern	Anxiety
Sadness	Depression
Remorse	Guilt
Sorrow	Hurt
Disappointment	Shame
Healthy anger	Unhealthy anger
Healthy jealousy	Unhealthy jealousy
Healthy envy	Unhealthy envy

stem from flexible and non-extreme attitudes towards adversities, while unhealthy negative emotions stem from rigid and extreme attitudes towards the same adversities.

As I have explained elsewhere (Dryden, 2021a), it is important for you to understand that your clients may use emotion words very differently from the way they are used in REBT theory. As such, you will need to explain very carefully the distinctions between healthy and unhealthy negative emotions and adopt a shared vocabulary when working with your clients. I will discuss this issue fully in Chapter 4.

Mixed emotions As I will discuss in Chapter 5, when you and your client select a problem to work on, this problem is called a nominated problem. While assessing a nominated problem, you will ask for a concrete example of its occurrence. You need to realise at this point that it is likely that your client will have a mixture of emotions about the situation in which their problem occurred, rather than having a single, unalloyed emotion.

For example, let's suppose that Betty, your client, has difficulty expressing her negative feelings to her friends when she considers that they take advantage of her. Thus, Betty keeps her feelings to herself with the result that her friends continue to use her. When you come to assess a specific example of this problem you may well find that Betty experiences a mixture of the following emotions: anger, hurt, anxiety and shame. Now, it is important to appreciate that each of these emotions is about a different *A*, which as you know may be an actual event or, more frequently, an inferred event. Thus, Betty may be:

- unhealthily angry when focusing on the selfish aspects of her friends' behaviour
- hurt when focusing on the uncaring aspects of their behaviour
- anxious when thinking about the possible rejection that might follow any assertion and
- ashamed when focusing on her own weakness for not having the courage to speak up.

I argue that if you want to deal with all these issues, then it is helpful to do an *ABC* assessment for each of the four unhealthy negative emotions that your client experiences. If you try to do one *ABC* assessment for the entire experience, you will become confused and so, undoubtedly, will your client.

In this situation, your client chooses the order in which to deal with these different problematic facets.

Meta-emotions As human beings, your clients have the ability to reflect on their experiences and think about their thoughts, feelings and behaviours. Thus, a client's emotion can itself serve as an *A* in an *ABC* episode in which their attitudes determine what subsequent emotions they will have about their prior emotion. These emotions about emotions are referred to as 'meta-emotions' in REBT. As is the case with negative emotions, negative meta-emotions can be healthy or unhealthy. Thus, as Table 1.6 shows, your clients may have healthy negative meta-emotions about both healthy and unhealthy negative emotions, and they may also experience unhealthy negative meta-emotions about both healthy and unhealthy negative emotions. The term used in REBT to describe the latter situation, where clients have emotional problems about their emotional problems, is 'meta-emotional problems'. As you will see in Chapter 9, the identification and analysis of meta-emotional problems plays a particularly important role in the overall REBT assessment process.

Table 1.6 Negative Emotion and Meta-emotion Matrix

	Healthy negative emotion	**Unhealthy negative emotion**
Healthy negative meta-emotion	Disappointment about being healthily angry	Disappointment about being unhealthily angry
Unhealthy negative meta-emotion	Shame about being healthily angry	Shame about being unhealthily angry

Behavioural consequences of attitudes

REBT theory distinguishes between an overt action and an action tendency. Whenever your client holds an attitude then they have a tendency to act in a certain way. Whether or not your client actualises that tendency and goes on to execute a behaviour consistent with it depends mainly on whether or not they make a conscious decision to go against the tendency. One major task that you have as an REBT therapist is to help your client to see the purpose of going against the action tendencies that are based on rigid and extreme attitudes and to develop alternative behaviours that are consistent with action tendencies based on the corresponding flexible and non-extreme attitudes. Before you can do this, you need to help your client to identify and examine their rigid and extreme attitudes and to develop and strengthen their alternative flexible and non-extreme attitudes. I will discuss more fully in Chapter 4 the action tendencies associated with each of the major healthy and unhealthy negative emotions listed in Table 1.5.

For now, I just want to stress that according to REBT theory, constructive behaviours and action tendencies stem from flexible and extreme attitudes towards adversities, and unconstructive behaviours and action tendencies stem from rigid and extreme attitudes towards the same adversities.

Thinking consequences of attitudes

You will recall that earlier I discussed the differences between actual events and inferred events. I argued that although inferences are cognitions, they are best considered as *A*s that trigger your client's basic attitudes at *B*. In this straightforward case, the *A* triggers the *B*, as shown in the following formula:

$$A \rightarrow B$$

However, the attitudes that your client holds can influence the subsequent inferences that they make at *C*. Remember that *C* can stand for thinking consequences of attitudes as well as emotional and behavioural consequences of attitudes. In this more complicated case, we can denote this influence by the following formula:

$$B \rightarrow C\ \text{Inf}$$

Let me illustrate the influence of attitudes on subsequent inferences at *C* in two ways. The first concerns a series of experiments that I conducted with my colleagues in the late 1980s. In one of these studies (Dryden et al., 1989), we asked one group of subjects to imagine that they held a flexible/non-extreme attitude towards giving a class presentation and another group to imagine that they held a rigid/extreme attitude towards the same presentation. Then we asked them to make several judgements

on a series of inferential measures related to giving the presentation, while maintaining the attitude that they were asked to hold. We found that the type of attitudes subjects held had a profound influence on the inferences that they subsequently made. In general, subjects holding the rigid/extreme attitude made more negatively distorted inferences about their performance in the class presentation and about other people's reactions to it than did subjects who held the flexible/non-extreme attitude.

The second illustration of the effect of attitudes on subsequent inferences at *C* is a clinical one. Sarah, a 34-year-old woman, came into therapy because she was depressed about her facial appearance. At the beginning of therapy, she held the following rigid and extreme attitude:

'I must be more attractive than I am, and I am worthless because I am less attractive than I must be.'

At this point she thought that everybody that she met would consider her ugly and that no man would want to go out with her. You will note that these latter statements are her inferences about the reactions of people in general and men in particular and that these inferences are the thinking consequences of her rigid and extreme attitudes. During therapy I (WD) worked predominantly at the attitude level and at no time did I encourage her to examine her distorted inferences. As a result of my interventions, Sarah came to hold the following flexible and non-extreme attitude:

'I would like to be more attractive than I am, but there is no reason why I must be. I don't like the fact that I am less attractive than I would like to be, but I can accept myself as a fallible, complex human being with this lack. I am not worthless, and my looks are just one part of me, not the total whole.'

As a result of this attitude change, Sarah reduced markedly her inferences that others would consider her ugly and that men would not want to go out with her. In fact, soon after her therapy ended, she started dating a man whom she later married. This clinical vignette shows quite clearly, I believe, the influence of attitudes on inferences.

*ABC*s interact in complex ways: the principle of psychological interactionism

So far in this chapter, I have discussed the *ABC*s of REBT as if they were separate processes, distinct from one another. During therapy it is important to deal with the *ABC*s as if they were separate components, because otherwise your clients will end up confused. In reality, though, REBT theory has, right from the outset, advocated the principle of psychological interactionism. This principle states that the events that we choose to focus on, our interpretations and inferences, the attitudes that we hold and the emotions, behaviours and thoughts that stem from these attitudes are all interrelated and reciprocally influence one another, often in complex ways. It is beyond the scope of this book for me to discuss fully and in detail these complex interactions. Those of you who are interested to learn more about the principle of psychological interactionism should consult Ellis (1994) and Dryden (2000).

Summary

Table 1.7 provides a summary of the main points of this chapter.

Having introduced you to the theoretical fundamentals of REBT in this chapter, in the next we will cover what you need to know about the practice of REBT to begin to practise it in a training seminar setting.

Table 1.7 Flexible/Non-extreme Attitudes vs Rigid/Extreme Attitudes: Examples with Shared and Differentiating Components

Attitude	Shared component	Differentiating components
I want to do well, but I don't have to do so ***Flexible attitude***		*. . . but I don't have to do so* ***('Negated demand' component)***
	I want to do well. . . ***('Desire' component)***	
I want to do well and therefore I have to do so ***Rigid attitude***		*. . . and therefore I have to do so* ***('Demand' component)***
It's bad if I don't do well, but it's not terrible ***Non-awfulising attitude***		*. . . but it's not terrible* ***('Non-awfulising' component)***
	It's bad if I don't do well. . . ***('Evaluation of badness' component)***	
It's bad if I don't do well and therefore it's terrible ***Awfulising attitude***		*. . . and therefore it's terrible* ***('Awfulising' component)***
It's a struggle for me to bear the discomfort of not doing well, but I can bear it, it's worth it for me to do so and I am worth doing it for. I am willing to do so, and I am going to do so -> doing so ***Attitude of bearability***		*. . . but I can bear it* ***('I can bear it' component)*** *. . . it's worth it for me to do so* ***('Worth bearing' component)*** *. . . I am worth doing it for* ***('I'm worth bearing it for' component)*** *. . . I am willing to do so* ***('Willingness to bear it' component)*** *. . . and I am going to do so* ***('Commitment to bear it' component) -> behavioural action***
	It's a struggle for me to tolerate the discomfort of not doing well. . . ***('Struggle' component)***	
It's a struggle for me to tolerate the discomfort of not doing well and therefore I can't tolerate it ***Attitude of unbearability***		*. . . and therefore I can't tolerate it* ***('Unbearability' component)***

If I fail to do well, that is bad, but I am not a failure, I am a complex, fallible human being who has failed ***Unconditional acceptance attitude***		*. . . but I am not a failure* ***('Negated global negative evaluation' component)***
	If I fail to do well, that is bad. . . ***('Negatively evaluated aspect' component)***	*. . . I am a complex, fallible human being who has failed* ***('Asserted complex fallible' component)***
If I fail to do well, that is bad and I'm a failure ***Devaluation attitude***		*. . . and I'm a failure* ***('Asserted global negative evaluation' component)***