The Rational Emotive Behaviour Therapist

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THE ASSOCIATION FOR RATIONAL EMOTIVE BEHAVIOUR THERAPY

Aims:

- To promote and develop the science of Rational Emotive Behaviour Therapy (REBT)
- To maintain a register of members
- To maintain a register of accredited practitioners
- To facilitate registration with the United Kingdom Council for Psychotherapy and other relevant organisations
- To promote the interests of the members of the Association in their professional activities
- To publish a journal for the academic and professional advancement of Rational Emotive Behaviour Therapy
- To publish a Newsletter and/or other literature and maintain a website for the purposes of distributing information and advancing the objects of the Association and keeping members and others informed on subjects connected with REBT
- To recognise or accredit training courses and/or institutions
- To run training events and conferences for the purpose of continuing professional development of members and other professionals
- To carry on all such activities as may be conducive to the aforementioned aims

The Association is a company limited by guarantee and not having a share capital.
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Editorial

To be or not to be online? That is the question

Stephen Palmer
Co-Editor

We are almost halfway through the first decade of the second millennium and The Association's main publication, *The Rational Emotive Behaviour Therapist*, is still published only in a paper version. We have a number of options we can choose to consider.

Shall we:

- Still only publish our journal in a paper version?
- Cease publishing a paper version and only publish an online version?
- Publish a paper and online version?
- Publish articles online only?
- Cease publishing a journal?

There are many benefits of paper versions of a journal. You can pick it up, read it, and put it on your shelf with the others. The main disadvantage is the associated publishing and mailing costs. Assuming we have set up an open access to an online version, we would have a greatly extended readership which would be downloadable 24/7 from many parts of the globe. This would help to promote REBT and our Association too.

With some professional bodies I'm involved with, the majority of their members are online. However, I'm aware that many of my REBT colleagues are not online. In fact only about 25% of members are on our AREBT Yahoo Internet Discussion Group. Hopefully this is not a reflection of REBT! To keep the Association's overheads low, should we only have an online journal or just publish articles online? Would this mean that many of our existing Association members would not receive a copy?

As editor, I would be interested to learn your views. Please post to the editorial address or email your correspondence on this issue to:

dr.palmer@btinternet.com

Incidentally, if you wish to join our AREBT Internet Group, please email me with your details and I'll subscribe you to the system.

There was no journal in 2003 as we did not have sufficient articles. I would like to encourage members to submit articles, case studies, conference reports and book reviews. Hope to see you at our next AREBT conference which will be held on 18 October 2004.

Conference Announcement

The Association for Rational Emotive Behaviour Therapy will hold its annual conference in London on 18 October 2004.

Enquiries to: Association for Rational Emotive Behaviour Therapy, PO Box 39207, London SE3 7XH, UK

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The Myth of the 'Superwoman': Stress Management for the Indian Woman[1]

Minnu Bhonsle, PhD

Introduction

What is stress? And is all stress unhealthy?

A certain amount of stress is necessary as it motivates you to work. It generates an enthusiasm to meet a challenge and thus it is creative.

The other kind of stress is destructive and causes distress. This happens when extra efforts are needed to cope with the demands made on you. This extra effort is called stress. The demands may come from others, i.e. from outside, and even from oneself, i.e. from within. In clinical work the term 'stress' is applied to those pressures and strains of living that reduce the quality of life, and require changes in the individual to restore homeostasis. The term also represents the result of several kinds of dysfunctional or irrational thinking.

The more adjustive resources you have, the better you are able to handle stress, and the better adjusted you are. But if stress keeps mounting up and your adjustive resources diminish, you will be in trouble. It is something like your bank account going down and the bills to be paid piling up. Therefore budgeting is required for a peaceful life. Similarly, a psychological budgeting of your stresses and adjustive resources is essential for personal adjustment and mental health.

Psychological stress arises from three sources: frustration, conflict, pressure.

Frustration arises from a failure to meet your needs and desires;

[1] Paper presented on the Advanced Certificate in REBT programme, New Zealand Centre for REBT, November 2002.

Conflict arises when there are two incompatible needs or valued goals; *Pressure* is the demand made on the individual from without or from within. This demand forces you to intensify your efforts.

However, added to this equation are social, cultural or family beliefs which the individual may have subsumed into her belief system (like the myth of the 'superwoman' or 'complete woman' in India). Thus, if she believes that she 'must' 'absolutely' 'always' perform 'perfectly' at work and at home too, an innocuous deadline may assume great importance. In reality, the 'must' is an internal and not an external pressure, as the individual does not have to hold on rigidly to this belief. Many clients receiving stress counselling cognitively appraise experiences as 'very stressful' as a result of their beliefs which distort the importance of an actual or feared event.

We acquire our values, beliefs and attitudes from the people with whom we associate, especially from parents, teachers and peers, from the mass media, and from a variety of other experiences. Well-meaning people have duped us (and themselves) into believing a mass of myths about how to lead satisfying and worthwhile lives. These faulty values make us uptight, afraid of criticism and rejection, overanxious about approval and disapproval, prone to feelings of guilt, and obsessed with polar opposites such as 'succeeding' or 'failing'. They obstruct sexual fulfilment, corrupt the relationship between husband and wife, parent and child, employer and employee, and they destroy the potential for true friendship. If we buy into these long-held myths and fallacies, we set ourselves up for continued and ever-increasing disappointment and stress. Such mistaken 'beliefs' can make just about anyone a neurotic.

Looking for the Complete Woman / Superwoman

My emphasis is stress in Indian women due to the myth of the 'complete woman' or 'superwoman'.

Many a young male studying abroad writes home to his mother asking her to find a bride for him who is 'modern but with Indian values'. Good human values I can understand, but what are these so-called Indian values? There could be stress in an Indian family because the daughter-in-law holding a management degree from the USA does not touch the father-in-law's feet in the morning (an Indian ritual), but instead says 'good morning, Dad'. The young man wants a 'perfect' blend of East and West. The Indian male also specifies that he wants a 'working woman (with a

huge pay packet), but not a career woman' – a woman who not only has in her the perfect blend of East and West, but one who can 'perfectly' juggle a career, her husband, her children, the housework, her in-laws, her personal beauty and fitness regime and, above all, she has to look like she is enjoying all of it. A really tall order. I know of a man whose wife looks after the entire accounts department of the family business, but there is a conflict between them because he expects her to serve a variety of fresh home-made pickles with his meals, just like his mother used to. Another condition that needs to be fulfilled is that the wife should be 'intellectual but not too brainy'. This means that the woman should be smart enough so that he can show off in society, but never too intellectual for the Indian male's comfort. She should be bright but never rock the boat of the relationship with debates and uncomfortable questions, e.g. she should have a management degree, discuss Iraq and Osama Bin Laden, but never ask why the men in the family eat first and the women later? She must look respectful when such demands are made on her, and she must know when to stop arguing, or else her assertiveness and confidence will be labelled as arrogant and 'masculine'. Gender equality should be discussed by her only in women's empowerment groups, but she must not try to implement it in the family. She must produce two children, preferably one boy and one girl, but she must make sure to preserve her pre-marriage figure for fear of losing her husband to another woman.

Now, can such a woman be a reality? Absolutely 'No'. This is a myth, and this myth is designed to leave every woman with a giant-sized inferiority complex. Some women may 'appear' like superwomen from afar, but if you go near them, you will observe the strain and stress of keeping up appearances, the self-punishing perfectionist streak, the inability to relax, and the burden of self-deception. This is the superwoman.

Imagine a woman who feels pressured to have Julia Roberts' smile, Audrey Hepburn's grace, Pamela Anderson's figure, Princess Diana's social

savvy, Indira Gandhi's dynamism, Oprah Winfrey's wit and wealth, Mother Teresa's compassion, and the meekness of a village belle. Imagine the anxiety it would cause to reach such an unattainable goal.

The Bitch In The House, edited by Cathi Hanauer, and no. 4 on the American non-fiction best-seller list, is a frank portrayal of women who have it all but struggle to understand why they are so angry with their husbands and children. The painful secret is now out. Working mothers may be charming at work, but are shrewish to their nearest and dearest – a tremendous metamorphosis which is a product of their have-it-all and do-it-all role.

Some Indian women react in the same way, but the majority of them implode instead of explode and internalise the anger and/or get depressed as they find themselves unable to assume the role of the mythical 'superwoman'. The rising cases of nervous breakdown and depression in women, including psychosomatic ailments, suicide attempts, eating disorders, addiction to alcohol, tranquilisers and mood-elevating drugs, speak volumes about the damage this myth has caused.

From Stress to Distress

Beliefs based on absolute social needs commonly produce stress reactions. People create traps for themselves with 'musts' that often cannot be satisfied (like the trap created by buying into the myth of the superwoman): for example, 'If I cannot be perfect in all my roles (a superwoman) then I'm worthless'.

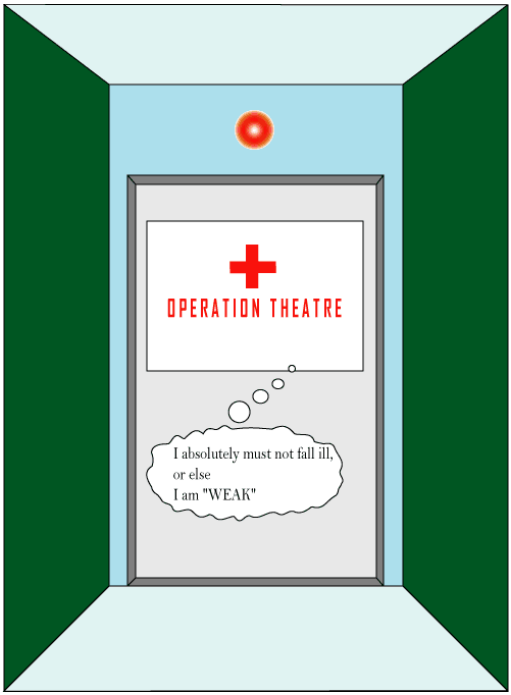
People with generalised anxiety require very little in the way of activating events to perpetuate their anxiety: their own compelling belief system about the events is usually sufficient.

The psychophysiological disorders that develop or worsen as a direct result of such stress include peptic ulcers, hypertension, migraine and tension headaches, lower back pain, temporo-mandibular joint syndrome, sciatica, lupus, multiple sclerosis, and others. Irrational beliefs are the foundation of the prolonged arousal and the emotional anguish that has been shown to be the prime cause of most ills associated with stress.

The cognitive process that facilitates the creation of stress almost always involves irrational beliefs. They include rigid, inflexible and usually unexamined beliefs, personal philosophies and attitudes that we all possess to varying degrees. These can take the form of unconditional demands, such as 'I have to be successful', 'I absolutely must be physically competent

and healthy or else I am inadequate'. For example, the woman who is vying for a promotion and is asked to meet a business deadline, while seeking to get home early to take her child to a music class, will tend to experience stress. Let us examine the underlying belief and demand that transforms these pressures into her experience of stress. She believes that 'I *must* be a superwoman or else I am a *total failure* and that would be *awful* and everyone will see what an *incompetent person* I am'.

If she feels she can cope, even if she is being unrealistic, then she may stay in the situation: for example, working towards a deadline. If it happens that she perceives that she cannot cope, then she may experience stress. At this point, psycho-physiological changes occur. Taken together, these comprise what is known as the 'stress response'. There is usually an emotion or combination of emotions such as anxiety, anger or guilt. These emotions may have behavioural, sensory, imaginal, cognitive, inter-personal and physiological components. She then applies coping strategies. If she believes that her intervention is not helping, she may see herself as failing, which then becomes an additional strain in the situation. Actual failure to meet the demand is also detrimental if the individual truly believes that the demand 'must' be met in a satisfactory manner.



I absolutely must not fall ill, or else I am 'WEAK'.

Interventions may be made by her which may reduce or alter the external or the internal pressures. If this occurs then she may return to a state of equilibrium. But if the interventions are ineffective, she may experience prolonged stress. This has many psychophysiological consequences which may even lead to mental breakdown or death due to the prolonged effect of stress hormones on the body.

Changing Life Mantras

Wrong information means wrong decisions, and wrong decisions mean wrong results; and so it follows that the wrong information be systematically rectified by a counsellor through teaching and re-educating the counsellee in balanced and correct ways of thinking and behaving, and helping him or her acquire rational, realistic and appropriate beliefs of life.

Women can cognitively and behaviourally address this psychological pressure in some of the following ways:

- See the myth of the superwoman as a myth. No human can have it all and do it all. By thinking that I should, I am trying to make myself out to be a supernatural entity.
- Learn self-acceptance irrespective of achievement.
- Learn to distinguish between selfishness and enlightened self-interest.
- Have a rational philosophy that love and approval are good to have, but they are not dire necessities. There will always be times when they are not forthcoming, so I'd better learn how to accept myself independently of what others think.
- Learn to make quick meals and involve the family in household chores. Achieve this through 'family meetings' where the duties can be chosen and done in rotation.
- Learn to delegate responsibility.
- You are the manager of the home, therefore you lay the ground rules at the home.
- Take care of health and maintain a high level of physical energy with appropriate diet, rest, adequate sleep, relaxation, exercise and medication if required. Giving way to crying for a while can also give tremendous relief from stress. (Challenge the irrational belief that the Indian superwoman 'must' not cry as it would mean she is 'weak'.)
- Take some time every day just for yourself – to do something you enjoy like reading, meditating, walking, being with friends, watching a favourite TV show. Plan a day off for yourself occasionally.
- Where there is a will there is a way. Therefore find a way to balance your time between yourself and others – most importantly, give up the fear of 'what will others say?' Remember their opinion is not a fact.
- Learn interpersonal skills of communication and train yourself in assertiveness – learn to say 'No'.
- Sometimes radical changes need to be made within ourselves to de-stress ourselves and there are times when we may have to seek counsel

and help to make these changes.

The 'superwomen' suffering from burnout require a comprehensive programme of treatment. This requires thorough therapeutic assessment by the therapist to ensure that the most suitable interventions are selected.

For successful therapy, however, certain conditions need to be fulfilled:

- *Identifying something as a problem.*
- *Accepting the possibility that something can be done about it.*
- *Expressing a desire to change.*
- *A willingness to make an effort and do whatever it takes to change.*

The fact is that psychological growth and emotional re-education, like any other form of learning and development, calls for active participation on the part of the learner. The client needs to *be* committed, *do* whatever it takes, and as a result *have* what she wants.

Thus the objective of all counselling and therapy is to get the counsellee to understand that the locus of control is in her, to take responsibility for her contribution to her situation, and thus to get her to participate fully in her own healing and work towards a harmonious life.

Thus stress management can be summed up in the words of St Francis:

God, grant me the
Serenity to accept the things I cannot change…
Courage to change the things I can
And Wisdom to know the difference…

Here Lies Super Woman. May she Rest in Peace.

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A Rational Emotive Behavioural Approach to Face-to-face, Telephone and Internet Therapy and Coaching: A Case Study

Stephen Palmer, PhD

Abstract

In this case study, the therapist provided rational emotive behaviour therapy (REBT) in England to a client who later returned home to her country of origin. Unable to obtain REBT, she decided to continue therapy with the therapist by using the telephone, private internet chat rooms and email. This paper focuses on her reactions to using the different domains for REBT.

Introduction

Generally, in published case studies only the views and observations of the therapist(s) are noted in the final report. Although case studies may provide useful information, they seldom ask the client to write as much or as little as they wish about their experience of therapy. There are few published case studies that compare the different mediums in which therapy or coaching can occur with the same client. Many traditional counsellors and therapists still refuse to use telephone counselling with their clients. More recently, the use of modern technology such as the internet and email has created a new arena for therapy and coaching to occur. Resistance to the use of telephones and internet as a medium for therapy is hopefully waning. However, clients are probably less resistant to their use than therapists.

This paper focuses on one particular client's experience of face-to-face, telephone, email, and online chat room (audio/voice) Rational Emotive Behaviour Therapy.

The mediums

Letter writing

Most traditional psychotherapy or counselling usually occurs in settings where the client and therapist are sitting in the same room, thus enabling them to hear and see each other (assuming they do not have a visual or hearing disability). This traditional face-to-face setting has many advantages as there is opportunity for immediate feedback, with both verbal and non-verbal cues being available to therapist and client. However, other mediums for therapy have existed for many years including letter and telephone counselling (see Wallbank, 1997). According to Wallbank letter writing has a number of advantages including (adapted Wallbank, 1997):
a) Opportunity to express thoughts and feelings and explore issues at a time when these are uppermost in the mind.
b) Letters can be written at any time such as the night when the children are asleep or one's partner is not around.
c) Letters can be continued over a period of days, weeks or months.
d) The client determines the timing of their side of the contract.
e) Increased sense of control by putting down on paper ideas, thoughts, emotions and worries.
f) Knowing that a counsellor is going to respond may help the client's personal progress and provides security.

Telephone counselling

Since the 1980s, telephone counselling has been used as one of the main methods of communication in voluntary bodies between clients and counsellors (or helpers). In fact McLeod (1993) suggested that it was the most used form of counselling. The client may receive by telephone, counselling, befriending, information, support and other services too (see Wallbank, 1997). Specific training has been available for working in this medium (Palmer & Milner, 1997). In countries such as China, where western forms of counselling have not been generally available, the 1990s saw an expansion of telephone counselling 'hotlines' which initially provided information and later counselling on a range of issues (Palmer *et al*, 1998). One of the main strengths of telephone counselling services is the ability to offer free and confidential support and advice. The support staff are usually trained and/or have personal knowledge of the particular difficulty the caller is contacting them about (see Wallbank, 1997).

More recently, with the advent of low cost mobile phone text messaging, clients have used text messages to contact their therapists, who have then replied accordingly.

However, therapists in general have been more reluctant to offer telephone counselling or psychotherapy to their clients. Often this medium for counselling has been frowned on by therapists. Possibly in many cases this resistance to offer their clients telephone sessions has been more to do with their reluctance to move beyond the safe environment of their counselling rooms, letting go of control, feeling uncomfortable with the communication medium, and/or refusing to compromise with the beliefs of the therapeutic approach they practise.

Online counselling and psychotherapy

Since the 1990s, with the advent of the internet, therapy has moved beyond the confines of either face-to-face or telephone mediums into the area initially termed 'computer therapeutics' by Lago (1996) or more commonly known as e-mail[1] (email) counselling, online counselling, web counselling or internet therapy. This method of communication shares advantages similar to letter writing, except that under specific circumstances it has a sense of immediacy if internet relay chat or instant email/discussion systems are used which can send messages back and forth very quickly (Goss *et al*, 2001a). Other advantages include the ability to easily send self-help material or other relevant documents such as blank and completed ABCDE forms, links to useful websites, the ability to access experts if living in remote areas, maintaining contact with therapists when travelling away from home or work, time to reflect on therapy-related issues and respond to the therapist in one's own time, and the use of emoticons for abbreviations of emotions[2].

Possible disadvantages of email or internet counselling include an apparent lack of visual cues, which some therapists see as essential to therapy, and a lack of security. However, the visual cues or non-verbal behaviour (see Argyle, 1975) may not be necessary for successful therapy to take place. Support and empathy can occur using email although the therapist needs to ensure that they communicate this by focusing on the relevant issues as expressed by the client and by the use of basic literacy

[1] Electronic mail.
[2] For example, emoticon for happiness or smile is a colon, a hyphen and a close bracket :-)

skills, allowing accurate paraphrasing and summarising of the client's concerns. Internet security can be improved by the use of encryption whereby the file is not accessible without a previously agreed password. A simple encryption method is available on Microsoft Word systems although more advanced techniques are available.

Online therapy can be iatrogenic as dysfunctional behaviours and irrational beliefs may be reinforced. For example, Goss and associates (2001a) suggest that socially phobic clients may have chosen to use this domain for therapy as it avoids social encounters. (However, see case study later.) Other concerns have been raised about online counselling, which have been expressed by practitioners and professional bodies including the American Psychological Society (Adams, 1998; APA, 1998; BAC, 1999; Zarr, 1984). In response to these concerns, especially with the increasing use of email and online therapy, the British Association for Counselling and Psychotherapy set up an online counselling working group which later published guidelines for therapists wishing to undertake this type of work (Goss *et al*, 2001b).

Online chat rooms

A further development of internet therapy is the use of internet relay chat rooms which allow for text or spoken communication between computer users. However, to maintain a reasonable level of security to prevent any unwanted visitor also entering the chat room during therapy, a non-listed, private membership by invitation only Yahoo Group[3] system can be set up for the sole use of the therapist and client. The benefit of this system is that the therapist and client can hold a conversation with each other, similar to telephone counselling. Unlike the telephone, the service is free and allows the client to speak to the therapist from any part of the technologically advanced world, assuming that the computer has a microphone and speakers. Most modern laptops have the microphone and speakers integrated into the system although they may need turning on and/or the volume increased. Video links are also possible but the quality is variable which can distract from therapy (see Ross, 2000).

Client's feedback

This section focuses on one client's views on using face-to-face,

[3] http://groups.yahoo.com.

telephone, verbal chat room and email/internet rational emotive behaviour therapy. She has experienced all four mediums with the same therapist (SP[4]) and was asked to note down her reflections on their use in her REBT sessions. She listed the advantages and disadvantages of each method.

The client suffers from anxiety, relationship difficulties and low self-esteem. Therapy was originally face-to-face on a fortnightly basis whilst she was attending postgraduate studies in London, England. Once she finished her studies, she returned to her own country in continental Europe and encountered great difficulty finding another qualified therapist who practised REBT. She then requested monthly telephone counselling to help continue her therapeutic gains. Although she found REBT useful, having face-to-face sessions helped her to avoid her irrational beliefs about being alone. Online and telephone counselling both offered her a form of REBT which was suited to her personality and provided additional therapeutic gains over face-to-face therapy.

The client's first language is not English so her responses have been slightly modified to improve clarity.

Face-to-face therapy

I believe that the REBT approach in a face-to-face therapy has the main advantage of being directive in nature. When my therapist noted on the whiteboard my irrational beliefs, it helped me to understand therapy.

This means that the more times my therapist elicited my irrational beliefs in the session, the more time was available to release the tension I felt and, therefore, change my irrational beliefs to rational ones. With my therapist's encouragement, I took risks.

Interestingly, due to my therapist's physical presence in therapy, unintentionally he decreased the intensity of feeling alone. Therefore, face-to-face therapy maintained the problem I had with not facing being alone.

I found face-to-face sessions challenging and often I couldn't express my emotions. It took a while to discuss my negative feelings towards others in the therapy session whereas perhaps I could have expressed them at the beginning of the session if I was less shy and more assertive. Even though my therapist frequently asked questions such as, 'How do you feel about today's session?' I was reluctant to share with him my negative feelings. Another factor was that I was too overwhelmed by my problems

[4] Stephen Palmer is an Albert Ellis Institute, REBT Certified Supervisor.

that had to be discussed. There was never enough time to discuss and focus on my feelings during the course of face-to-face therapy. However, it didn't occur to me to express my emotions because I was anxious about other day-to-day problems that I had to cope with.

Online counselling

I have found email communication to be efficient. When I want to express how I feel at times of intolerance, I can write my emotions and email them to my therapist.

Online counselling helps me to save money so I can afford therapy whereas a telephone call makes me be concerned about the money I will spend.

My therapist's responses to my emails helped me to think again about my irrational thoughts as I could review his notes and prolong the time I spent carefully considering his questions such as, 'Where does this irrational belief get you?' Then I chose to develop a corresponding rational belief in the intervening time.

I realised with email contact how I had increased my demandingness on my therapist. During some difficult life situations, I remember that I emailed my therapist wanting (demanding) a telephone session and he generally was able to make an appointment. But what if he didn't? It was possible but it didn't occur and I want to thank my therapist for being there for me at times of hopelessness.

Later on when I reviewed our email correspondence, I underlined the demanding beliefs I held that related to my therapist. This helped me to use coping statements such as, 'I would like to discuss my problems with my therapist but if not, it's not the end of the world. It is annoying but I can stand my anxiety and accept my therapist's priorities' (job, lectures, other clients and so on).

Even though we used email, he was able to pick up on when I felt life was hopeless and he quickly responded[5].

I used forceful coping statements such as 'I can stand almost everything', 'Use flexible thinking', 'Have a goal to make me happy'; and pragmatic statements such as, 'Life is too short to be stressed'.

Telephone counselling

A telephone therapy session is a good way to talk with my therapist,

[5] Close attention was given to any beliefs expressed by the client that could relate to hopelessness.

especially when a face-to-face communication is impossible due to geographical distance. I really want my irrational, inflexible, demanding beliefs to be challenged to allow me to feel better.

Listening to the intonation of my therapist's voice on the telephone helped me to mentally review my irrational beliefs and persuade me to think and act out more flexibly. For example, I may choose to accept a flexible belief, 'It may be desirable to have my friend join me, but if not, it's NOT THE END OF THE WORLD. TOUGH, TOO BAD'.

Moreover, my therapist's self-disclosure of personal examples used during the telephone sessions has helped me to put into practice the rational beliefs challenging my demandingness and loneliness. I have found my therapist's modelling encouraging. Generally my therapist's own personal examples reminded me to put up with the intolerant aspects of my negative emotions. I started experiencing high frustration tolerance and became more assertive. This helped me to build up my confidence.

As an assignment, I took the risk of asking a friend not to call me until the time he returned home from work trips. This has helped me to become more comfortable about being alone. I reinforced my new assertive behaviour by socialising with different friends. I practised holding a preferential attitude about others and attempted to maintain a high frustration tolerance in relationships. As a result, I choose to have different people around me instead of staying with difficult friends just because I was lonely.

On the other hand, there are some drawbacks with telephone counselling. One problem is that I don't have time to keep notes when I am talking and listening to my therapist. This is important as notes help me to keep a record of forceful, coping sentences which we devlop in therapy.

Upon my request for another appointment, sometimes my therapist was unable to agree immediately a mutually acceptable day and time[6]. He would have to confirm later by email. This has proved helpful as I have had to adapt to those intolerable emotions[7] I brought on myself. Not only did I change my attitude to 'I can survive with my anxiety', but I also lowered my demands on my therapist.

[6] The problem arises when the therapist will not be working at a suitable location for telephone therapy.
[7] Mainly anxiety.

Private internet chat room (audio/voice)

Using the chat room is cheaper than a long-distance telephone counselling session. It had the advantage of being able to express my problems in ABC terms both in a text or a spoken way in the chat room. Unlike the telephone, I didn't have to hold any receiver to my ear so it simplifies my talking style[8].

No one else has accessed the chat room during the time of therapy. This allowed me to talk freely.

Initially the only difficulty was that both of us could not talk simultaneously. This was due to external environmental background noise which switched the system on. This was just annoying[9].

Client summary

Generally, my therapist responded to my telephone requests at times when I felt hopeless. Keeping in email contact helped me to express easily my feelings of hopelessness and my intolerance to situations and negative emotions. My therapist was able to listen to me and pick up on when I was intolerant and was prepared to accept me, whatever I wanted to discuss, even if I avoided people. However, down the telephone he would forcefully repeat, 'YOU CAN STAND ALMOST EVERYTHING, even negative emotions. You'd better accept other people as they are instead of keeping yourself unhealthily anxious and frustrated'.

During therapy, I found that the pragmatic disputing helped me to challenge my unassertive thoughts and behaviours. I can choose not to feel anxious and frustrated by becoming less demanding on others. Therapy has also helped me to develop a new rational belief of high frustration tolerance such as, 'I can stand loneliness, anxiety and unfairness in my relationships and in myself as well'.

To conclude, from my view as a client, all that matters is a flexible method of communication. All the methods we have used have proved to work effectively. The only obstacle for a client in REBT is not persisting in adopting a flexible attitude in the problems he/she encounters. If a client is emotionally, cognitively and behaviourally disturbed I would

[8] The conversation comes over the computer loudspeaker system.
[9] Yahoo Chat Room has a facility for either talking simultaneously handsfree or taking it in turns. The latter is advisable if one speaker has a sensitive microphone or has high background noise, e.g. loud ventilation systems.

recommend the best way to counter it is: **better quickly, rather than slowly!**

All it takes is a flexible client and a flexible therapist to work together. Hopefully they can tolerate obstacles and choose to overcome them flexibly without a demanding philosophy.

Therapist's summary

This client has benefited from using the different domains for therapy. Although face-to-face therapy helped her to understand the ABCDEs of REBT, regular therapy sessions unintentionally helped her to avoid facing her irrational beliefs associated with loneliness. Only on leaving London and returning to her country were these beliefs triggered by external events and exacerbated by the geographical distance from her therapist. The telephone and online rational emotive behaviour therapy was used to elicit and then challenge these irrational beliefs. The internet allowed the quick and easy mailing of REBT worksheets.

Another benefit of both the telephone and online mediums was that the client perceived herself more in control of the therapy in contrast to face-to-face sessions. She could be more assertive during the therapy sessions and was able to spend time reflecting on her responses to email communication. It is likely that this client would have found computer aided therapy useful too (see Marks *et al*, 1998).

General recommendations

On behalf of the British Association for Counselling and Psychotherapy[10], Goss and associates (2001b) developed guidelines for the use of the internet for therapy. For therapists working in the UK wishing to undertake online counselling it is important for them to read these guidelines. Beyond just the therapy aspect, there are additional difficulties that the unwary can encounter. For example, in some US states, only licensed therapists working within the relevant State are legally able to undertake therapy (online or otherwise) with its citizens. How do you first contract with a client online? Some of these issues are covered in this document (also see Page, 2001). It is important that online therapists know how to encrypt (password protect) files and have knowledge of data protection legislation. Technical and legal advice may need to be sought.

[10] During 2001 Stephen Palmer chaired the BACP Online Therapy Working Group which later published the guidelines.

However, clients are keen to use the modern technology, especially those whose job or lifestyle takes them on journeys away from the therapist's location.

Conclusions

Clients may not only find telephone and online counselling convenient, but it may offer them advantages over face-to-face therapy depending upon their personality, skills, expectations of therapy, and previous life experience.

Therapists who resist modern technology may not be assisting their clients to maximise their use of time or therapy. By the end of this decade, it is likely that many therapists will have offered their clients online therapy. It is clear how Rational Emotive Behaviour, Cognitive and Behavioural approaches to therapy, training and coaching can easily adapt to the internet and telephone domains. It is less clear how analytical and related approaches to psychotherapy could adapt to the modern technology (however, see Neubeck and Neubeck, 1998).

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The Relationship between Cognitive Distortions and Anger

Jerry Wilde

Abstract

This study was designed to examine the relationship between cognitive distortions and levels of anger reported by undergraduate college students. Participants were seventy-nine (13 = males, 66 = females) adult undergraduate students enrolled in an educational psychology course. The instruments used in this study were the Cognitive Distortion Scales (CDS) by Briere (2000) and the State-Trait Anger Expression Inventory-2 (STAXI-2) by Spielberger (1999). Of the twelve scales, subscales, and index of the STAXI-2, eight reached statistical significance when compared with scores on the CDS. Higher scores on a measure of cognitive distortions (CDS) are associated with increased levels of anger even though the subscales on the CDS appear unrelated to 'demandingness', which is the distortion believed to be primarily responsible for anger according to REBT theory.

The Relationship between Cognitive Distortions and Anger

This study was designed to examine the relationship between cognitive distortions and levels of anger reported by undergraduate college students. Theorists such as Albert Ellis (1962, 1973, 1977b, 1979) and Aaron Beck (1976) have stated that there is a strong relationship between cognitions and emotions. According to Ellis, emotions are significantly influenced by and, to a certain extent, created by cognitions. Such ideas date back to the first century BC when the Stoic philosopher Epictetus wrote, "People are disturbed not by events but by the views they take of them" (Ellis & Harper, 1975, p.33). In other words, it is not external events

that cause emotions, but an individual's cognitions about these events that create feelings.

Ellis (1962, 1977b) has postulated twelve irrational beliefs or cognitive distortions believed to be at the core of a majority of emotional disturbance. These beliefs have been condensed to four fundamental irrational beliefs:
1) *Self-worth or self-rating statements* (often leading to depression) – 'I'm a rotten person because I made a mistake.'
2) *Demanding or should statements* (often leading to anger) – 'Others should treat me fairly.'
3) *Awfulising statements* (often leading to anxiety) – 'Things are terrible, awful, and horrible if I don't find easy solutions to my problems.'
4) *Low frustration tolerance statements* (often leading to avoidance or withdrawal) – 'I can't stand it when things don't work out perfectly.' (Ellis & Harper, 1975).

Beliefs are said to be rational if they: (a) are true, (b) can be supported by evidence or proof, (c) are logical, (d) are not absolute commands, (e) are desires, wishes, hopes, and preferences, (f) produce moderate emotions such as sadness, irritation and concern rather than extreme emotions such as depression, rage, and anxiety, and (g) help clients reach their goals (Walen, DiGiuseppe & Wessler, 1980).

Cognitions and Anger

REBT postulates that the cognitive distortion responsible for bringing about the emotional state of anger is usually a demanding belief such as, 'Things SHOULD or MUST be the way I want them to be'. Anger is almost always created by a *demand* of some type. Typically the demanding belief is formulated using key words such as *should*, *ought to*, *have to*, and *must* (Wilde, 1995).

While the primary beliefs leading to anger are usually demands in one form or another, there are also secondary corollaries that contribute to anger. These beliefs are considered secondary because they tend to be focused on the nature of the offending party or the nature of the perceived misdeed. Ellis (1977a) stated that the following corollary beliefs also often lead to anger:
1) How *awful* for you to have treated me so unfairly!
2) I *can't stand* you treating me in such a manner!
3) Because you have acted in that manner towards me, I find you a *rotten person*.

Ellis (1962, 1976) has stated that humans have a tendency to escalate their desires and wishes into absolute demands. This is especially true when these desires are strong. The fact that nearly all humans share this habit has led Ellis to believe that thinking irrationally is a basic biological tendency. Contrary to the view postulated by Ellis is the belief that thinking patterns are learned and, therefore, not biologically based.

Deffenbacher *et al* (1996) has proposed that angry individuals tend to possess numerous cognitive distortions that lead to increased levels of anger. Below is a synopsis of Deffenbacher's beliefs regarding the type of cognitive errors often committed by anger prone individuals.

1) *Poor estimation of probabilities* – individuals with anger problems tend to overestimate the probability of negative outcomes and underestimate the likelihood of positive outcomes.

2) *Attributional errors* – anger prone individuals attribute negative acts as being done intentionally with the expressed purpose of maliciously attacking them. They believe they have the ability to read others' minds.

3) *Overgeneralisations* – angry clients tend to use overly broad terms when describing time (i.e. excesses use of 'always' and 'never') and use global descriptions of people (i.e. stupid, lazy).

4) *Dichotomous thinking* – also thought of as black-and-white thinking.

5) *Inflammatory labelling* – using descriptive terms that are emotionally charged, which only increases the person's anger.

6) *Demandingness* – believing others *should* not act in certain ways or that they *must* not behave as they have, in fact, behaved.

7) *Catastrophic thinking* – evaluating unmet demands in an exaggeratedly negative fashion (i.e. 'It's horrible, terrible, and awful things haven't gone my way').

Episodes of Anger

Averill (1982, 1983) used college students and adults to examine episodes of anger. The subjects reported that 75% of their anger was at a loved one, friend, or acquaintance Eight per cent (8%) of the time their anger was directed at someone well known and disliked and 13% was toward a stranger. An overwhelming majority of anger (85%) was the result of being accused of committing some misdeed. Once subjects were angry, 60% of the responses were self-calming and 59% reported talking the incident over. Direct physical aggression was reported only 10% of the time, but verbal or symbolic was more common at 44%.

Kassinove and Sukhodolsky (1997) examined anger episodes using both American and Russian subjects. Anger was reported to be triggered approximately 80% of the time by actions of another person. In both countries, the episodes occurred across all days of the week. Regarding what people wanted to do, the most frequent responses were yelling and arguing/making sarcastic remarks (selected by 87% of the Americans and 60% of the Russians), and wanting to resolve the problem/control the anger and get rid of it (selected by 65% of the Americans and 64% of the Russians). The most frequently reported actual responses during anger were yelling and arguing, making sarcastic remarks, making a complaint, and resolving the problem/controlling the anger to get rid of it. Only 10% of the participants (11% of Americans and 8% of Russians) indicated that they actually did hit a person and/or destroy something but 38% of the overall sample wanted to engage in violence.

Anger and Health: Suppression or Expression

It is beyond the scope of this article to discuss all the findings related to hostility and health. Suffice to say that a number of studies have found an association between levels of hostility and a wide variety of health problems. Researchers have consistently found suppressed anger to be related to a number of medical conditions such as hypertension, coronary artery disease, and cancer (Greer & Morris, 1975; Harburg, Gleiberman, Russell and Cooper, 1991; Harburg, Blakelock & Roeper, 1979; Spielberger, Crane, Kearns, Pellegrin & Rickman, 1991). It would be inappropriate to assume that these findings suggest that 'expressed anger' is healthier than 'suppressed anger'. Berkowitz (1970) has found that individuals who punish, curse at, or otherwise aggress against others almost always begin to feel *more* angry instead of feeling less irate.

Murray (1985) reports that giving subjects an opportunity to express their anger after they have been criticised often makes the subjects even angrier. These findings are pertinent to this study since several of the scales and subscales of the State-Trait Anger Expression Inventory-2 (STAXI-2) (Spielberger, 1999) are concerned with anger expression and/or anger control.

Method

Participants

Participants were seventy-nine (13 = males, 66 = females) adult

undergraduate students enrolled in an educational psychology course at Indiana University East. The students were primarily of sophomore standing but there were a few freshmen and juniors also included in the sample. The mean age was 23 years, 4 months.

The two instruments used in this study were both completed during a single-class period. Data was collected over a three-semester period from the spring of 2002 to spring 2003.

Materials

Cognitive Distortion Scales

The Cognitive Distortion Scales (CDS) by Briere (2000) consists of forty items that, in turn, are each included in one of five scales: (a) Self-Criticism (SC), (b) Self-Blame (SB), (c) Helplessness (HLP), (d) Hopelessness (HOP), and (e) Preoccupation with Danger (PWD).

Self-Criticism (SC) measures low self-esteem and self-devaluation. Self-Blame (SB) measures the extent to which the respondent blames him or herself for negative, unwanted events that have transpired in his or her life. Helplessness (HLP) measures the perception of being unable to control important aspects of one's life. Hopelessness (HOP) measures the extent to which the respondent believes that the future is bleak and that he or she is destined to suffer or fail. Preoccupation with Danger (PWD) evaluates the tendency to view the world as a dangerous place (Briere, 2000).

Each of the forty items is rated according to its frequency of occurrence within the last month, using a five point scale ranging from 1 (never) to 5 (very often). The normative sample for the CDS consisted of 611 subjects (53% female, 47% male) with a mean age of 47 years (range between 17 and 89). The ethnic composition was 80% Caucasian, 6% African American, 3% Hispanic, 3% Asian and 1% Native American. The other 5% of the sample did not respond to the question.

The five scales were analysed for internal consistency which produced coefficients ranging from .89 (for Preoccupation with Danger) to .97 (for Hopelessness). Construct validity for the instrument was assessed by comparing the CDS to other established measures such as the Suicidal Ideation scale of the Personality Assessment Inventory (PAI; Morey, 1991). Comparisons between these two scales produced coefficients ranging from .68 (for Preoccupation with Danger) to .89 (for Hopelessness). The CDS was also compared with the Sad Mood scale of the Multiscore Depression Inventory (MDI; Berndt, 1986) and produced coefficients

ranging from .51 (for Self-Criticism) to .64 (for Hopelessness). Comparisons between the Depression scale of the PAI and the CDS yielded correlational coefficients between .68 (for Preoccupation with Danger) to .87 (for Hopelessness).

State-Trait Anger Expression Inventory-2

The State-Trait Anger Expression Inventory-2 (STAXI-2) (Spielberger, 1999) is composed of 57 items and consists of six scales, five subscales, and an Anger Expression Index. Subjects respond using a 4-point Likert-type scale (1 = almost never to 4 = almost always) to various sentence stems for the different scales of the STAXI-2.

State Anger (S-Ang) is composed of 15 items and measures the intensity of angry feelings and the extent to which a person feels like expressing anger at a particular time. The sentence stem for State Anger (S-Ang) is 'How I feel right now'. The State Anger scale is composed of three subscales: Feeling Angry (S-Ang/F), Feel Like Expressing Anger Verbally (S-Ang/V) and Feel Like Expressing Anger Physically (S-Ang/P).

The second scale on the STAXI-2 is the ten item Trait Anger (T-Ang) which measures how long angry feelings are experienced over time. The sentence stem for Trait Anger (T-Ang) is 'How I generally feel'. The Trait Anger scale has two subscales known as Angry Temperament (T-Ang/T) and Angry Reaction (T-Ang/R).

The third scale is Anger Expression-Out (AX-O) which measures how often angry feelings are expressed in either verbal or physically aggressive behaviour. The sentence stem for the remaining scales and the Anger Expression Index is 'How I generally react when angry or furious'. The fourth scale is Anger Expression-In (AX-I) which measures how often angry feelings are experienced but not expressed. Anger Control-Out (AC-O) contains eight items and measures how often a person controls the outward expression of angry feelings. Anger Control-In (AC-I) also has eight items and measures how often a person attempts to control angry feelings by calming down.

Finally, Anger Expression Index (AX Index) contains 32 items and provides a general index of anger expression based on the responses to items in the AX-O, AX-I, AC-O, and AC-I scales.

The normative data on the STAXI-2 was gathered from over 1900 individuals. Of this sample, 1644 were from a heterogeneous normal sample (977 females, 667 males) and 276 were from hospitalised psychiatric

patients (105 females, 171 males). Since many of the items on the STAXI-2 were incorporated from the original STAXI, many of the studies supporting the validity of the STAXI-2 reported data comparing various instruments with the original STAXI. The original STAXI Trait-Anger Scale was evaluated using 280 undergraduate college students and 270 Navy recruits (Spielberger, 1988). These 550 subjects completed the STAXI, the Buss-Durkee Inventory (BDHI, Buss & Durkee, 1957), and the Hostility (Cook & Medley, 1954) and Overt Hostility (Schultz, 1954) of the Minnesota Multiphasic Personality Inventory (Hathaway & McKinley, 1967). All reported correlational coefficients between the STAXI and the other three measures reached statistical significance for both males and females.

Comparisons between the STAXI State Anger and Trait Anger Scales and the Neuroticism and Psychoticism scales of the Eysenck Personality Questionnaire (EPQ; Eysenck & Eysenck, 1975) for a sample of 789 college students (545 females, 334 males) produced statistically significant results as well. EPQ Neuroticism correlated with S-Anger scale produced coefficients of .27 and .43 for females and males respectively. Additionally, the EPQ Neuroticism correlated with T-Anger scale produced coefficients of .49 and .50 for females and males respectively. EPQ Psychotism correlated with S-Anger scale produced coefficients of .27 and .26 for females and males respectively. Finally, the EPQ Psychotism correlated with T-Anger scale produced coefficients of .20 and .21 for females and males respectively. All of these correlations were significant at the .001 level.

Results

Cell means and standard deviations of the CDS and STAXI-2, and their respective subscales, are presented in *Table 1*. Subjects' scores on the scales and subscales of the CDS and STAXI-2 were analysed using analysis of variance (ANOVA) with the CDS scores serving as the independent variable and the STAXI-2 as the dependent measure. Several of the comparisons produced statistically significant results.

Of the twelve scales, subscales, and the index of the STAXI-2, eight reached statistical significance when compared with the CDS. Those reaching statistical significance included: (a) State Anger (S-Ang), $F(5, 73) = 8.66$, $p < .000$, (b) Feeling Angry (S-Ang/F), $F(5, 73) = 6.17$, $p < .000$, (c) Feel Like Expressing Anger Verbally (S-Ang/V), $F(5, 73) = 7.18$, $p < .000$, (d) Feel Like Expressing Anger Physically (S-Ang/P), $F(5, 73) =$

Table 1: Cell Means and Standard Deviations for STXI-2 and CDS

STAXI-2	**M**	**SD**
State Anger (S-Ang)	17.11	4.05
Feeling Angry (S-Ang/F)	6.34	2.10
Feel Like Expressing Anger Verbally (S-Ang/V)	5.60	1.52
Feel Like Expressing Anger Physically (S-Ang/P)	5.18	.80
Trait Anger (T-Ang)	18.77	5.42
Angry Temperament (T-Ang/T)	6.82	2.93
Angry Reaction (T-Ang/R)	8.68	2.28
Anger Expression-Out (AX-O)	15.80	4.32
Anger Expression-In (AX-I)	16.97	3.99
Anger Control-Out (AC-O)	22.95	4.77
Anger Control-In (AC-I)	21.77	5.07
Anger Expression Index (AX Index)	36.62	3.10
Cognitive Distortion Scales	**M**	**SD**
Self-Criticism (SC)	19.19	6.68
Self-Blame (SB)	17.31	6.37
Helplessness (HLP)	16.20	6.77
Hopelessness (HOP)	14.05	7.37
Preoccupation with Danger (PWD)	16.73	6.33

N=79

6.51, $p < .000$, (e) Trait Anger (T-Ang), $F(5, 73) = 4.00$, $p < .003$, (f) Angry Reaction (T-Ang/R), $F(5, 73) = 3.69$, $p < .005$, (g) Anger Expression-Out (AX-O), $F(5, 73) = 2.95$, $p < .018$, and (h) Anger Expression Index (AX Index), $F(5, 73) = 2.91$, $p < .019$.

The four subscales of the STAXI-2 that failed to reach statistical significance were when compared with the CDS were: (a) Angry Temperament (T-Ang/T), $F(5, 73) = 1.46$, $p = .215$, (b) Anger Expression-In (AX-I), $F(5, 73) = 1.33$, $p = .26$, (c) Anger Control-Out (AC-O), $F(5, 73) = 2.31$, $p = .052$ and (d) Anger Control-In (AC-I), $F(5, 73) = .742$, $p = .594$. *Table 2* displays the findings for the STAXI-2 subscales.

In order to determine which subscales of the CDS accounted for the most variance in the STAXI-2 scores, stepwise multiple regressions were calculated with the five CDS subscales as predictor variables and the various scales, subscales, and index scores on the STAXI-2 as the criterion.

Table 2: Summary of Findings for STAXI-2 and CDS Scales and Subscales

	F	p
State Anger (S-Ang)	8.66	.000**
Feeling Angry (S-Ang/F)	6.17	.000**
Feel Like Expressing Anger Verbally (S-Ang/V)	7.81	.000**
Feel Like Expressing Anger Physically (S-Ang/P)	6.51	.000**
Trait Anger (T-Ang)	4.00	.003**
Angry Temperament (T-Ang/T)	1.46	.215
Angry Reaction (T-Ang/R)	3.69	.005**
Anger Expression-Out (AX-O)	2.95	.018*
Anger Expression-In (AX-I)	1.33	.260
Anger Control-Out (AC-O)	2.31	.052
Anger Control-In (AC-I)	.742	.594
Anger Expression Index (AX Index)	2.91	.019*

** $p < .01$; *$p < .05$; df = 5, 73

The collective impact of the five CDS subscales was also calculated for the STAXI-2.

When State Anger (S-Ang) was used as the dependent measure, respondents' scores on the CDS account for 37% of the variance on the STAXI-2 (R2 = .372). The Beta coefficients for two of the CDS subscales were also statistically significant (Self-Criticism, B = -.332 and Hopelessness, B = .542).

When Feeling Angry (S-Ang/F) was used as the dependent measure, respondents' scores on the CDS account for 30% of the variance on the STAXI-2 (R2 = .297). The Beta coefficients for two of the CDS subscales were also statistically significant (Self-Criticism, B = -.346 and Hopelessness, B = .461).

When Feel Like Expressing Anger Verbally (S-Ang/V) was used as the dependent measure, respondents' scores on the CDS account for 35% of the variance on the STAXI-2 (R2 = .349). Only the beta coefficient for the subscale Hopelessness (B = .542) was significant.

When Feel Like Expressing Anger Physically (S-Ang/P) was used as the dependent measure, respondents' scores on the CDS account for 31% of the variance on the STAXI-2 (R2 = .308). Only the beta coefficient for

Hopelessness (B = .510) was significant.

When Trait Anger (T-Ang) was used as the dependent measure, respondents' scores on the CDS account for 22% of the variance on the STAXI-2 (R2 = .215). None of the CDS subscales were statistically significant.

When Angry Temperament (T-Ang/T) was used as the dependent measure, respondents' scores on the CDS account for 9% of the variance on the STAXI-2 (R2 = .091). None of the CDS subscales were statistically significant.

When Angry Temperament (T-Ang/T) was used as the dependent measure, respondents' scores on the CDS account for 9% of the variance on the STAXI-2 (R2 = .091). None of the CDS subscales were statistically significant.

When Angry Reaction (T-Ang/R) was used as the dependent measure, respondents' scores on the CDS account for 20% of the variance on the STAXI-2 (R2 = .202). None of the CDS subscales were statistically significant.

When Anger Expression-Out (AX-O) was used as the dependent measure, respondents' scores on the CDS account for 17% of the variance on the STAXI-2 (R2 = .168). None of the CDS subscales were statistically significant.

When Anger Expression-In (AX-I) was used as the dependent measure, respondents' scores on the CDS account for 8% of the variance on the STAXI-2 (R2 = .084). None of the CDS subscales were statistically significant.

When Anger Control-Out (AC-O) was used as the dependent measure, respondents' scores on the CDS account for 5% of the variance on the STAXI-2 (R2 = .048). None of the CDS subscales were statistically significant.

When Anger Expression-Index (AX-Index) was used as the dependent measure, respondents' scores on the CDS account for 17% of the variance on the STAXI-2 (R2 = .166). None of the CDS subscales were statistically significant.

Discussion

Eight of the twelve measures on the STAXI-2 were statistically significant when compared with the CDS, which lends credence to the fundamental beliefs associated with REBT. Ellis (1962, 1973, 1977b, 1979)

has stated that there is a strong relationship between cognitions and emotions. More specifically, irrational thinking/cognitive distortions are related to disturbed emotions. The results of this study support that contention.

It is interesting to note that of the five subscales comprising the CDS, none appear closely related to 'demandingness', which is the cognitive distortion most responsible for angry feelings according to REBT theory. The REBT model theorises that anger is the result of absolutistic beliefs in which people create commandments for the rest of the world and then 'damn' those who do not follow their rules. Anger is almost always created by a *demand* of some type.

Four of the five subscales on the CDS are more closely related to the types of cognitive distortions associated with feelings of low self-esteem and depression. Self-criticism (SC), Self-blame (SB), Helplessness (HLP), and Hopelessness (HOP) could all be described as containing distortions closely related to depressive thinking. The fact that a majority of the measures between the CDS and STAXI-2 still reached significance lends strong support for the REBT model. In general, higher scores on a measure of cognitive distortions (CDS) were associated with higher scores on measures of anger (STAXI-2) even though the subscales on the CDS appear unrelated to the distortion believed to cause anger.

The Trait Anger (T-Ang) subscale of Angry Temperament (T-Ang/T) failed to reach statistical significance. The stem associated with Trait Anger is 'How I generally feel'. Subjects who rated themselves as generally not experiencing a great deal of anger scored lower on the CDS. This finding also supports the REBT model. The construct of 'temperament' is defined as "the behavioural style of an individual, or the tendency to behave in a certain way in a certain situation" (Hepburn, 2003, p.59). This definition would imply a pervasive behavioural style which is apparently not dependent upon cognitions pertaining to events in an individual's life.

It also supports the REBT model that scores for Anger Expression-In (AX-I) failed to reach significance. Anger Expression-In (AX-I) measures how often angry feelings are experienced but not expressed. This scale focuses on the expression of anger rather than the cognitions that bring anger about in the first place. Anger Control-Out (AC-O) contains eight items and measures how often a person controls the outward expression of angry feelings. Anger Control-In (AC-I) also has eight items and measures how often a person attempts to control angry feelings by calming

down. Again, all three of these scales (AX-I, AC-O, and AC-I) are related to the attempt to control anger as opposed to the cognitive distortions related to the emergence of anger. REBT theory is primarily concerned with the existence of anger rather than the modulation of angry feelings.

While it might have been interesting to examine the data separately for males and females, this was not done given the composition of the sample of subjects in this study. There were 66 females and only 13 males. It would be difficult to draw valid conclusions when the female subjects outnumber the male subjects five to one.

It would be interesting to examine the relationship between the CDS and measures of depression such as the Beck Depression Inventory (Beck, Ward, Mendelson, Mock & Erbaugh, 1961). The CDS has been compared to other instruments such as the Suicidal Ideation Scale of the Personality Assessment Inventory (PAI; Morey, 1991). Comparisons between these two scales produced correlational coefficients ranging from .68 (for Preoccupation with Danger) to .89 (for Hopelessness). The CDS was also compared with the Sad Mood scale of the Multiscore Depression Inventory (MDI; Berndt, 1986) and produced correlational coefficients ranging from .51 (for Self-Criticism) to .64 (for Hopelessness). Comparisons between the Depression scale of the PAI and the CDS yielded correlational coefficients between .68 (for Preoccupation with Danger) to .87 (for Hopelessness). It is not surprising that the scores on the CDS were statistically significant when compared with measures of depression given the nature of the subscales. The CDS appears to be more closely related to low self-esteem and depression than it does to feelings of anger. However, as the results of this study suggest, cognitive distortions appear to affect a wide variety of emotional responses that might appear, on the surface at least, to be unrelated to the subscales on the CDS.

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The Differences and Similarities of Rational Emotive Behaviour Therapy and Person-Centred Counselling: A Personal Perspective

Jeremy Connell

Introduction

This article compares and contrasts Rational Emotive Behaviour Therapy (REBT) and Person-Centred Counselling (PCC). In theoretical terms, PCC's belief in the 'actualising tendency' is a more trusting view of human nature than the REBT view that human beings tend towards irrationality. PCC sees personal congruence as the foundation of psychological health whereas a non-absolute view of reality is central to REBT thinking. For PCC incongruence, i.e. contradictions between how a person sees him or herself and his or her authentic experience, lies at the heart of psychological disturbance. For REBT the emphasis is on irrational beliefs. In approach, REBT focuses on bringing about philosophical change in the client, while PCC regards a nurturing relationship between therapist and client as central. REBT is structured and active directive. It is about educating, challenging and implementing techniques. PCC is non-directive, giving primacy to therapist attitudes and provision of the core conditions. Both REBT and PCC rely on a constructive working relationship between therapist and client, regard human beings as complex and fallible and have a similar therapeutic objective. Their analyses of psychological disturbance also have much in common. REBT's ego disturbance is similar to PCC's conditions of worth, for example, and 'musts' and 'shoulds' are similar to the rigid constructs that typify PCC incongruence. Neither PCC nor REBT will work for everyone. The article touches on each approach's possible limitations and concludes with a personal view on integrating them in client work.

1 Theory

First, an outline of each therapy's view of human nature, and how it defines psychological health and disturbance.

1 (i) Therapeutic view of human nature

REBT holds that people are essentially hedonistic. They aim to stay alive and live happily. They have two basic biological tendencies. First, they tend towards irrationality, which means that they naturally make themselves disturbed. Second, more optimistically, they have considerable potential to work to change their irrationalities.

PCC holds that every human being has an 'actualising tendency', an instinctive drive towards fulfilling their true potential as unique human beings. But life's circumstances block or distort this tendency and this leads to psychological disturbance (more below).

1 (ii) Psychological health

In REBT, a non-absolute view of reality – the opposite of dogmatism or fixed thinking in any field – is seen as the core of psychological health. Albert Ellis (1979), REBT's founder, associates positive mental health with the following aspects: self-interest; social interest; self-direction; tolerance; acceptance of ambiguity and uncertainty; flexibility; scientific thinking; commitment; calculated risk-taking; self-acceptance; and acceptance of reality. He sees psychologically healthy people as experiencing the full range of healthy emotions, positive and negative.

In PCC, the litmus test is the nature of a person's 'self-concept' (view of self). People are 'fully functioning' (mentally healthy) if they see themselves in a way that allows them to be in touch for at least some of the time with their deepest experiences and feelings, without having to censure or distort them. The key personality traits associated with PCC's view of psychological health are: openness to inner and outer experiences; sensitivity to feelings; an ability to live fully in every moment, perceiving oneself as a free agent; and confidence to trust oneself to decide and do 'what feels right'.

1 (iii) Psychological disturbance

Irrational beliefs and the effect they have on a person's behaviour and emotions are key to the REBT assessment of how someone becomes psychologically disturbed. Dryden (1996) describes irrational beliefs as

"evaluations of personal significance stated in absolute terms such as 'must', 'should', 'ought' and 'have to'. They are rigid, illogical, inconsistent with reality and self- and other-defeating". They are demands as opposed to rational desires, preferences and wishes. REBT uses Ellis's (1962) ABC model to explain psychological disturbance. This holds that it is not the difficult or challenging situations people face in life (A) that cause consequences in the form of 'unhealthy' emotions (extremes such as anger or anxiety) and destructive or unhelpful behaviour (C); rather, it is their subjective, irrational beliefs in relation to these situations (B).

REBT identifies two main types of disturbance: ego disturbance (self-damnation) and discomfort disturbance, also known as low frustration tolerance. Ego disturbance refers to demands made about one's own or another person's behaviour. I might, for example, believe 'I must sort out this client's problem. If I don't it means I am a hopeless therapist'. Or I might think that 'Other people must like me. If they don't, that proves there is something wrong with me'. Discomfort disturbance is less fundamental and refers to 'awfulising' and 'I-can't-stand-it-itis'. For example, an international traveller has this kind of disturbance if he or she believes 'I must travel in the comfort of first class. If I don't, it will be awful and I will not be able to stand it'.

According to Dryden (1996), "Ellis believes that human beings tend naturally to perpetuate their problems and have a strong innate tendency to cling to self-defeating, habitual patterns, thereby resisting basic change". They may, for example, continue to believe deep down in the A–C connection, re-indoctrinate themselves with irrational beliefs or fail to act meaningfully to counter them due to low frustration tolerance.

In PCC, *incongruence* between a person's self-concept (the way the person sees him or herself) and his or her real, authentic self is at the root of psychological disturbance. The wider the gulf between the two, the more incongruent he or she is.

A person's self-concept is heavily dependent on the attitudes towards him or her of 'significant others' (parents, teachers, influential peers) as he or she grows up. From earliest infancy the person has an overwhelming need for the acceptance and approval of others and, if necessary, will deny or distort their own visceral experience and instincts in order to obtain them. The amount the person has to sacrifice their own unique way of being will depend on the congruence or psychological health of their significant others. If the person grows up in a tolerant and accepting

environment, he or she is likely to develop a self-concept that allows them to stay tuned to their deepest feelings and experiences. If, however, they grow up in an atmosphere of dogmatic judgements and sharp criticism, they are likely to develop a false self-concept riddled full of 'conditions of worth'. This means that they will regard their sense of worth as conditional upon winning the approval of significant others. They will seek to avoid their disapproval and only behave in ways that are acceptable to them. They are likely to lose trust and confidence in their own innate resources and wisdom, weakening their ability to make decisions and making them inclined to rely on others for guidance. In PCC terminology, the person will be described as having an external 'locus of evaluation'.

Incongruence (false self-concept divorced from the real self) usually leads to low self-esteem and a negative self-concept. An incongruent person may, for example, go through life feeling anxious and confused and may have a constant need to please other people. If the person has a positive self-concept, he or she is likely to be defensive or engage in self-deception, refusing to allow adverse judgements about him or her into his awareness. The crucial point is that incongruent individuals are unlikely to recognise contradictions between how they see themselves and their authentic experience of the world. Psychological disturbance is perpetuated because they deny or distort this experience in order to defend their false self-concept.

Extreme examples of incongruence are: a lack of ownership or recognition of feelings; an inability to experience life in the moment and adapt to change; an unwillingness to communicate about personal issues or form close relationships; rigid constructs; and no recognition of, or sense of responsibility for, problems.

2 Approach

So what are the therapist's objectives and methods and what is the nature of the therapeutic relationship in REBT and PCC?

2 (i) Objectives

The REBT therapist seeks to enable the client to achieve profound philosophical change through transforming the client's irrational beliefs into rational ones in all areas of his or her life. The therapist wants the client to think generally in terms of preferences, not demands; to accept him or herself, warts and all, as a unique human being; to rate their

behaviour only and not him or herself; to feel healthy (uninhibiting) emotions; and to achieve higher frustration/discomfort tolerance (no more awfulising). If profound philosophical change is not possible, the therapist will focus on specific problems, seeking to correct distorted inferences made by the client and to help him or her bring about productive cognitive and behavioural changes.

The person-centred counsellor's objective is to establish a supportive, trusting and nurturing relationship with the client, which enables him or her to develop a more positive self-concept, more in tune with his or her real self and the promptings of his or her actualising tendency. In PCC, the relationship is seen as central in enabling the client gradually, as Thorne (1996) puts it, to "dare to face the anxiety and confusion which inevitably arise once the self-concept is challenged by the movement into awareness of experiences which do not fit its current configuration". In offering the client 'the core conditions' (more below), the therapist seeks to encourage the client to move beyond his or her confusion and choose his or her own way. The therapist seeks to enable the client to increase self-understanding, recognise experience for what it is rather than distort or deny it, and begin to define him or herself rather than accept the definitions or judgements of others.

2 (ii) Method

In REBT, as in any effective approach, a constructive working relationship with the client is the platform for meaningful therapy. Once this is established, the therapist will explain the rudiments of REBT theory to the client. Therapists will cover in particular the B–C connection in Ellis's ABC model. The therapist will then help the client to identify accurately specific problems, the irrational beliefs (musts and their derivatives) in relation to him or her and the unhealthy emotions that these beliefs engender.

The REBT therapist has a variety of tools to help the client replace his or her irrational beliefs with rational beliefs, based on unconditional self-acceptance and higher frustration tolerance. Dryden (1996) notes that these include techniques to promote:

a) cognitive change – for example, verbal disputing of inferences and irrational beliefs, bibliotherapy and rational emotive imagery;
b) emotive-evocative change – for example, shame-attacking exercises;
c) behaviour change – for example, in vivo desensitisation, anti-

procrastination exercises and assertiveness skills training.

Through actively challenging the client's irrational beliefs using the appropriate techniques and encouraging relevant homework between sessions, the therapist will enable the client ultimately to become his or her own therapist and in the long term to see REBT as a life philosophy.

Planned strategies or structured techniques do not feature in the PCC approach. As Thorne (1996) explains, "The approach is essentially based on the experiencing and communication of attitudes (by the therapist) and these attitudes cannot be packaged up in techniques". "The therapist will … focus not on problems and solutions but on communion, or on what has been described as a person-in-person relationship" (Thorne, 1996, citing Boy and Pine, 1982). The attitudes to which Thorne refers are the core conditions of PCC: empathy, congruence (genuineness) and unconditional positive regard (total acceptance) for the client. Carl Rogers, PCC's founder, believed that if these conditions are present in the counselling relationship, therapeutic movement will almost invariably occur. Once the therapist has established that it is appropriate to offer PCC to a particular client, his or her 'method' is consistently to provide the core conditions in his or her relationship with the client.

2 (iii) Nature of the therapeutic relationship

REBT regards the PCC core conditions as a desirable basis for the therapeutic relationship. Dryden (1996) refers to a study by DiGiuseppe *et al* (1993) which found that REBT therapists were rated highly by their clients on providing the core conditions. Ellis has commented that he believes undue warmth in the relationship is counterproductive in the long term because it might inappropriately reinforce clients' approval and dependency needs. Other REBT therapists take a different view (Dryden, 1985). The overall priority, however, is for the therapist to be flexible in adopting a style that is most helpful to the client. Some clients might feel that therapists have more credibility if they emphasise their knowledge and expertise whereas others will respond better to a likeable human being.

As therapy progresses, the REBT therapist takes an active directive and collaborative approach to working with a client, helping him or her to distinguish between goals that are realistic and unrealistic, self-enhancing and self-defeating. The work is structured in the sense that both therapist and client have particular tasks to fulfil. It is the therapist's responsibility to help the client see the B–C connection, teach the client to identify

irrational beliefs and distorted inferences, and teach the client to apply him or herself persistently to changing these through the use of REBT techniques. Clients are responsible for observing their emotional and behavioural disturbances, relating these to their cognitive determinants and working continually to change their irrational beliefs and distorted inferences.

I have already emphasised the centrality of the core conditions in the PCC relationship. Here the therapist is neither directive nor diagnostic. He or she demonstrates trust in human nature and is willing to be manipulated. He or she makes no attempt to assess 'progress', regarding this as something for the client to determine. The priority is to apply the core conditions in a relationship of equals. Mearns and Thorne (1988) drew attention to the 'investment of the self of the counsellor' in PCC. They emphasised the therapist's belief "that it is precisely her ability to become involved and to share her client's world which will determine her effectiveness". They noted that to achieve this, the therapist first needs to apply the core conditions to him or herself: "The relationship which the counsellor has with herself will, to a large extent, determine the quality of the work she is able to initiate with clients".

Mearns and Thorne (1988) identify three stages in the counselling relationship: the foundation is trust; this leads to a deeper level of intimacy where the client is able to reveal deep aspects of his or her experiencing; and finally, the therapist and client achieve increasing 'mutuality'. At the mutuality stage, the therapist is likely to be increasingly self-disclosing and to risk more of him or herself in the relationship.

3 Similarities, differences and scope

3 (i) Similarities

Both REBT and PCC theory see human beings as complex, constantly in flux and fallible. Self-acceptance, self-direction, flexibility and an acceptance of reality – especially the reality of uncertainty, ambiguity and change – are seen by both therapies as crucial ingredients of psychological health. The REBT concept of ego disturbance as a result of a client making unrealistic, illogical and unhelpful demands on him or herself or others is similar to PCC's conditions of worth and external locus of evaluation. The latter are key drivers of psychological disturbance in PCC theory in that they distance a client's self-concept from his or her true self.

REBT's 'musts' and 'shoulds' also reflect the rigid constructs that are a feature of incongruence in PCC thinking.

In addition to defining psychological health and disturbance in similar terms, the REBT and PCC approaches share similar objectives. Both aim to nurture unconditional self-acceptance and a recognition of human fallibility. PCC seeks to move clients away from 'oughts', an internalised sense of duty springing from externally imposed obligations – away from living up to others' expectations. This is indistinguishable from REBT's goal of moving clients away from their irrational beliefs. In PCC as in REBT, the therapist seeks to model a client's thinking and behaviour so that the client eventually learns to become his or her own therapist. In REBT the therapist does this explicitly through teaching and persuasive argument or challenge. In PCC the process is implicit in the relationship. Here the therapist's objective is for the client to learn to accept and listen to him or herself as the therapist accepts and listens to him or her.

3 (ii) Differences

In theoretical terms, PCC sees human nature through the other end of the telescope from REBT. In PCC the actualising tendency is a positive force driving every individual to fulfil his or her true potential, but it is impeded to a greater or lesser extent by a false (usually negative) self-concept. REBT starts from Ellis's hypothesis (Ellis, 1976) that all human beings have a strong biological tendency to disturb themselves, i.e. an intrinsic negative force drives them. They also have the potential, however, to challenge their disturbance by changing their irrationalities.

REBT acknowledges that environmental factors contribute to emotional disturbance and that children are particularly susceptible to influence in society. But REBT does not give the same weight as PCC to the influence of 'significant others'. It holds that we bring our ability to disturb ourselves to our experiences. Werner and Smith (1982) put it as follows: "Humans vary in their suggestibility: while some humans emerge relatively unscathed emotionally from harsh and severe childhood regimes, others emerge emotionally damaged from more benign regimes" (cited by Dryden, 1996). Dryden (1996) notes that many irrationalities in a person – procrastination, for example – run counter to the teaching of significant others.

In terms of therapeutic approach and style, REBT and PCC are very different. REBT is active and directive. The therapist diagnoses a client's

irrational beliefs and then teaches him or her the cognitive and behavioural skills to replace these with rational beliefs. PCC is strictly non-directive: there is no overt diagnosis or teaching. The therapist may gently question a client's irrational thinking if he or she feels congruent in doing so, but will not dispute or challenge it as an REBT therapist will. All the emphasis in PCC rests on the client continuously receiving the core conditions from the therapist. As Dryden (1996) explains, REBT therapists "strive to establish the same core conditions as their person-centred colleagues (but) do not regard (the conditions) as necessary and sufficient for therapeutic change to occur", however desirable. "I strive to accept my clients as fallible human beings", Dryden says, "but do not endeavour to form very close, warm relationships with them". Put another way, the relationship is seen as a means to an end in REBT thinking, not an end in itself, as in PCC.

Therapist quality is key to the effectiveness of REBT, PCC and any other therapeutic approach. As I indicate below, however, it is indispensable in PCC, which relies entirely on the ability of the therapist to offer the core conditions in relation to the client. An REBT client may be able to compensate for any perceived shortcomings in therapist quality through the use of bibliotherapy, for example, or by talking to rationally minded friends.

3 (iii) Limitations

REBT is effective in relation to a wide range of client problems. But it will only work if the client ultimately accepts that he or she makes him or herself emotionally disturbed. If this is not accepted and the goal is for someone or something else to change, REBT is unlikely to work. Dryden (1996) notes that clients "who steadfastly refuse to work towards helping themselves outside therapy generally do less well (than clients who do their homework tasks) or are therapeutic failures". He quotes data from Ellis (1983) supporting this view and suggesting that traits such as severe disturbance, anger, grandiosity, stubbornness and rebelliousness would interfere with a client benefiting from REBT.

Dryden (1996) also observes that some clients who strongly believe they need his love, or non-sexual intimacy with him, leave REBT therapy disappointed because they do not get what they think they need.

The effectiveness of both REBT and PCC will be limited if the therapist's skills are poor due, for example, to inadequate training or supervision. The limitations of PCC are very likely to reflect the therapist's

personal limitations. If, for example, a person-centred therapist's congruence (genuineness) is relatively superficial, he or she will not be able to offer the client "a relationship of such quality that transformation can occur", as Thorne (1996) puts it. The therapist's intuition of thought and feeling will not be deep enough to resonate with the client.

Clients who are rigid and authoritarian in their attitude to life, who seek certainties or like 'experts' to direct them, are unlikely to find PCC helpful. Thorne (1996) also notes that "overly intellectual or logically rational people may … find it difficult to engage" in a PCC relationship "where often the greatest changes result from a preparedness to face painful and confusing feelings which cannot initially be clearly articulated". These clients may have even less motivation to engage if they have been referred for therapy by someone else rather than choosing it for themselves.

Conclusion

Despite their theoretical similarities, REBT and PCC are markedly different approaches and ask different skills of the therapist. Integrating them in client work is therefore a challenge. According to Ellis (1978), "some REBT therapists often modify the preferred practice of REBT according to their own natural personality characteristics. For example, some practise REBT in a slow-moving passive manner, do little disputing and focus therapy on the relationship between them and their clients". In my view such modification of the approach is unlikely to be effective. REBT is likely to work best if practised robustly, systematically and clearly within the bounds of a strong therapeutic alliance.

The boundaries of the relationship between therapist and client need to be clearly understood by both parties. This means that early on in the relationship, a therapist practising both REBT and PCC needs to provide the client with sufficient information about the two approaches for him or her to make an informed choice as to which he or she will find most helpful. The client may benefit from a combination of the approaches in the course of therapy. In this case, the therapist and client will need to agree which approach is appropriate at any particular time, or in relation to any particular issue. At this stage in my practice, I give priority to offering PCC's core conditions early on in a session. I am, however, ready to use REBT techniques with the client's consent, where it seems appropriate and natural to do so. This may happen, for example, if a client is emotionally disturbed by a specific problem or trapped in patterns of distorted thinking.

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Book Reviews

PANIC ATTACKS
By Christine Ingham
Thorsons, 2000. An imprint of Harper Collins Publishers
77–85 Fulham Palace Road, Hammersmith, London W6 8JB
(£6.99, paperback, 198 pages, ISBN 0-00-710690-4)

This book is practical advice from someone who has a large amount of personal experience of panic attacks. The author has found ways of dealing with attacks and wants to help prevent others from suffering in the same way.

The book is written in a very clear, structured way. The introduction states what the book is going to cover, and at the end of every chapter is a brief summary of the main points covered.

I found the book very easy to read and thought that it was written in a very caring way that made you feel supported and encouraged. As someone who has never had a panic attack, it was interesting to read about the different possible causes, some of which can be biological: before reading the book, I thought the causes were solely psychological.

One interesting point is that it is thought that people who show a high degree of conformity and always do what is expected of them could be more likely to have panic attacks. There is also a suggestion that hypersensitivity to bodily sensations could be a result of denying emotional feelings. If these feelings are ignored and pushed away, there is more time to focus on what the body is feeling, and this could be used as a useful distraction from the emotions instead of acknowledging them.

The book is written in a very positive way and explains that panic attacks can have a purpose, and that is to let you know that there is something wrong in your life that needs changing. If you were calm, relaxed and content in the first place you probably would not be having panic attacks. It gives the reader hope that he or she can overcome them and have more control because other people have done before them.

There is a very good explanation of the flight and fight response,

the roles of hormones, and the physical reactions of the body. Panic attacks are nothing to be afraid of – it is the body's way of trying to actually protect itself and prevent you from coming to harm.

There is a section on triggers and how they increase the likelihood of you having a panic attack; for example, coffee increases the amount of adrenaline in the bloodstream. The section on solutions is useful as it includes going to the doctor, what to expect, what drugs could be prescribed and their side-effects, and what sort of questions to ask the doctor. The attitude of the author, though, is that drugs are probably not the best route to choose, especially not on their own, as "the bottle ends up having more control over the situation than we do".

A reader who suffers may take comfort in the fact that they are not alone as it supplies facts and figures such as "every time you sit on a bus of 20 people, 7 could be experiencing panic attacks". There is reassurance that no-one has ever come to harm during a panic attack and this is repeated constantly throughout the book. This repetition for the most part is a good thing as one of the strongest fears for someone during a panic attack is that they are going to die.

One of the strongest messages put across is that panic attacks should be faced up front, otherwise you will always live in fear. It encourages the reader to become curious and familiar with them and find out as much as possible. Accepting that you have them in order to remove the big wall of resistance, fear and suppression opens the mind to enable you to learn from them.

One issue highlighted in the book that is often overlooked in all sorts of therapies is that when you face your panic attacks you also need to look at what secondary gains you might be getting, such as extra support, comfort and sympathy. The author reminds the reader that change can bring on stress and that you do not need to rush into it but plan ahead. However I think you need to be careful regarding the client when suggesting this as some people will use this as an excuse and never get started.

A lot of the suggestions and theories in the book seem to be similar to things I have learnt on the Stress Management Diploma course I have attended. One of these elements is about control and choice. You can choose to learn from panic attacks and turn them into something positive. You can also learn to control your own heart rate, blood pressure and breathing, which most people assume are automatic. Once people are aware that

they can control these things, they could be more open to the fact that they can also control their thoughts as well, and that it is they who decide what to think and choose to have negative thoughts.

Negative thoughts play a part in a panic attack in that you start to fear another attack. This can cause hypersensitivity and if you feel your heart racing you might then think, 'Oh no, not another panic attack'. In that sense, anticipating another attack is almost the same as having one.

This realisation of things being within your control would hopefully result in someone taking more responsibility for their health and seeing that they have to heal themselves, as no one else can.

Other elements that are covered in the book are problem solving techniques, taking positive action, assertiveness, relaxation and breathing, time management, cognitive techniques and thoughts. The author also talks about being kind to yourself and seeing yourself through someone else's eyes, and the fact that you can't always change the situation so you have to change your attitude towards it instead.

Review by Hannah Thompson

HOW TO CONTROL YOUR ANGER BEFORE IT CONTROLS YOU
By Albert Ellis, PhD and Raymond Chip Tafrate, PhD
Robert Hale, 1999
Clerkenwell House, Clerkenwell Green, London EC1R 0HT
(£16.99, hardback, 192 pages, ISBN 0-7090-6544-2)

This book explains how to reduce anger, the cost of that anger, REBT techniques to understand the root causes as well as the myths that people hold about anger, and how to deal with it.

It starts by talking about the cost of anger in its damage to relationships and its ability to cloud all reason, and that it can and often does lead to aggression as well as the physical damage of heart disease.

The section about myths was interesting since a lot of people believe that venting your anger, especially in private, is a good way of letting it out of your system and that it does no damage that way. The authors believe there is research to show that in fact this reinforces the angry feelings and also leads to artery damage due to the chemicals released into the bloodstream.

REBT theory and an explanation of the ABC method are covered. There is a brilliant section about irrational beliefs and the different emotions that stem from these, and also the four most common irrational beliefs that cause anger. Reading this has made me realise that I have irrational beliefs about how people treat me. This has led me to avoid them and the hostile situations. I need to address this and go into these situations with different rational beliefs.

Problem solving skills are talked about and the fact that these have been shown in some studies to significantly reduce anger. It is a good idea to have a set of coping tactics for 'horrible' situations and people.

There were some in-depth explanations of how to dispute irrational beliefs and some extra ways of questioning them that I had not come across before. There were six major questions listed that you need to ask: What irrational belief do I want to dispute and surrender? Can I rationally support this belief? What evidence exists of inaccuracy of this belief? Is there evidence of accuracy about my belief? What bad things can actually happen if they continue to treat me this way? What good things can happen if they continue and I can't stop them?

I enjoyed reading about other techniques, such as the 'Paradoxical Intention'. One idea here was to reduce your irrational belief to absurdity by drawing out the strangest implications. Another idea was to do the opposite of what you feel you wanted to do. This is supposed to interrupt your behaviour pattern and decrease your anger.

Making a contract with yourself was another technique in which you only let yourself be angry if you can prove with clear evidence confirmed by others that a) you have been treated unfairly, b) it caused you a considerable amount of harm, and c) you lost considerable amounts of money. This is supposed to reduce the amount of times that you get angry so that you break the habit and you think that, actually, what were you getting angry about anyway?

'Referenting' is a useful tool to use when you have irrational beliefs about someone. People confuse ideas about the behaviour that someone displays with the actual person. If you are upset, write a list of the negative things, then a list of the positive aspects and then a list of neutral aspects. In this way, overall, you should have a much more balanced picture and accurate description of an individual instead of the black picture you have painted about one incident.

Another mistake people make is that they attribute vindictive

motives to people who mistreat them where none exists, and they always assume the worst. This is a very good way of making yourself angry when they may have been acting obliviously or just ignorantly without realising the harm they were inflicting. Haven't you ever done something by accident? Remember to give other people the benefit of the doubt before storming in and accusing them.

The book even goes on to explain bizarre techniques such as the humorous way of using songs for irrational beliefs to make you realise how completely ridiculous they are. I think these should be used with care to avoid offending your clients!

This is an excellently written book, fairly easy to read, and it helped to reinforce the REBT techniques I had previously learnt. I like to try to remember that 'I am a person who merely acted stupidly – not a stupid person'!

Review by Hannah Thompson

Obituary: Dr Al Raitt

It is with great sadness, we announce the death of Dr Al Raitt. He was the Director of The Institute for RET, UK, and had served on the Editorial Board of *The Rational Emotive Behaviour Therapist* for many years. The Association for Rational Emotive Behaviour Therapy awarded him an Honorary Fellowship for his contribution to REBT in the UK.

Our thoughts are with his family.

Stephen Palmer

in association with the Centre for Rational Emotive Behaviour Therapy

PROGRAMME OF COURSES HELD IN LONDON / EDINBURGH

Modular Programmes

Diploma in Stress Management
Advanced Certificate in Cognitive-Behavioural Approaches to Psychotherapy and Counselling
Diploma in Rational Emotive Behaviour Psychotherapy and Counselling

Focus on …… Diploma in Stress Management

*The **Diploma in Stress Management** is a flexible modular programme that students can take at their own pace according to their own needs. The individual modules comprising the programme are cognitive-behavioural, multimodal and rational-emotive-behavioural in their approach. They provide a minimum of 100 hours of skills and theory based training. You may expand this to incorporate additional optional modules depending on your interests. Completion of this Diploma provides eligibility for full membership of the International Stress Management Association and membership of the Institute of Health Promotion and Education. The modules are run by experienced counsellors, psychotherapists, health educators, industrial trainers and consultants. Students may wish to complete the shorter **Certificate in Stress Management** first. For further details, please request a brochure. **Professor Stephen Palmer** is Director of the Centre for Stress Management.*

Primary Certificate Courses (2 days)

Assertion & Communication Skills Training 13–14 October
Cognitive Behavioural Therapy & Training 16–17 June, 22–23 September, 24–25 November
Advanced CBT Skills 2–4 November
Critical Incident Stress Debriefing 18–19 October
Multimodal Therapy & Counselling TBA
Problem Focused Counselling, Coaching & Training 24–25 May, 25–26 October
Rational Emotive Behaviour Therapy 8–9 July, 6–7 October, 15–16 December
Advanced REBT Skills 4–6 May, 20–22 October
Organisational & Occupational Stress Management 2–3 September
Stress Management 10–11 May, 1–2 July, 3–4 August *
Trauma & PTSD (Level 1) 14–15 June
Trauma & PTSD (Level 3) 8–9 November
Relaxation Skills Training 18–19 May, 15–16 September, 8–9 December

Courses held in London unless stated otherwise. *Courses held in Edinburgh. Trainers include: Professor Stephen Palmer, Michael Neenan, Gladeana McMahon, Kasia Szymanska, Liz Doggart, Irene Tubbs and Nick Edgerton.

One Day Courses / Seminars

Setting Up in Private Practice 10 December **Work Related Stress: Management & Prevention** 26 June **Stress Management Training, Coaching & Counselling** 27 June **Psychological Coaching: A Cognitive Approach** TBA

Other Courses

Correspondence Course in Stress Management

Limited numbers only on each course. The Centre also offers stress audits, consultancy & research, counselling, therapy supervision; in-house courses, seminars and workshops; staff counselling for organisations. Full details from:

PROF. STEPHEN PALMER, PhD • CENTRE FOR STRESS MANAGEMENT • 156 WESTCOMBE HILL • LONDON SE3 7DH
Course details: Tel 020 8293 4114 (24hr answerphone) Fax 020 8293 4114
Course admin: 020 8293 4334 Course availability: 020 8318 4448 Website: http://www.managingstress.com

RECOGNISED BY THE INSTITUTE OF HEALTH PROMOTION AND EDUCATION AS A CENTRE OF EXPERTISE
COURSES RECOGNISED BY THE IHPE FOR CONTINUING PROFESSIONAL DEVELOPMENT

COMMUNITY HEALTH SHEFFIELD (NHS Trust)
and
SHEFFIELD HALLAM UNIVERSITY

POST GRADUATE CERTIFICATE IN RATIONAL EMOTIVE BEHAVIOUR THERAPY

A ONE YEAR PART TIME SKILLS BASED COURSE IN THE PREMIER COGNITIVE THERAPY

This masters level course (60 points at level 3) will commence in 2004 and be based at the Dept. of Behavioural Psychotherapy in Sheffield.
Rational Emotive Behaviour Therapy is a practical, action orientated approach to a wide range of psychological and behavioural problems.
There is a growing awareness of the need to be able to offer skilled, evidence based effective therapy and counselling across a wide range of issues in the provision of health care in both clinical and non-clinical settings.
Rational Emotive Behaviour Therapy provides practitioners with skills to deal effectively with a wide range of problems (e.g. depression, anxiety based disorders, substance misuse, personality disorders and relationship problems).

It is designed primarily for professionals in mental health (psychiatrists, psychologists, psychotherapists, counsellors, nurses, occupational therapists and social workers), who wish to extend their range of therapeutic interventions with their clients.

The course will last one academic year.
The proposed start date is 2004.

For application forms and additional information contact:
JOHN BLACKBURN
BEHAVIOURAL PSYCHOTHERAPY
MICHAEL CARLISLE CENTRE
75 OSBORNE ROAD
NETHER EDGE
SHEFFIELD
S11 9BF
TEL: 0114 271 8699 FAX: 0114 271 8680

in association with the Centre for Rational Emotive Behaviour Therapy

CERTIFICATE IN COACHING
19–24 July,
27 September – 2 October,
29 November – 4 December

CERTIFICATE IN COACHING
Conversion course specifically for qualified counsellors and psychotherapists
21–26 June

AIM
These six-day Programmes provide delegates with an underlying philosophy of Coaching together with a range of practical skills required to be able to undertake Coaching with individuals.

KEY OBJECTIVES
During the six-day Programme delegates will:
- Be able to define coaching
- Understand the difference between coaching and counselling
- Become knowledgeable about types of clients and their problems
- Understand the concept of the life audit and how to structure initial meetings
- Develop and have an opportunity to practise a range of relevant skills
- Become proficient in using a coaching assessment form
- Explore four learning styles and relate these to the learning cycle
- Explore and resolve difficulties impeding goal-attainment
- Understand the importance of keeping a time log to improve time keeping
- Troubleshoot obstacles to action plan implementation

COURSE CO-DIRECTORS
Gladeana McMahon, author of *Confidence Works – Learn how to be your own life coach*
Michael Neenan, co-author of *Life Coaching – A Cognitive-Behavioural Approach*
Professor Stephen Palmer, co-author of *Dealing with People Problems at Work*

PRIMARY CERTIFICATE COURSES
PERFORMANCE COACHING: 6–7 July, 17–18 November
PSYCHOLOGICAL RESILIENCE: a coaching perspective: 14–15 July
HEALTH COACHING: 27–28 October
COACHING FOR CONFIDENCE: 10–11 November

OTHER COURSES
Certificate in Psychological Coaching (CBT and REBT based): 6–10 September
Certificate in Stress Management and Performance Coaching (modular)
Certificated Correspondence Course in Life Coaching: A Cognitive-Behavioural Approach
Masterclass: Psychological Coaching: A Cognitive Approach: TBA

DIPLOMA COURSES (modular programmes)
Coaching; Psychological Coaching; Coaching Psychology

COURSES HELD IN LONDON

Prof. Stephen Palmer, PhD, C Psychol, Centre for Coaching, 156 Westcombe Hill, London SE3 7DH
Course Details and Application Form: Tel 020 8293 4114 leaving name and address on 24hr answerphone **Course Admin:** Tel 020 8293 4334; Fax 020 8293 4114
Website: www.centreforcoaching.com **Email:** admin@centreforcoaching.com

Courses recognised by Association for Coaching (visit their website at www.associationforcoaching.com)

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Request for Assistance

WE NEED YOUR HELP – ANNUAL CONFERENCE 18 OCTOBER 2004

Would you like to assist the Association? If so we are looking for a small group of people willing to assist organise and run this year's Annual Conference on 18 October.

The help we are looking for is:

- assistance on the day with registering individuals
- people prepared to assist directing people to workshops
- assistance with administration prior to the conference

If you are interested in helping out please contact:

Gladeana McMahon
Chair
gladeana@dircon.co.uk
020 8852 4854