British Journal of Guidance & Counselling

Publication details, including instructions for authors and subscription information:
http://www.tandfonline.com/loi/cbjg20

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Version of record first published: 16 Oct 2007.

To cite this article: Michael Abrams & Albert Ellis (1994): Rational emotive behaviour therapy in the treatment of stress, British Journal of Guidance & Counselling, 22:1, 39-50

To link to this article: http://dx.doi.org/10.1080/03069889408253664

STRESS MANAGEMENT AND COUNSELLING

Rational emotive behaviour therapy in the treatment of stress

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ABSTRACT *Rational emotive behaviour therapists view stress-related disorders as originating in irrational beliefs (iB's), philosophies and attitudes, as opposed to the stressor. People who suffer from stress differ from people who suffer from emotional or neurotic problems mainly in that the stressed people have iB's about specific, short-term or more readily identifiable events, as opposed to the more mundane and diffuse difficulties suffered by the neurotic individual. Both the conscious and unconscious antecedents to stress difficulties and how they relate to distorted thinking and psychophysiological disorders are discussed from an information-processing perspective. Rational emotive behaviour treatments for stress-related disorders are detailed and explained.*

Introduction

When mental health professionals examine stress as an object of treatment, we are really talking about the distress, both physical and emotional, that ensues from a series of interpersonal and environmental irritants, or a particularly compelling one. The term 'stress' is a broad or generic term applying to many different states and situations that act on the psyche and body to reduce homeostasis (Elliot & Einsdorfer, 1982). The lack of a consistent definition of stress makes any discussion of treatment difficult. After all, stress is not always bad. Yerkes & Dodson demonstrated this over a generation ago. Stress-related arousal frequently serves to enhance performance. In clinical work we typically use the term to apply to those pressures and strains of living that reduce the quality of life, and require changes in the individual to restore homeostasis. We shall also use the term to represent the result of several kinds of dysfunctional or irrational thinking.

Does 'stress' exist?

The key issue for the rational emotive behaviour therapist is: how does the environmental irritation become oppressive? The answer is largely found within the stressed individual, not in the events. It is quite clear that the very same event will produce physiological or emotional arousal in one set of individuals and virtually no

reaction in others. How then do the dysfunctional emotional and physical states that we call stress come about?

The answer is simple: stress does not exist. There is no iconoclasm intended here. We mean it quite literally: stress does not exist in itself. Stress is like good or evil: it exists only in its perceptions and reactions of the beholder (or the stressee). To quote Shakespeare:

> Hamlet: Why, then 'tis none to you; for there is nothing either good or bad but thinking makes it so....

The evidence proves the same for stress. There is nothing intrinsically stressful or assuaging but thinking makes it so (Ellis & Abrahms, 1978). This is the foundation of the rational emotive behaviour treatment for stress-related and most emotional disorders (Ellis, 1962). Specifically, the rational emotive behaviour therapist works to bring the individual who is quite distressed by events in his or her environment to a state of mind similar to that of one who does not respond excessively to the same putative stressors. Only on rare occasions can a therapist help his or her client by eliminating their problem for them. The therapist is most effective in changing the client's reaction to the problem, which will tend to persist despite the best efforts of most clients and therapists. Specifically, the REBT therapist will seek first and pre-eminently to change the client's philosophies, attitudes and beliefs which lead to disturbance.

Stress v. other disturbances

Those who react to activating events (A's) with severe stress differ from those who have other disturbances in several key ways. First, stress tends to be more associated with physical illnesses or symptoms than do other psychological reactions. Second, stress reactions tend to be based on a single 'catastrophic' event or a group of noxious events that linger over time. This is in contrast to someone who suffers from, for example, chronic anxiety in which there tend to be a large array of activating events that ultimately lead to anxiety. In REBT terms, in stress reactions the A's are often more salient in the formula than the B's (the person's beliefs). This is particularly true of a particular kind of stress, post-traumatic stress disorder (PTSD), where the A's are so stark, unpredictable and harmful (such as rape, incest, or torture) that a large percentage of 'normal' people, who would take less noxious events in good stride, tend to upset themselves severely and bring on terrifying flashbacks and nightmares for a period of years (Warren *et al.*, 1989, 1990; Ellis, 1993).

Thus people with generalised anxiety require very little in the way of activating events (A's) to perpetuate their anxiety: their own compelling belief system about possible A's is usually sufficient. In contrast, the person suffering from a stress reaction can usually point to some objectively bad events that are the impetus of his or her malaise. This has the disadvantage of reinforcing the apparent connection between the A and the C. The stressed individual will conclude that 'my job is giving me an ulcer', or 'my husband's temper is giving me these migraines', and so on. As

we will show later on, one prime goal of rational emotive behaviour therapy is to demonstrate to the client that the activating event does not by itself cause his or her psychological or psychophysiological consequence: his or her beliefs about the event do!

Physiological and psychological reactions

Irrational beliefs and self-defeating styles are the essential origin of stress (Decker *et al.*, 1982; Vestre & Burnis, 1987; Forman *et al.*, 1987). However, the individual's particular reaction to stress tends to be constitutional. Let us examine for a moment the psychophysiological disorders that develop or worsen as a direct result of stress. These include digestive system ulcers, hypertension, migraine and tension headaches, lower back pain, temporo-mandibular joint syndrome, sciatica, lupus, multiple sclerosis, and others. We do not suggest that there is a linear correspondence between these stress-related illnesses and irrational beliefs. Rather, we have found that 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 (Larbig, 1978; Woods & Lyons, 1990; Hart *et al.*, 1991).

The process by which irrational beliefs lead to psychophysiological disorders closely follows Selye's general adaption syndrome. The process begins with some activating event in the person's environment. The person then either consciously or unconsciously evaluates this event as good, bad, dangerous, or unjust, based on his or her belief systems. At this point there follows arousal of the autonomic nervous system. With continued arousal, the weakest systems in the body begin to break down. The unconscious aspects of this process also makes stress disorders more difficult to treat than those disorders in which there is a reaction to an overt problem.

REBT and the cognitive psychology of stress

Since REBT is a cognitive-behavioural therapy, let us clarify what we mean by 'unconscious'. We do not refer to any dynamism (such as the id or the superego) taking direct action or direct control of behaviour. Instead we refer to several cognitive processes that are rapid and require minimal capacity. This principle was set forth by Donald Broadbent more than 35 years ago. He described the mind as a processing system with a limited capacity. That is, we can perceive only a small portion of what we sense, and we can consciously apprehend less than that. Just as we cannot be aware of all the external stimuli to which we are continually exposed, we cannot be simultaneously aware of all of our internal information.

The vast array of experiments utilising priming methods and implicit learning methods demonstrate that we are not always at one with our mental data base. Priming experiments reveal that our memorial stores can become activated without our awareness (Scarborough *et al.*, 1979; Jacoby & Dallas, 1981; Jacobs & Nadel, 1985). Implicit learning and memory experiments have shown that humans can acquire complex information without any knowledge of having done so (Abrams &

Reber, 1988; Reber, 1989). Other cognitive processes that are not always accessible to consciousness are attitudes, biases, schemata, and scripts that are quiescent and unconscious until activated. At that time they influence consciousness rapidly and indirectly, but they are not independent of will. With effort they can be ascertained and, if appropriate, disputed, and replaced with new attitudes, scripts and schemata.

Kahneman *et al.* (1982) demonstrated that most of us form judgements based on what may be faulty heuristics. They further warned that our acquisition of these heuristics may be involuntary. They and their co-workers have failed to show, however, that if a person is made aware that he or she is making judgements based on a faulty heuristic, and is given an alternative means of making a judgement, he or she will not do so. In most cases, he or she will.

We all possess these underlying prejudices but are only aware of them if they are addressed in some fashion. Most people do not think about how they feel about thin people or fat people until they come upon one of them. Their unconscious attitudes are not inaccessible but can act directly on behaviour without directly entering verbal awareness. Other unconscious cognitive processes involve more specific judgements about individuals. We frequently make assessments about a person's nature, beauty or honesty after only a brief view of his or her face. These assessments, too, tend to be based on unconscious judgements (Lewicki, 1985, 1986). Another important phenomenon is based on the declarative–procedural-knowledge distinction. This model shows that we have the ability and knowledge necessary to perform many tasks without any conscious awareness of having it (Cohen & Squire, 1980; Cohen & Corkin, 1981; Jacoby & Witherspoon, 1982). In fact, there is research which indicates that many experts really do not know how they are able to do what they do so well (Nisbett & Wilson, 1977).

In general, then, what we call unconscious, the experimental psychologists tend to refer to as those stages of information processing that occur outside of awareness. In almost all cases these unconscious processes can be made conscious with effort. A similar process occurs in somatoform disorders which tend to occur with high frequency among stress sufferers (Lipowski, 1988; Frost *et al.*, 1988). In these cases the stressed individual begins to exhibit physical symptoms that cannot be clearly pinned down. Of course, many people actually become ill, but are not accurately diagnosed. But those who feel ill without actually being so, do so because of their own beliefs. One of our clients exemplifies this.

The case of Gaetano

Gaetano was referred to the clinic of the Institute for Rational–Emotive Therapy in New York. He had been suffering from severe pains in his neck and jaw. He had consulted an otolaryngologist and a neurologist as well as his family physician. Exhaustive medical testing failed to discover any organic basis for his symptoms.

During therapy Gaetano revealed that he had come from Italy as an adolescent, and was raised in this country with conservative Italian values. He eventually did quite well as a construction manager, and married an American-born

businesswoman. Over time the conflict between their two cultures began to greatly distress Gaetano. His wife, Gloria, was 'too domineering and too independent'. She came and went as she pleased, and never accepted his authority as 'the man' of the household. This led him to create an increasingly violent rage that he had great trouble acknowledging. After a few sessions, he said he had fantasies of killing her. When asked why he did not simply divorce her, he said he could not do so.

The house they lived in was where Gaetano had been raised, and the house his father had died in. To give it up would be both painful and humiliating. He said he could not stand the idea that Gloria could end up owning it: this would be a terrible indignity he could not bear. Thus Gaetano had locked himself into what Miller (1944) called an avoidance-avoidance conflict. He strongly 'needed' to avoid his wife, but he also 'needed' to avoid the hassles inherent in ending his hated marriage. He began picking up women in bars and sleeping with them in motels. By doing this he felt he was getting justice for the pain his wife was putting him through, but in turn he suffered great guilt. So, feeling trapped, he began to express himself through his neck and jaw pains.

The process by which his situation was converted to physical symptoms began with his irrational beliefs. Some of these were:

(1) 'I *cannot stand* to be with Gloria one more moment.'
(2) 'I *must* get rid of her, even if I have to kill her.'
(3) 'Wanting to kill my wife makes me a *terrible person.*'
(4) 'I *must* not lose my house, it would make me *a fool.*'
(5) 'It would be terrible and dangerous if I let my rage show.'
(6) 'I *must* punish her by sleeping with other women.'
(7) 'I'm a *terrible worthless man* for cheating on my wife.'

The irrational beliefs about Gaetano's marriage were like a series of cul-de-sacs. He was trapped, and his growing rage led to increased anxiety and physical tension. But two other factors led to the symptomology, the first being constitutional. Some people appear to possess the innate tendency to express emotions through physical symptoms (Templer & Lester, 1974; Suls & Rittenhouse, 1987). This notion is not new. Alexander (1950) proposed that people with these disorders have a biological predisposition to bring them on. Gaetano probably had this tendency: otherwise he would have probably expressed his distress in more traditional ways.

The second factor was Gaetano's beliefs and feelings about inescapable catastrophe. He saw this as too terrible to be real, so he literally denied its existence, and instead focused on a part of his body that was reacting in a typical way to his stress. The muscle tension in his jaw and head that commonly accompanies many stress reactions was interpreted as an illness. The focus on his illness distracted him from, even relieved him of, the pain of his apparently inescapable dilemma.

Thus when people perceive stressors as being so terrible as to fall outside the domain of any conceivable life event, they may tend to dissociate. In REBT terms, psychophysiological and somatoform disorders often result from extreme awfulising, combined with some additional irrational beliefs. These beliefs may be to the effect

that 'something bad absolutely will happen to me!' or 'any physical symptom proves something terrible is happening to my body!'

Gaetano's therapy focused on three aspects of his difficulty. The first was the system of beliefs that he was in a terrible situation. He was helped to see that although his situation was bad, it was far from so bad as to make life unbearable. He was shown how to increase his frustration tolerance so that he could 'stand' to be with his wife until a way out of his circumstances could be found.

His second set of irrational beliefs, that *he absolutely must not* be enraged and have fantasies of revenge, led to his self-downing. He was shown that although it would have been preferable for him to accept his wife's disagreeable ways without rage, he was not a bad person for feeling enraged. He was also shown that his wife was not the absolutely bad person he was making her out to be, simply because she differed from him and because he could no longer tolerate her.

The final aspect of Gaetano's therapy helped him to work on practical solutions. He was encouraged to tell his wife how he felt and to consult an attorney. After a couple of painful months of legal and domestic negotiations, she agreed to a divorce, and he was able to keep the house. His symptoms vanished.

Irrational beliefs and stress

Rational emotive behaviour therapy (REBT) predicates its treatment of most neurotic problems on the hypothesis that humans, to varying degrees, endorse and act on convictions that are self- and socially-defeating. These partially learned and partly constructed irrational beliefs lead to a significant portion of psychological difficulties. There are other factors involved in mental disorders, but these can only be partially addressed with psychotherapy. The other causes are genetic, biochemical, and structural. Psychotherapy indirectly treats these other ailments in the same way that it helps with other problems of life that are unyielding—by helping people change what they can change, and accept and endure what they cannot change.

REBT uses a simple model in its system of therapy: the ABCDE model. The A refers to an unfortunate activating event in people's lives that results in a dysfunctional behavioural or emotional reaction. B is the belief system that largely determines or regulates their response to the A. C is their disturbed consequence to the A and B. D refers to the disputing that challenges their irrational disturbance-creating beliefs. Finally, E is their effective new philosophy that they are encouraged to adopt.

In most discussions of REBT, the C (consequences) refers to emotional reactions. However, in the case of stress the C is often organic or physical symptoms. This is very similar to the model of stress adopted by the National Academy of Sciences (Dollahite, 1991) which expressed stress reactions in terms of an xyz model. In their version they refer to the x as the *potential activator*, the y as the individual's *reactions* to the potential activator, and the z as the *consequence* of the x's and y's. The authors also label interactions between the x's and y's as *mediators*. These researchers came to the same conclusion that I (AE) came to in 1955.

External events do not by themselves result in disturbance—whether stress or any other kind. The range of reactions to unpropitious events is so wide that people's perceptions and evaluations of these events are the prime mediators of their reaction (Ellis, 1962, 1978, 1985a, 1988, 1991; Ellis & Dryden, 1987).

The cognitive process that facilitates the creation of stress almost always involves irrational beliefs (Woods, 1987; Vestre & Burnis, 1987; Forman, 1990; Henry *et al.*, 1991). These have been detailed extensively in previous articles and books, but briefly 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!'; 'All people who have hurt me *must* be severely punished!'; 'I *absolutely must* be physically competent and healthy or life is terrible!'

Negatively distorted judgements (awfulising) are also efficient stress producers. Some typical ones are: 'It would be *awful* if I were to lose this case!'; 'I *couldn't stand* to be fired'; 'I am *totally worthless* if I lose my business!'

Beliefs based on absolute social needs commonly produce stress reactions. People create traps for themselves with musts that often cannot be satisfied: 'I *must* get the respect of or love from all significant people!'; 'Other people *must* respect my needs!'

Stress reactions to irrational thinking differ in one important way from other disturbed consequences (C) in that the stressed individual tends to link a number of irrational conclusions together into an overwhelming whole. The woman who is vying for a promotion and is asked to produce a key business report on a near-impossible deadline, all the while seeking to get home early enough to get her child out of day care, will tend to experience stress. But let us examine the underlying beliefs and demands that transform these social pressures into her experience of stress. The stress process begins with her compelling desire to get the promotion, which becomes the demand: 'I must get a promotion and I will be a *total* failure if I blow it!' or 'I must get the promotion or I'll never get anywhere!' Next, she becomes aware of the deadline, and further elevates her arousal with a belief like: 'If I don't get the report in by tonight, they'll know I'm not competent, and that would be *awful*!', or 'I'll never get it done right in the time they have given me, and they'll see what an incompetent person I am!'

Research has provided compelling evidence that complex cognitive processes, like speech, becomes automatic and extremely rapid with repetition (Posner & Snyder, 1974). Thus habitual statements, like the preceding, will at times be subtle and rapid. So it requires effort to first bring them into awareness and then to practise disputing them once we clearly see them. Without the effort to understand these irrational cognitions, we are at their mercy. As noted above, experimental psychology has demonstrated that many judgments occur rapidly, and sometimes outside of awareness, and that they often result in emotional changes (Foster & Grovier, 1978; Kunst-Wilson & Zajonc, 1980; Zajonc, 1984). It is difficult, if not impossible, to physically control these reactions. But a change in personal philosophy ultimately leads to the cognitive changes that can bring them under control.

Treatment

Rational emotive behaviour therapy uses a large number of cognitive, emotive and behavioural techniques to help people who over-react to stressors and who add to their appropriate feelings of concern, displeasure, and frustration about these stressors, inappropriate, self-defeating feelings of severe stress, anxiety, and panic. Thus, rational emotive behaviour practitioners often use biofeedback and relaxation techniques (Fried & Golden, 1989; Fried, 1990), hypnosis (Ellis, 1985b; Stanton, 1989), self-instructional training (Meichenbaum, 1977), meditation and yoga (Benson, 1975; Ellis, 1984; Goleman, 1993), behavioural exercises (Ellis & Abrahms, 1978) and other methods that other therapists use.

In addition to these traditional methods, REBT usually includes a number of special cognitive techniques, especially active-directive disputing (D) of clients' dysfunctional and irrational beliefs (B). Thus, when a rational emotive behaviour therapist works with someone suffering from stress-related disorders, the first step usually involves finding the events that the client is making stressful. The next critical step involves finding the beliefs, attitudes and personal philosophies by which clients convert the perceptions to dysphoria. It is this aspect of REBT that most tests the skill of the therapist.

Many clients seeking help for stress-related disorders feel trapped by the events that are distressing them. They typically have strong convictions in the absolute badness of these happenings. Therapists therefore need to be sensitive and cautious in challenging these beliefs. Clients suffering from severe stressors are convinced, either overtly or implicitly, that these 'terrible' things are the direct and only cause of their problems. Helping them come to see that the things are indeed bad but that their 'terribleness' is largely their own creation will be resisted unless therapists first establish that they empathetically accept the clients' suffering as real. Perhaps the worst thing any therapist can do is to dismiss a particular stressor as 'insignificant' or 'minor'. If the client perceives it as monumental, the therapist had better accept this as the starting point.

The next step is to find the specific beliefs, philosophies, and attitudes that create stress. This can be accomplished by interviewing clients about their feelings when they encounter stressors. Once their disturbed emotions are clarified, the therapist in collaboration with the client probes for the irrational beliefs and dogmas that create stress reactions, and shows clients how to actively and forcefully dispute (D) these beliefs (B).

More specifically, REBT teaches clients how to do the following disputing:

- *Disputing absolute musts*: 'Why *must* I always succeed and experience no unfortunate hassles'? *Answer*: 'I never *have* to succeed, though I would very much *prefer* to do so. I really *have to* experience many unfortunate hassles because that is the nature of normal living. It's too damned bad—but hardly *awful* or *terrible*.'
- *Disputing I-can't-stand-it-itis*: 'Where is the evidence that I *can't stand* these stressors that are now occurring?' *Answer*: 'Only in my nutty head! I won't die of them and can be happy in spite of them. They're not *horrible* but only bearably painful!'

- *Disputing feeling of worthlessness*: 'Is it true that I am an inadequate, worthless person if I do not handle stressful conditions well and even make them worse?' *Answer*: 'No, I am a person who may well be acting inadequately at this time in this respect but I am never a totally worthless (or good) person, just a fallible human who is doing my best to cope with difficult conditions.'

As REBT shows people how to look for their absolutist shoulds, oughts, and musts, and for their awfulising, can't-stand-it-itis, and self-downing about the stressors that they experience, it also employs a number of other cognitive methods that it has invented or adopted to help people change their dysfunctional thinking for more effective and less disturbing thinking. Thus it uses reframing, and shows clients how to find good things in some of the bad things that happen to them and how to accept the challenge of not upsetting themselves when they are under unusual stress. It helps them, when they procrastinate or are addicted to harmful feelings and behaviours, to referent a number of disadvantages of what they are doing and to forcefully go over them several times a day, so as to plant them into their consciousness. It 'works out' with clients' coping rational self-statements, particularly philosophical ones, that they keep using to face some of the worst stressors and to refuse to upset themselves about. Such as: 'Yes, I am really under great strain right now and there is nothing that I can do about relieving some of it, but I don't have to eliminate it and I *can* lead a reasonable happy life even if these difficulties continue.'

Rational emotive behaviour therapy encourages clients to do cognitive homework, including the steady filling out of the REBT Self-Help Form (Sichel & Ellis, 1984). This helps them to find and dispute their irrational beliefs. It provides them with psychoeducational materials, such as pamphlets, books, and audiovisual cassettes, that show them how to use rational-emotive anti-disturbing and problem-solving methods (Ellis, 1978, 1988; Ellis & Harper, 1975). It encourages them to record their therapy sessions and to listen to these several times. It pushes them to learn REBT methods and to teach them to others, so as to implant them into their own hearts and heads. It shows them how to model themselves after other individuals who have coped well with stressors.

Rational emotive behaviour therapy always uses a number of emotive-evocative, dramatic methods to help individuals cope with stress situations. Thus it teaches them how to use rational-emotive imagery (Maultsby, 1971), in the course of which they work on their disturbed feelings when they imagine a very stressful event happening, and change these to appropriate feelings of sorrow, regret, and frustration. It encourages them to do its famous shame-attacking exercises (Ellis, 1973, 1988) and learn to deliberately do foolish and ridiculous acts in public and not to upset themselves or put themselves down when others disapprove of them for doing these acts. It show them how to create and use very forceful and dramatic coping statements to change some of their disturbance-creating thoughts and feelings. It encourages them to tape-record some of their worst irrational beliefs and to strongly dispute them on tape, and then let their therapists and other people listen to their disputations to see how forceful they really are. It provides them with

rational humorous songs and other humorous ways of interfering with their taking stressors too seriously (Ellis, 1987).

Behaviourally, REBT employs a number of action methods to help people overcome their overly stressful reactions to the difficulties of their lives. Thus, it encourages them to use *in vivo* desensitisation and exposure methods to overcome some of their irrational fears. It shows them how they can deliberately stay in poor situations (e.g. remain in a job where their supervisor is hostile and negative) until they give up their own feelings of horror and terror—and then decide whether to leave these situations. It shows them how they can reinforce themselves when they do REBT homework that they agree to do and penalise themselves when they fail to do it. It gives them skill training in important areas where they feel very stressed, so that they will function better and enjoy themselves more in these areas. Thus it often provides clients with assertion, communication, relationship, and social skills training.

As usual, then, rational emotive behaviour therapy uses a good number of cognitive, emotive, and behavioural methods, some of which are special to REBT, to help people make their lives less stressful and to cope with stressors that they cannot change. It especially tries to help them push themselves to improve unpleasant social and environmental situations; but to unconditionally accept themselves, other people, and the world, even when unusually stressful conditions persist. As Hauck (1977) points out, when people are faced with unpleasant situations, they have three main choices: to change, stay with, or leave them. Whichever of these choices them make, REBT endeavors to help them accomplish it with a minimum of stress or emotional disturbance. Severe stressors are often inevitable; undue stress about them is not.

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