

WINDY DRYDEN

REASON TO CHANGE

A Rational Emotive
Behaviour Therapy
Workbook

Second Edition



Reason to Change

Rational Emotive Behaviour Therapy (REBT) is an approach to counselling and psychotherapy in which great emphasis is placed on how attitudes are at the root of emotional problems and their solution. The first edition of *Reason to Change* was written as a one-of-a-kind workbook teaching the practical skills of REBT.

In this updated edition, Windy Dryden teaches, in a very specific way, the skills needed to use this therapeutic approach in practice in a thorough and accessible way. Each skill is explained in detail, and examples are given of how each skill can be put into practice. These skills include:

- developing a problem list and setting goals
- choosing a target problem and assessing a specific example
- examining attitudes
- dealing with your doubts, reservations and objections
- taking action.

By using these skills in an active way, it can be possible to address affectively emotional problems such as anxiety, depression, shame, guilt, hurt, unhealthy anger, unhealthy jealousy and unhealthy envy. This book can be used by people on their own, and by those who are consulting an REBT therapist. It will also be of interest to therapists and counsellors.

Windy Dryden is in part-time clinical and consultative practice and is an international authority on Rational Emotive Behaviour Therapy. He has worked in psychotherapy for more than 45 years and is the author and editor of over 240 books.



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A Rational Emotive Behaviour
Therapy Workbook

SECOND EDITION

Windy Dryden

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Preface

Rational Emotive Behaviour Therapy (REBT) is an approach to counselling and psychotherapy that falls fairly and squarely within the cognitive-behavioural therapeutic (CBT) tradition. In this tradition great emphasis is placed on the role that thoughts, attitudes and behaviour play in the development and maintenance of emotional problems.

It is generally recognised that REBT was the first CBT approach to make an impact on the world's therapeutic stage. Its founder, Albert Ellis, who originated REBT in 1955 and who died in 2007, is regarded as one of the two grandfathers of the CBT movement (Aaron Beck, the founder of Cognitive Therapy, being the other). You may like to know that I have trained with both Ellis and Beck but see myself very much as an REB therapist.

Indeed, I have been practising REBT since 1977 and have written many books on the subject. This book, however, is different from most of my other REBT books in that here I have attempted to teach, in a very specific way, the skills that you need to acquire if you are to get the most from this therapeutic approach.

While I have written this workbook so that it can be used by people on their own, it can also be used by those who are consulting an REB therapist. To get the most from the book, though, it is important that you do not just read it. Rather, use the skills in an active way to help yourself address affectively your emotional problems. To help you do this I have explained each skill in detail and have provided an example of how each skill has been put into practice. Feel free to photocopy the forms as you work through the book.

I have written this book primarily for people whose emotional problems *interfere* with the quality of their lives. If this fits your situation, you can use this book on your own or while consulting an REB therapist. However, if your problems *disable* rather than just interfere with your life, do not use this workbook on your own. Consult an REB therapist and use it in conjunction with such consultations (see Appendix 1 to find out how to contact an REB therapist in your area). If you are in doubt about this issue, talk it over in the first instance with your GP or other relevant professional.

Lack of space prevents me from giving you detailed suggestions to help you deal with each of the eight disturbed emotions for which people seek therapeutic help: anxiety, depression, shame, guilt, hurt, unhealthy anger, unhealthy jealousy and unhealthy envy. However, in Appendix 5 I provide reading suggestions for most of these problematic emotions. You can use this workbook in conjunction with such reading since the texts dovetail very well.

You may be wondering why I have called this workbook *Reason to Change*. The answer is twofold; first, in order to change you need to have a reason to change, and, second, you need to use your reason to change!

I hope that you benefit from using this workbook and, as I say at the end, I would be very interested to learn of your experiences in doing so. Good luck!

Windy Dryden

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Prologue

As you will see later in this workbook, REBT is based on an ‘ABC’ framework for understanding both psychological disturbance and health. ‘A’ stands for an adversity, ‘B’ has traditionally stood for a person’s beliefs about the adversity, and ‘C’ stands for the consequences that the person experiences as a result of holding their beliefs about ‘A’. In the first edition of this workbook, I used these terms and also used the terms ‘irrational’ or ‘rational’ to describe those beliefs that underpinned a person’s disturbed responses to adversity (i.e. ‘irrational’) and those beliefs that underpinned that person’s healthy responses to the same adversity (i.e. ‘rational’). However, I have always been dissatisfied with the term ‘beliefs’ and the terms ‘irrational’ and ‘rational’ which describe the different types of beliefs that REBT argues underpin psychological disturbance and health, respectively, and decided formally to change them several years ago (Dryden, 2016). I will be using the new terminology in this second edition of the workbook. But, first, let me explain the reasons why I made these important changes in terminology.

From beliefs to attitudes

A few years before I took the decision to make these changes, I carried out research on how REBT’s ‘ABC’ framework was understood by different professional and lay groups.¹ This research revealed a range of confusions and errors made by these groups about each element in the framework (Dryden, 2013), but particularly about ‘B’. For example, the term ‘belief’ was often used to describe adversities at ‘A’ rather than evaluations at ‘B’ (e.g. ‘I believe that you don’t like me’). I concluded that such confusions and errors about ‘B’ could be rectified by using the term ‘attitude’ rather than ‘belief’ since the term ‘belief’ is often used by people in a way that is very different from the way it is used in REBT.

Thus, the term ‘belief’ has been defined by the *Oxford Dictionary of Psychology*, 4th edition (Colman, 2015) as ‘any proposition that is accepted as true on the basis of inconclusive evidence’. Thus, as we have seen, a client may say something like: ‘I believe my boss criticised me’, and while they think that they have articulated a belief, this is not actually a belief as the term has been used in REBT, but rather an inference. As you will see, it is very important to distinguish between an inference at ‘A’ and an attitude (or belief in the traditional REBT sense) at ‘B’ and anything that helps this distinction to be made routinely is to be welcomed. Using the term ‘attitude’ rather than ‘belief’ was the best way I could see to do this.

Definitions of the term ‘attitude’ are closer to the meaning that REBT theorists ascribe to the term ‘belief’. Here are three such definitions of the term ‘attitude’:

¹ The four groups were: (a) authors of textbooks on counselling and psychotherapy; (b) REB therapists; (c) Albert Ellis (when he was in the twilight of his career) and his wife Debbie Joffe Ellis (2011); and (d) patients in a psychiatric hospital who were taught the REBT framework.

- ‘an enduring pattern of evaluative responses towards a person, object, or issue’ (Colman, 2015)
- ‘a relatively enduring organization of beliefs, feelings, and behavioral tendencies towards socially significant objects, groups, events or symbols’ (Hogg and Vaughan, 2005: 150)
- ‘a psychological tendency that is expressed by evaluating a particular entity with some degree of favor or disfavor’ (Eagly and Chaiken, 1993: 1).

Before deciding to change the term ‘belief’ to the term ‘attitude’ in my writings and clinical work, I used the term ‘attitude’ rather than ‘belief’ with my clients and found that it was easier for me to convey the meaning of ‘B’ when I used ‘attitude’ than when I used ‘belief’ and they, in general, found ‘attitude’ easier to understand in this context than ‘belief’.

Consequently, I decided to use the term ‘attitude’² instead of the term ‘belief’ to denote an evaluative stance taken by a person towards an adversity at ‘A’ which has emotional, behavioural and thinking consequences (Dryden, 2016). In deciding to use the term ‘attitude’ rather than the term ‘belief’, I recognise that when it comes to explaining what the ‘B’ stands for in the ABC framework, the term ‘attitude’ is problematic because it begins with the letter ‘A’. Rather than use an ‘AAC’ framework which is not nearly as catchy or as memorable as the ‘ABC’ framework, I suggested using the phrase ‘Basic Attitudes’³ when formally describing ‘B’ in the ‘ABC’ framework. While not ideal, this term includes ‘attitudes’ and indicates that they are central or basic and that they lie at the base of a person’s responses to an adversity.

In using the term ‘basic’, I have thus preserved the letter ‘B’ so that the well-known ‘ABC’ framework can be used. However, when not formally describing the ‘ABC’ framework I will employ the word ‘attitude’ rather than the phrase ‘basic attitude’ when referring to the particular kind of cognitive processing that REBT argues mediates between an adversity and the person’s responses to that negative event.

From ‘irrational’/‘rational’ beliefs to rigid and extreme/flexible and non-extreme attitudes

Another change that I initiated is the movement away from the terms ‘irrational’ and ‘rational’ to the terms ‘rigid and extreme’ and ‘flexible and non-extreme’ when describing the attitudes that underpin psychological disturbance and psychological health. The reason I made that change is that the terms ‘irrational’ and ‘rational’ tend to be a turn-off to both clients and non-REB therapists. Towards the end of his career, Ellis himself regretted that he chose the name ‘Rational Therapy’ to describe his therapy. He said that he wished that he had called it ‘Cognitive Therapy’ but did not do so because the term ‘cognitive’ was not in vogue in the mid-1950s.⁴

2 As this is still a relatively new development, please note that other REB therapists (including myself in the first edition of this workbook) still employ the word ‘beliefs’.

3 This phrase was suggested by my friend and colleague Dr Walter Matweychuk.

4 Interestingly enough, when Ellis changed the name of his therapy from ‘Rational Therapy’ to ‘Rational-Emotive Therapy’ in 1962 and ‘Rational Emotive Behaviour Therapy’ in 1993, he had the opportunity to change the ‘rational’ part of the name to ‘cognitive’ but did not do so.

On the other hand, clients can see readily that the attitudes that underpin their psychologically disturbed responses to adversities are rigid and extreme. These terms are less pejorative than the term 'irrational', which tends to be equated in many clients' minds with the term 'crazy' or 'bizarre'. Far from being seen as something to strive for, the term 'rational' is seen by clients as being robot-like and unemotional. On the other hand, the terms 'flexible' and 'non-extreme' when describing the attitudes that underpin psychologically healthy responses to adversities at 'A' are more acceptable to clients.

I hope that this explains the reasons for the changes in terminology in this new edition of the workbook.

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CHAPTER 1

THE REBT VIEW OF PSYCHOLOGICAL PROBLEMS

The importance of informed consent

When you consult a professionally trained therapist,¹ it is likely that they will belong to a recognised professional body and that body will have a code of ethics and practice by which your therapist is expected to abide. One of the principles in this code is known as the principle of informed consent. This principle states that it is a mark of ethical practice that you should give your informed consent to a therapeutic approach before your therapist proceeds to help you by using this approach with you. If we look at the principle of informed consent carefully, we will quickly see that, in order for you to give your consent to proceed with an approach to counselling/psychotherapy, you have to be informed about it.

When you consult a Rational Emotive Behaviour Therapist (henceforth known as an REB therapist), at some point early in the therapy process, they will explain to you something about REBT so that you can make an informed decision as to whether to proceed with this approach or whether to consult a therapist from a different therapeutic persuasion. Now, your REB therapist is unlikely to overwhelm you with too much information about REBT at the outset. Rather, they will tell you something about the REBT view of psychological problems and something about how the approach is practised.

As I mentioned in the Preface to this text, you may be using this workbook in conjunction with having consultations with an REB therapist or on your own as a self-help manual. Either way, in this chapter, I am going to explain the REBT view of psychological problems and, in the next chapter, I will discuss some of the fundamentals of REBT practice so that you have sufficient information about REBT to give your informed consent to proceed with this workbook or to seek a different kind of help if it transpires that REBT is not the approach to counselling or self-help that you are looking for.

There is a viewpoint in American social work that makes an important distinction between an 'applicant' and a 'client' that is very relevant here. This viewpoint states that when you seek help from a therapist, you have the status of an 'applicant'. You become a 'client' when you give your informed consent to proceed with therapy. Thus, at the moment, you are an applicant. I hope that after you have read what

¹ In this book, whenever I use the term 'therapist', I mean a person who is qualified to help people with their emotional problems. This person may be a therapist, counsellor, psychotherapist, clinical psychologist, counselling psychologist, psychiatrist or any other trained mental health practitioner.

I have had to say about the REBT view of psychological problems (in this chapter) and how REBT addresses these problems (in the next chapter), you will become a client. If not, and you decide to seek a different approach to counselling, I wish you well and suggest that you consult a book entitled *The Which? Guide to Counselling and Therapy* written by Shamil Wanigaratne and Mike Brookes (2013). This book will tell you something about different approaches to counselling and psychotherapy that are available.

The 'Giving a Speech' Model

Let me begin by inviting you to join me as a participant as I go over the 'Giving a Speech' Model. This model gets to the heart of REBT's view of psychological problems.

There are four steps to this model.

Step 1

I want you to imagine that you have been asked by your boss to give a speech to a group of visiting dignitaries (the first half of which will be before their morning coffee break and the second half after it) and you hold the following basic attitude² towards the possibility of not giving a good speech (which is the adversity):

I want to give a good speech, but it isn't absolutely necessary for me to do so. If I don't give a good speech, it will be bad, but it wouldn't be the end of the world.

How would you feel about the possibility of not giving a good speech while holding this attitude? If you think about it, you would probably feel concerned about the possibility of not giving a good speech, but you wouldn't feel unduly anxious about it.

Step 2

Now, in this second step, I want you to imagine again that you have been asked by your boss to give a speech to a group of visiting dignitaries (the first half of which will be before their morning coffee break and the second half after it), but this time you hold the following different attitude towards the adversity (the possibility of not giving a good speech):

I want to give a good speech and therefore I absolutely must do so. If I don't, it would not just be bad, it would be truly awful.

² As I mentioned in the Prologue, in this book I will use the terms 'basic attitude' and 'attitude' interchangeably. The term 'basic' shows that attitudes are at the 'base' of a person's psychological response to an adversity and is a reminder that attitudes represent 'B' in the 'ABC' framework.

How would you feel this time about the possibility of not giving a good speech while holding this different attitude? If you think about it, you would probably feel very anxious about the possibility of not giving a good speech.

Now I want you to focus on one important point here:

While facing the same adversity – the possibility of not giving a good speech – your different feelings are determined by different attitudes.

Step 3

In the third step of the model, I want you to imagine that you still hold the attitude that you absolutely have to give a good speech and it would be terrible if you didn't. You give the first half of your speech and at the end of it you conclude that it has gone down well. Now, how would you feel about that? You would probably feel relieved or pleased.

Step 4

But, suddenly, still holding the attitude that you have to give a good speech and it would be awful if you didn't, you suddenly stop feeling relieved or pleased and become anxious again. What do you think you would be anxious about? That's right, you would probably be anxious about the possibility that the second half of your speech wouldn't be good.

Conclusion

The point of this model is the following:

That all humans, black or white, rich or poor, male or female, from whichever culture, make themselves emotionally disturbed when they don't get what they rigidly demand they must get and are vulnerable to emotional disturbance when they do get what they rigidly demand because the situation may change and their rigid demands may no longer be met. However, if humans stayed with their preferences and realised that they don't have to have these preferences met, then they would still experience negative feelings when their preferences weren't met, but these negative feelings would be healthy and would motivate them to change what can be changed and adjust constructively to what can't be changed.

Have you ever heard the famous dictum attributed to Epictetus, the Stoic philosopher: ‘People are disturbed not by things, but by their views of things’? The REBT view of psychological problems or disturbance is very nicely summarised by a re-formulation of this dictum, namely:

People are disturbed not by situations, nor by the adversities that feature in these problem-occurring situations, but by the rigid and extreme attitudes that they hold towards these adversities.

The REBT view of psychological health follows on from the above thus:

People respond healthily to the adversities that feature in their problem-occurring situations when they hold flexible and non-extreme attitudes towards these adversities.

REBT’s ‘Situational ABC’ models of psychological disturbance and health

The above two statements contain all that is needed for me to outline the way REBT makes sense of your psychological problems and how you can deal with these problems in healthy ways. Before I present these two models let me define each element of the models.

‘Situation’

The situation refers to a descriptive account of the context in which your problematic response or healthy response occurs.

‘A’

‘A’ stands for ‘adversity’ and represents what you respond problematically to or healthily to in the situation described above. ‘A’ remains the same whether you are responding problematically or healthily in the ‘situation’.

‘B’

‘B’ stands for the ‘basic attitudes’³ you hold towards the adversity. As will be shown these ‘basic attitudes’ will be rigid and extreme when you respond problematically to the adversity or flexible and non-extreme when you respond healthily to the adversity.

³ Most often referred to as ‘attitude’ in this workbook.

‘C’

‘C’ refers to the emotional, behavioural and thinking consequences of holding your attitudes at ‘B’ towards the adversity at ‘A’ in the situation. These consequences will be unhealthy and unconstructive or healthy and constructive depending on whether your attitudes at ‘B’ are rigid/extreme or flexible/non-extreme.

Figure 1.1 outlines REBT’s ‘Situational ABC’ models of psychological disturbance and health. You will notice from this figure that the ‘situation’ and the adversity at ‘A’ are common features in both psychological disturbance and psychological health. This is important. As made explicit in the statements on psychological disturbance and health presented above, the REBT model argues that since people disturb themselves about adversities that feature in problem-occurring situations, both the adversities and the situations in which they feature need to be present to remind people that psychological health is not about bypassing adversity but about facing adversity and dealing effectively with it. This stance characterises the REBT approach that is described in this book.

Let me now consider more formally the rigid and extreme attitudes that occur at ‘B’ in the ‘Situational ABC’ framework which REBT considers to be at the core of many psychologically disturbed responses to adversities. I will also consider the alternative flexible and non-extreme attitudes that are at the core of psychologically healthy responses to the same adversities. These flexible/non-extreme attitudes also occur at ‘B’ in this framework.

Rigid and extreme attitudes and their healthy flexible and non-extreme alternatives

Rigid and extreme attitudes have the following characteristics. They are:

- a inconsistent with reality
- b illogical or nonsensical, and they
- c lead largely to dysfunctional consequences for the person.

On the other hand, flexible and non-extreme attitudes have the following characteristics. They are:

- a consistent with reality
- b logical or sensible, and they
- c lead largely to functional consequences for the person.

Rigid attitudes versus flexible attitudes

I will begin by considering rigid and flexible attitudes. For most of his professional life, the originator of REBT, Dr Albert Ellis, considered these attitudes to be at the very core of psychological disturbance and health respectively.

| | |
|--|---|
| 'Situation' | |
| Adversity ('A') | |
| Basic Attitudes ('B') (Rigid and Extreme) | Basic Attitudes ('B') (Flexible and Non-extreme) |
| <i>Rigid =</i> | <i>Flexible =</i> |
| <i>Extreme =</i> | <i>Non-extreme =</i> |
| Consequences ('C') (Unhealthy and Unconstructive) | Consequences ('C') (Healthy and Constructive) |
| <i>Emotional =</i> | <i>Emotional =</i> |
| <i>Behavioural =</i> | <i>Behavioural =</i> |
| <i>Thinking =</i> | <i>Thinking =</i> |

Psychological Disturbance

Psychological Health

Figure 1.1 REBT's 'Situational ABC' models of psychological disturbance and health