Chapter 4

Albert Ellis and the Model of REBT: The ABC Model of Psychotherapy

“What upsets people are not things in themselves but their judgments about things. For example, death is nothing dreadful (or else it would have appeared so to Socrates), but instead the judgment about death is dreadful—that is what is dreadful.”—Epictetus, p. 326

From the Psychodynamic to the Philosophical Perspective: The Development of the Model

Rational Emotive Behavioral Therapy (REBT) is a cognitive-behavioral model developed by Albert Ellis during the mid-20th century. Ellis, a clinical psychologist, trained in psychoanalysis, part of the training process for a psychotherapist at that time. Ellis completed his training in 1947 and started his supervisory training, employing traditional psychoanalytic methods with his clients. To his dismay, he realized their inefficiency as a mode of therapy. He questioned the number of sessions, the length of therapy, the passivity of the therapists, and the role of transference in resolving the clients’ past parental conflicts. The insights that he observed were important but insufficient in inducing a change in the client’s disturbance. Like A.T. Beck, Ellis noted clients’ self-talk as a source of their disturbance. He termed what Beck referred to as “automatic thoughts” as “self-statements” and “irrational beliefs,” while agreeing with Beck’s observation of the tendency of depressed and anxious individuals to think automatically about themselves as failures. Ellis went on to say:

“I knew from my first year of using REBT with scores of clients that behind their “automatic” unrealistic thoughts were often unconscious, deeper evaluations that “really” led to their disturbances and even helped them create
their disturbed thoughts. For example, "if I fail at this valuable relationship, and if people despise me for failing that will mean I am a rotten failure and an incompetent person." And "if I fail at this task, I'll be no good at anything important, and because being successful is beneficial, I'll be an inept individual." (Ellis, 1994a, p. xvi)

Ellis decided to terminate his psychoanalytic training and later published his seminal paper, "Rational Psychotherapy," presented in 1956 at the American Psychological Association's Annual Convention in Chicago. The first edition of his book *Reason and Emotion in Psychotherapy* appeared in 1962; in it he outlined his ideas about human nature and psychotherapy. In the 1950s Ellis was interested in Pavlovian ideas about dogs that responded to signaling (presenting food with or without noxious stimuli), which resulted in approaching or avoiding the meat presented to them. He soon realized, however, that unlike dogs, human approach or avoidance processes involved evaluations of "self-consciousness or thinking about thinking" (1994a, p. 11).

Ellis observed that humans can define, create, and evaluate "real" life (pleasant or stressful) situations as well as imagined ones. This was to become a central tenet in his REBT model of explaining human disturbance or distress. The introduction of the distinction between preferences, wishes, and desires (rational thinking) as functional forms of thinking, and absolutist needs and "must" (irrational thinking) as stress-increasing ones, laid the foundation of Ellis's ABC model of psychotherapy. These two alternative forms of thinking represent two contradictory yet innate human tendencies. One is the innate human tendency to interpret in an absolutist manner the occurrence of adverse situations ("It shouldn't have happened and if it did, it's awful"), while the other is the strong biological human motivation to change or improve things for the better (including changing one's defeatist thoughts and feelings).

In the ABC model Ellis included also the G (Goal) component that represents the human motivation to change and achieve one's goals. The D (Disputation) and the E (new Effect) represent the importance of disputing irrational thoughts that block the individual's motivation. Both tendencies are apparent in this model. Next to the wishes and desires to achieve goals, humans have a tendency to construct musts and demands that block them from actualizing themselves. When disputation (D) has successfully been applied, the result is a new Effect (E). The emphasis is on the choice one has to construct preference-focused beliefs (rational beliefs) or demand-focused beliefs (irrational beliefs). While the former increase the likelihood of more satisfying life activities, the latter are more likely to increase emotional distress.
Ellis postulated that the innate tendency to think irrationally is universal, and is assumed to have had survival reasons which nowadays are no longer functional. Human personality disturbances are thus a combination of biological predisposition and cultural-environmental factors. Adopting these views can explain Ellis's departure from the psychoanalytic approach of viewing human disturbance as related to unresolved conflicts with parental figures in early childhood (which in psychoanalytic therapy can be overcome with an insight about it). Rather, he came to view the past as a given event which cannot be changed, although the meaning that one attributes to it can (according to REBT, attributed meanings about one's past are changeable).

Right from its inception the cognitive model focused on the centrality of cognitions as a source in understanding emotional disturbance, but emphasized the circularity between thoughts and feelings. Related to the centrality of cognitions are two kinds of anxieties that Ellis refers to, ego anxiety that is identified in most CT psychotherapy, and discomfort anxiety, which he identified as a source of emotional disturbance. While ego anxiety is the client's total self-downing of themselves, discomfort anxiety deals with the client's low frustration tolerance. "Discomfort anxiety is emotional hypertension that arises when people feel (1) that their life or comfort is threatened, (2) that they must not feel uncomfortable and have to feel at ease, and (3) that it is awful or catastrophic (rather than merely inconvenient or disadvantageous) when they don't get what they supposedly must get" (1994a, p. 253).

Another important concept relates to secondary symptoms of disturbance. This concept stemmed from Ellis's observation that people tend to make evaluations about their thinking. The following quotation from the first edition of *Reason and Emotion in Psychotherapy* (1962) describes the construction of the thinking about thinking error:

If you strongly construct negative feelings (C1) such as panic and severe depression about unfortunate Activating Experiences (A1) you then may create a set of rational beliefs (rB2) about your (C1) such as "I don't like feeling panicked. I wish I were not." But also often create a set of irrational beliefs (iB2) about your (C1), such as "I must not be panicked! It's awful to feel this way. I can't stand it! I am no good for making myself panicked!" You then have pronounced secondary symptoms (C2) about your primary ones (C1)." (p. 19)

Again, it is not the negative event and the construing of negative feelings about it that produces distress, but evaluating the negative feelings experienced as ones that "ought," "should," and "must" not occur, is what is likely to increase emotional distress and therefore is considered as a disturbance about
disturbance (Ellis, 1962, 1994a). In REBT in particular, secondary (or even tertiary) symptoms of disturbance are identified, assessed, and followed by showing the clients how to minimize their effect.

REBT stresses that the link between the A (Activating event) the B (Belief), and the C (Consequence) is cyclical; also thinking, emoting, and acting are interactional; though thinking is a major source for creating distress, it can be changed into a more functional one. In other words the way we think influences the way we feel and behave as much as the way we feel and behave affects our thinking. Secondary symptoms are the evaluation of how we might feel under certain negative circumstances (thinking about the fear I will experience if I enter the elevator increases the panic I experience).

Core Philosophy and the Belief-Consequence Connection: Functional and Dysfunctional Emotions

When first formulating his cognitive model, Ellis (1962, 1994a) assumed that emotional problems resulted from people talking to themselves in a self-defeating manner, but realized that self-talk only partially explained it. People’s core philosophy underlying self-talk was the reason for disturbance. A core philosophy (schema according to Beck) is the person’s construction of past experiences with people or events with which they evaluate or interpret similar potential events or experiences. These processes are formed in early childhood and continue to be repeated in self-talk both consciously and unconsciously (‘below-the-surface irrational belief,’ Ellis, 1994a, p. 28) and are activated under what is perceived by the person as an adverse event. Though core philosophy is shaped in early childhood, its repeated construction and reconstruction (indoctrination is the term used by Ellis (1994a) becomes an integral part of the worldview. In his words (1994a),

> Once I had clearly begun to see that neurotic behavior is not merely externally conditioned or indoctrinated at an early age, but that it is also internally reindoctrinated or auto-suggested by people to themselves until it becomes an integral part of their presently held (and continually self-reiterated) philosophy of life, my work with my clients took on a radically new slant. (p. 30)

Clearly, a philosophical approach aimed at helping people change the meaning they attribute to their past experiences replaced a psychodynamic orientation where the therapist’s aim is to help clients focus on their past.
How does emotional disturbance develop? It is likely to occur when individuals evaluate, based on core philosophy, their strong wishes to actualize themselves in a demanding and absolutist manner. There are three main categories: Demanding directed toward the self, toward others, and toward the world; demanding (absolutist musts, shoulds, and oughts) that takes the form of self-devaluation, devaluing others, and devaluing the world; and low frustration tolerance (LFT), and "awfulizing."

In the REBT model of therapy, Ellis (1994a) stressed the universality of the tendency to think "irrationally," the demand-based interpretation that self, others, and the world should be the way one wants them to be, and that human construction of demanding is carried out in an idiosyncratic manner.

Originally the model was called Rational Therapy to indicate the role of cognitions in understanding emotional disturbance, and to distinguish it from more traditional psychodynamic therapies that viewed emotional symptoms as the sole key to understanding disturbance. Philosophies, especially of the positive stream, were Ellis's inspiration in shaping his therapeutic model, one that throughout the years has undergone changes and revisions to its latest version, now referred to as Rational Emotive Behavior therapy (REBT). Interestingly, although the title did not always indicate the function of emotions, Ellis has strongly advocated the cyclical interaction between the Activating event (A), the Beliefs, and the Behavioral and Emotional Consequences (B-C).

The interaction between beliefs and emotions (and behaviors) has been referred to as the B-C connection in the ABC model. In the first version, the distinction between emotions related to "rational" and "irrational" beliefs was described in terms such as "appropriate" and "inappropriate" emotional consequences, later to become "healthy" and "unhealthy" ones. More recently, the different emotions are referred to as "functional" and "dysfunctional" emotional consequences, minimizing the judgmental element and emphasizing the subjective component of interpretation. In as much as the terms represent linguistic changes of the two types of emotional consequences, they indicate more importantly the covariance of interpretation to a given event rather than merely describing a symptomatic state of the individual. Stated differently, sadness and depression are both negative emotional consequences, each related to a particular interpretation which differs from what Ellis has called rational and irrational beliefs.

The REBT model postulates that emotional consequences (C) are not solely determined by the activating event (A) but largely by the beliefs (B) they have about the event (see figure 4.1).
Loss (especially sudden and unexpected death) may be regarded as an adverse external event (A) that affects one's belief system (B), and consequently, one's emotions and behaviors (C). "People's cognitions, emotions, and behaviors are not pure but part of an organismic or holistic interaction" (Ellis, 1994b, p. 217). A cyclical interaction occurs among the event (A), the beliefs about the event (B), and the emotional and behavioral consequences (C) (Ellis, 1962, 1994a).

Absolutistic evaluations at B (irrational beliefs) are dysfunctional not in or by themselves but because they largely result in emotional upsetness at C (Consequence). "Awfulizing," low frustration tolerance, and self-condemnation are forms of irrational demandingness that are often followed at point C by emotional upsetness such as depression, anxiety, extreme shame, and guilt. The
human tendency to irrational evaluation often reaches a peak following a
death event, because of the thought held by bereaved individuals that the
death should not have happened to them or that it is too painful for them to
withstand (Ellis, 1976, 1994c).

If thinking, and in particular thinking about thinking, is a central compo-
nent in emotional disturbance, then an important way to change these irra-
tional beliefs is to use cognitive methods of which disputation has become
associated with REBT.

REBT in Grief Therapy: The ABC of Constructing Rational
and Irrational Meaning to the Loss

REBT in grief therapy integrates ideas about the human tendency to think
irrationally when experiencing an adverse event, and a constructionist per-
spective that stresses a search for meaning that was shattered or threatened as
a result of traumatic experiences.

A few elements underlie REBT in grief:

1. A loss through death is an irreversible adverse event which can be
evaluated and interpreted in many different ways.
2. The distinctions between two types of thinking (rational and irra-
tional) imply that the human tendency to irrationally evaluate the
experiences can also be rationally interpreted. Evaluations and inter-
pretations are a matter of choice.
3. The reciprocity between the event, the belief, and the emotion is
related to the evaluations made about them.
4. REBT in grief distinguishes between adaptive emotional consequences
(sadness, sorrow) and maladaptive ones (depression, anxiety).

Cognitive processes following a loss through death are central to REBT:
how the event is processed will determine the emotional and behavioral con-
sequences that in turn affect the cognitive process. In grief that follows a loss
the emotional consequence will remain negative, but its quality (i.e., as a
functional or dysfunctional emotional consequence), depends on whether the
cognitions are adaptive (rational) or maladaptive (irrational). Rationality and
irrationality do not equal positive versus negative thinking that are followed
by positive or negative emotions. Rather, it is a substance that is comprised of
each type of belief. Both rational and irrational beliefs are predictions and
conclusions that persons draw about events in their lives which are generated
from their schemas or core beliefs.
As an objective negative event, it is unavoidable that loss through death will involve negative evaluations and emotions. However, REBT distinguishes between negative evaluations that increase emotional distress and those that moderate it. The predisposition to think “irrationally” in an almost automatic manner tends to increase after experiencing an adverse event and is usually followed by extreme emotions such as avoidance (“I don’t want to think that this happened to me”) or intrusion (“I can’t stop thinking why, why did it happen?”). The more traumatic the event, such as death from road accidents, wars, terror attacks, and natural disasters, the more likely is it that there will be a tendency to think in extreme patterns. Although temporarily less profound, “rational” thinking continues to be a source of a more realistic appraisal of the event and its consequences in one’s lifetime. The tendency of individuals who experienced a traumatic event to compulsively repeat their memories and perceptions of the event is explained from a psychodynamic framework, as the ego’s attempt to master the overwhelming effect of a traumatic experience in efforts to assimilate it through repeatedly reviewing the event (Horowitz, 1986). Both psychodynamic and cognitive frameworks identified a human tendency of extreme response to traumatic events, and each observed the pattern of reaction to the event and the process that follows, but each emphasized different components or mechanisms for its explanation.

The distinction between the occurrence of an adverse event and its evaluation has always been a major tenet in REBT. Ellis, in his early writings used the word catastrophizing to indicate the person’s tendency to think irrationally and to exaggerate the evaluation of an event (any event perceived by the individual to be negative), and later changed it to awfulizing to signify that catastrophes, over which one has no control, do occur but their evaluation is a cognitive “choice.” In other words, Ellis emphasized that it is the evaluation of an adverse event rather than the event itself that explains the individual’s response. Moreover, evaluations are always subjective and idiosyncratic and take many forms. This in turn explains the variety of emotional, behavioral, and sensational consequences. The question then is what are considered the adaptive and maladaptive forms of grief?

Processing Adverse Events: “Rational” and “Irrational” Ways

How does REBT view adaptive and maladaptive grief? According to REBT, adaptive grief involves more flexible, realistic evaluations of the event, whereas maladaptive grief takes the form of distorted inflexible thinking,
thereby increasing emotional distress. As mentioned earlier, REBT stresses the reciprocity between the belief system and emotional response. Hence, a dysfunctional emotional response is related to a dysfunctional evaluation that intensifies the distress, which then strengthens the cognitive processing, thus forming a continuous distress loop.

A major factor in emotional disturbance is linked to negative evaluations or dogmatic demandingness relating to oneself, others, and the world (Ellis, 1962, 1993). For example, bereaved persons with distorted thinking may interpret loss as an intended rejection (“How could he or she have done this to me?”) (Beck, 1976) or as a confirmation for being worthless (“I am guilty and a worthless person for not saving his or her life”) (Malkinson & Ellis, 2000).

Based on the main tenets of REBT, overreaction or a lack of reaction to the death of a loved one are not in themselves “right” or “wrong,” neither preferred nor undesirable, but rather are related to a specific set of beliefs that result in either functional or dysfunctional (adaptive or maladaptive) emotional consequences. In the case of loss through death, negative emotional reactions (e.g., sorrow, sadness) are viewed as normal and adaptive “rational” cognitions.

Rational, functional beliefs (B) are realistic evaluations of adverse events (e.g., “Life has changed forever, it’s sad and painful”; “The doctors did all they could do to save my child, I don’t blame them”; “I know we did everything to keep him alive but that didn’t help and he died”; “How sad and unfortunate that this happened to me”), and their related emotional consequences (C) are negative but not as upsetting: sorrow, sadness, regret, frustration, and concern (Ellis, 1994b, 1995).

The REBT approach to grief is that it is a normal and healthy reaction to a very stressful life event. As distinguished from depression, grief is a process of experiencing the pain of the loss and searching for a new meaning to life without the dead person, and it is also a process of restructuring one’s irrational thinking to a more rational, realistic mode. Unlike depression, it is a process of searching for alternatives for a life without the loved one, who is the center of the pain and yearning. It is an oscillation between grieving the loss and having to make choices regarding the reality of the loss (Neimeyer, 1999, 2000; Stroebe & Schut, 1999).

Put differently, within the REBT conceptual framework, the grief process is a healthy form of thinking and emoting that helps the bereaved person organize his or her disrupted belief system into a form of adaptive acceptance. Thoughts about the death are not avoided, nor are they constantly remembered; rather, they are rearranged into a system that includes sadness
and pain. Thus the bereaved person is enabled to adapt and live with the
great loss. Grief that has a healing effect and that adapts to the sad reality,
which no longer includes the deceased, involves pronounced negative emo-
tions such as sadness, frustration, and pain. Yet it minimizes maladaptive, self-
defeating feelings of depression, despair, horror, and self-deprecation.

Although the REBT model considers a more traumatic activating event or
adversity (A) to render a greater effect on one's beliefs (B) and on one's emo-
tional and behavioral consequences (C), it also considers the nature and
closeness of the relationship to affect the bereaved's response. Parental loss of
a child is particularly stressful when compared to other losses (Rubin &
Malkinson, 2000), but it is not unlikely that an expected death of a close
friend will be evaluated in a way that can evoke a strong reaction (Doka,
1989, Neimeyer & Jordan, 2002; Attig, 2004). The combination of the cir-
cumstances, the nature of closeness to the deceased, past experiences with
losses, as well as other demographic variables, are likely to yield individualist-
ic and idiosyncratic evaluations, and emotional responses will be in ac-
cordance. Different evaluations have the potential of increasing or moderating
emotional responses. REBT postulates that when evaluations are exaggerated
they are dysfunctional, because they increase the distress of an already stress-
ful event over which the person has less control, as compared to the choice of
its interpretation that can exerted. Thus, in this case, the Belief-Consequence
connection will most probably result in overreliance on irrational beliefs that
in turn will increase stress and reduce the individual's coping resources.

How does REBT view complicated grief? It is seen as an irrational evalua-
tion, with distressing emotional consequences held by the bereaved over
time, these evaluations are referred to as "irrational" maladaptive cognitions
(e.g., "Life is not worth living without my loved one"; "I can't stand my life
without my loved one"). From this perspective complicated grief is defined as
prolonged and persistent over time with distorted, irrational beliefs as the
dominant set of cognitions affecting the intensity of emotional consequences
(Malkinson & Ellis, 2000).

In addition, while those individuals with functional beliefs are still trauma-
tized and feel very badly about their loss, those with dysfunctional beliefs not
only tend to feel continuously devastated, but also to create secondary symp-
toms about their primary bad feelings. As Moore (1991) pointed out, not
only does irrational thinking tend to promote upset feelings, but one's traum-
atically upset feelings also tend to lead to irrational thinking: "Not only
does cognition significantly influence emotion but emotion appears to signif-
cantly influence cognitions" (p. 10). Following a traumatic death event, peo-
ple tend particularly to have both self-defeating (irrational) evaluations of the
event, and self-defeating evaluations about their disturbed emotions (secondary symptoms or disturbances). For example, a mother who lost her teenage son in a road accident (Adverse event) feels angry with her son (emotional Consequence); she is telling herself that he was careless and he should have taken a better care of himself (Belief). She then tells herself that she shouldn’t think this way about her son and becomes angrier at herself for even considering such a terrible thought. The mother’s self-directed anger at her son is a secondary symptom or secondary disturbance anger about being angry (Walen, DiGiuseppe, & Dryden, 1992). In such cases, an irrational pattern of response is often more dominant than a rational one.

Bereaved individuals often respond extremely rigidly to the level of pain tolerance following an adverse event and develop a disturbance over a disturbance. At times when the experience of grief is perceived by the bereaved to be too painful and unbearable (“Grieving is too painful”) or when the reality of the loss is too difficult to comprehend (“I don’t even want to think about him or her as dead”), avoidance of experience is an emotional consequence. In other words, having a secondary reaction over the primary one is a disturbance over a disturbance (Walen et al., 1992).

“Reason” and Emotion in Grief

Grief therapy following a loss, unlike other forms of therapy, begins when a change in the person’s life has occurred. Thus, the process of grief therapy is the result of a change rather than a process of change (DiClemente & Procheska, 1982). It begins with a problem or distress that the client wishes to solve or change. Grief therapy is then initiated because of a change.

By its very nature, the normal process of grief entails sadness, pain, yearning, anger, guilt, shame, and envy, which are negative emotions, all or some of which can be experienced by the bereaved individual; the occurrence and intensity of these emotions is not only likely to vary from individual to individual, but will also vary during different phases of the individual process. As was suggested earlier, the persistence of intense negative emotions over time that increase emotional distress is considered maladaptive. Depending on the phase, the goal of therapy is either to normalize or moderate negative emotions in order to facilitate a more adaptive process. Characteristically in grief, the flooding effect of emotions tends to be associated first and foremost with the adverse event and less with the way it is being evaluated (“I am angry because he or she died”). The tendency is to undermine the role that cognitions play (“I tell myself that I shouldn’t have agreed to him taking the car”) in
mediating between the event and the emotions one experiences. Underlining the centrality of cognitions is a significant source for helping the bereaved to regain an inner control where the external one existed at a minimal level if at all.

A closer look (Table 4.1) at different emotional consequences will reveal differences in cognitive evaluations between functional and dysfunctional emotional consequences such as sadness and depression, concern and anxiety (importantly, the meaning ascribed to the terms can vary from individual to individual signifying not only linguistic differences but also perceived and experienced life events).

If the evaluation of the event is critical to understanding the course the process takes, what is the B-C connection of the experience of loss? The cognitive pattern related to sadness through a negative evaluation of the event is a realistic and flexible one: "Life has changed forever," or "I will miss my loved one very much", this is distinct from depression, which is also a negative evaluation but is typically stated in a more absolute, rigid self-focused and total manner: "Since she died my life is worthless, I therefore don't want to live any more, I feel worthless."

Inasmuch as sadness is seen as an obvious and natural response to loss, pain is also common and natural but often is avoided only for the bereaved person to realize its dominant part in healing. The inclination to avoid the pain is the evaluation of its associated suffering ("I can't bear the intensity of the pain"). Similar to sadness, pain is assigned different meanings by bereaved persons as they search for a meaning to life without the deceased. Unlike sadness, pain is thought to be a fear-provoking emotion that should be avoided. Not only is pain a normal reaction in grief, it is an inevitable part of its experience. The process of realizing that the presence of the loved one in everyday life is no

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**TABLE 4.1**

Grief related evaluations and emotional consequences

<table>
<thead>
<tr>
<th>Sadness: Life has changed forever.</th>
<th>Depression: My life is worthless.</th>
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</thead>
<tbody>
<tr>
<td><strong>Anger:</strong> He or she didn’t think about the outcomes.</td>
<td><strong>Rage:</strong> How could he have done it to me?</td>
</tr>
<tr>
<td><strong>Pain:</strong> It’s painful to think that I will never see her again.</td>
<td><strong>Anxiety:</strong> It’s too painful, I don’t want to think about it, I can’t stand the pain.</td>
</tr>
<tr>
<td><strong>Concern:</strong> I couldn’t help it, I will miss her greatly.</td>
<td><strong>Guilt:</strong> It’s my fault. I wish I were dead.</td>
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</tbody>
</table>
longer tangible, necessitates a shift toward a presence of memory and an inner representation, and is very painful. Many routine activities that involved the loved one are valid no longer. Detaching from what life has been with the deceased to life without him or her is a painful journey. It entails deconstructing a reality and reconstructing a memory. Minute decisions are taken almost everyday, especially during the acute phase. They involve “undoing” or “unweaving” the lost relationship to redoing and reweaving the fields of memory.

Pain can take many forms. Among bereaved individuals there are those who avoid the pain of the loss because it is too painful and is evaluated such that they will be unable to withstand what is considered unbearable (“I avoid going to places that he used to go to do shopping because it’s too painful”; “I took all the pictures away because seeing them is having to accept that he is dead, which I rationally know but the feeling is too painful and I can’t stand it”). But pain can also be associated with a strong wish not to forget the deceased. Such is the case with bereaved individuals who want to or must maintain the pain as a way of remembering the deceased (“That’s the only way to remember him or her”). In REBT terms it is the bereaved’s evaluation of the pain and the reason for maintaining or avoiding it which is the focus of assessment to determine its functionality or dysfunctionality (“I must remember . . . and suffering the pain is the only way to do so”; or “The pain is so overwhelming that the only way to survive it is by avoiding it”).

Similar to sadness, pain as an integral part of the process of searching for a meaning to life without the deceased, can partly be avoided as an adaptive way (a functional avoidance), but when avoidance is absolute it can result in increased emotional distress. “It is painful to think that I will never see/hear/talk to my beloved,” will result in experiencing a moderately, less intense pain, whereas, “I can’t stand the pain, it shouldn’t be so painful, and it’s not fair that I have to suffer so much,” or “I deserve the pain for not preventing the loss,” are cognitions that are most likely to increase distress and need be avoided.

The same can be applied to anger, a normal and common feeling in grief but the distinction is made between functional and dysfunctional anger, each related to a certain set of cognitions. “When I think of the circumstances of the death of my beloved I get very angry at him or her for not being more careful” (rational thinking); or “How could he or she have done it to me, I will never forgive him or her” (irrational thinking). Guilt, shame, and hostility can be viewed in a similar manner, assessing the functionality or dysfunctionality of the emotional consequence to identify the set of cognitions, self-worth, or self-defeat, that maintains each one.
Without doubt, feelings are viewed as having a function in the process of
reconstructing what was shattered and inasmuch as we know their intensity
during the acute phase of grief, we also understand that the cognitive process
of assembling the pieces and their assimilation will result in a reduced inten-
sity of feeling.

From a cognitive perspective, teaching clients the B-C connection is also a
way to help them regain control over an uncontrollable loss. Moreover, it is a
painful journey of making choices in reconstructing an alternative worldview
about one's life after experiencing a loss.

Constructing a Rational Meaning of the Loss

Ellis has been criticized for his “rationality” approach, which has been under-
stood to exclude emotions from human experience (Ellis, 1994a, 1994b). In
REBT terms beliefs are “rational” or “irrational” not in and of themselves, but
are defined to be so because of the emotional consequences they elicit that
can be either functional or dysfunctional. Stating it differently, emotional
consequences (more or less distress) will indicate how rational or irrational
beliefs are.

Another criticism raised by constructivist therapists is that REBT and
other forms of CT assume that distorted thinking can be “restored” or “cor-
rected” rather than, as they emphasize, created (Mahoney, 2004; Neimeyer,
2000). But a closer look reveals that cognitive therapies and REBT in particu-
lar hold that cognitions are constructed and affect emotions and behaviors;
emotions and behaviors also affect cognitions by interaction. They are inter-
related in that each affects the other in a circular way.

In Ellis’s words (1994a):

Unlike most other therapies, REBT clearly distinguishes between healthy
negative feelings like keen sadness and grief when one suffers a great loss—
and unhealthy negative feelings such as serious panic and depression when
one suffers a similar loss. It therefore encourages strong negative feelings
(C’s) about unfortunate Activating Events (A’s), but doesn’t favor all nega-
tive emotions. It discourages unhealthy negative feelings by showing
clients their functional and dysfunctional Beliefs (B’s) about their unfortu-
nate A’s and by teaching them how to maximize the former and minimize
the latter. (p. 309)

Moreover, people largely create their emotional distress by strongly
adhering to an extreme and inflexible way of evaluating events in their lives,
what Ellis has termed *irrational beliefs* (1994a). These constructions are partly learned and influenced by the cultural context in which the individual is set, and partly are innate biological tendencies which intensify under stressful circumstances. If man creates self-defeating constructions, he can change these constructions into less disturbing stress-producing ones. In this respect we can assume that evaluations are bidirectional and can be constructed in either a rational or an irrational manner.

Experiencing the loss of a loved one is a life event that triggers stress-related evaluations; certain types of evaluations, especially if they are rigid "musts," potentially increase distress, while other less rigid and more flexible evaluations may lead to a moderate level of distress. The flooding effect of emotions increases the feeling that one has no control, this in turn intensifies emotions and increases the sensation of loss of control. Helping individuals to regain an inner control involves "teaching" them the connection between evaluations and emotions and showing them the difference between "rational" and "irrational" beliefs and the related emotional consequences. As proposed by Ellis, the psychoeducational approach has become strongly associated with cognitive therapies, REBT included. Although criticized for its active, directive style, which minimizes the individual's "natural" desire to adopt an alternative self-model, the psychoeducational approach does not contradict the constructionist perspective, but rather complements it. Often-times, traumatic events are followed by a temporary sense of helplessness, weakening existing inner resources, which from a cognitive perspective can and need to be strengthened or even restored. Learning to construct an alternative evaluation is essential. For example, a woman who has lost her husband in a terror attack and is left with three children now believes she has the responsibilities of both mother and father, a thought which is probably at least partly true. However, she can be shown how to be less demanding of herself as a mother and as a person, and this will enable her thereby to moderate an already stressful situation. She describes how this feeling increases her stress when she cannot attend to her children's needs, which results in failing herself by not coping as she must. She further criticizes herself because she must respond in the way she did in the past when her husband was alive and could balance her demands.

Viewing individuals as story-tellers for whom loss severs their narrative, and grief as the process of its reconstruction, as posited by constructivists, integrates well with the REBT notion of individuals developing a philosophy about life whereby they evaluate events that are especially adverse in their lives. Cognitive grief therapy as presented in this book approaches intervention as a process of both reevaluating one's distress, increasing emotions, and
changing related cognitions to “rational” ones, and reconstructing and renarrating a life story that was disrupted as a result of loss.

The following is an illustration of integrating REBT that focuses on dysfunctional cognitions (correction) and a constructivist’s concept of meaning construction (creating). It is the case of a woman who had suffered the sudden and unexpected loss of her husband some months earlier from a heart attack. The devastation of the loss was experienced on several levels, as the woman tried to make sense of life without her beloved husband. Although she was active functionally, made decisions, and considered her future with regard to work, she was sad, found herself crying frequently, talked about how much she missed her husband, and wondered how her life would be without him. She mentioned that she avoided doing certain activities, not because she didn’t know that her husband was dead, but doing these things was too painful and was a reminder of the reality of his death. It was almost as if she needed to control her own stream of thoughts by determining what she could and wanted to think about. She seemed to know what thoughts elicited pain and tried to avoid them. Her way to regulate and control the level of pain that she feared she would be unable to withstand, was by avoiding it.

Two elements are salient in the client’s account of her life following the loss: Disruption of her life story, and elements of distress-increasing evaluations of the reality that excluded her husband.

I don’t buy apples because my husband loved them. And if I buy them they will be kept in the bowl in the kitchen so I will see them all the time and it will be too painful. It will remind me that he is dead, something that is too painful. If I don’t see the apples I can avoid thinking about it, avoid the pain and avoid the reality of the loss that I rationally know I am wrong about, but thinking about it is too painful. I am trying to “control” the pain by avoiding things like that.

During therapy the aim is to lessen, but not avoid, the experience of pain. Paradoxically, experiencing pain is the way to heal the fear of not being able to withstand it. Explaining how the loop of avoidance does not result in “no pain” but on the contrary might increase it, the client has information about her dysfunctional evaluation: “It will be too painful and I can’t stand it, I am suffering enough” and change it into a more adaptive way of thinking. It is painful and perhaps I can try to buy apples and see how I feel.” A few sessions later the client said laughingly: “I bought apples.” She experimented with an alternative evaluation and behavior to realize that avoidance maintained rather than prevented the “awfulness” she was experiencing in continuing to search for meaning to life without her husband in a less disturbed way.
The therapist gives information about dysfunctional beliefs and encourages but does not force the client to experiment. This is especially important in cases of avoidance, which like many other distressful responses, tend to be habituated. The importance of a detailed cognitive assessment is stressed: What does the client do or not do since the loss, what is the intensity level (overdoing, moderate, or excessively doing it), and what are the emotional consequences of each?

Thus from the cognitive constructionist perspective it is the combination of both psychoeducational interventions such as information giving, with what is considered to be constructivist ones, that may yield effective outcomes in assisting the client to deal with the changed reality and to find a path to learning to live with adaptive pain.

Elements of correcting dysfunctional thinking with elements of searching and creating new meaning are apparent. Often the reason for maintaining a certain belief is related to yet another belief that “if this is so, then it must be right or true.”

Like other CBT and CT models, REBT uses a variety of interventions—cognitive (disputation, thought restructuring, and reframing), emotional (guided imagery), and behavioral (practicing skills as homework assignments)—to improve the person’s coping, reduce emotional disturbance, and increase self-control, especially when circumstances are uncontrollable. As a psychoeducational model it relies on the individual’s active involvement both during and between sessions (homework assignments) in changing and adopting a more rational evaluation of the event, resulting in more functional emotional and behavioral consequences.

Conclusion

REBT as developed by Albert Ellis suggests that the origins of emotional disturbance are cognitive, emotive, and behavioral and that cognition is a mediator between an event and its emotional consequences. Dysfunctional emotions largely follow from irrational thinking (demandingness). A central tenet in REBT is that human beings are born with a biological predisposition to think irrationally. Some are born with a greater tendency to think irrationally and will therefore exhibit more distorted evaluations. The biological tendency to think irrationally coexists with the healthy human tendency to actualize oneself (Ellis & Bernard, 1985). The premise that emotional disturbance and behavioral symptomatology are maintained as a result of dysfunctional evaluations is central to REBT and cognitive therapy. It has been
adapted to cognitive grief therapy, distinguishing between the adaptive and maladaptive course of grief. Its belief was that these can be modified through a variety of cognitive, emotional, and behavioral techniques both during the sessions and between the sessions in the form of homework assignments. These can be applied in cases of acute and prolonged grief following death, such as combining guided imagery, exposure techniques, thought stopping, cognitive restructuring, breathing exercises, and skill acquisition that are all aimed at assisting clients to adapt to the new reality without the deceased. Interventions include helping the bereaved to construct more adaptive evaluations and to reconstruct new meanings. This integrated approach emphasizes the idiosyncrasy of cognitive processes, while recognizing the universality of grief reaction following loss. From the REBT perspective, viewing cognitions as central to understanding emotional disturbance indicates the choice a person has in interpreting a “choiceless” event such as a loss event (Attig, 1996, 2000).

Thus in cognitive grief therapy, a distinction is made between “rational” adaptive thinking, which results in the emotional consequence of sadness, and “irrational” maladaptive thinking, which results in prolonged distress and at times depression. Grief therapy is a multifaceted process of assisting the bereaved to cope with the stress that follows the loss and to cognitively construct a more balanced or rational inner relationship with the deceased. A variety of cognitive (thought restructuring), cognitive emotional (imagery), and cognitive behavioral (learning new social skills) interventions are at the disposal of the therapist.