Rational-Emotive Therapy and Aural Rehabilitation

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Rational-emotive therapy is an approach to counseling based on the premise that, while it is not always possible to change life circumstances, we have the power to alter our responses to those conditions. The key to promoting change lies in recognition and exploration of irrational beliefs which form the basis for many emotional responses. Successfully challenging irrational thoughts and replacing them with more rational perspectives encourages individuals to behave in less self-defeating ways. The underlying theory of Albert Ellis' rational-emotive therapy model and its applications to hearing loss management are discussed.

Audiologists' responsibilities extend beyond assessment of type and degree of hearing impairment. These responsibilities include providing information, support, assistance with stress management, and/or behavior modification. Addressing these concerns within the time constraints of most clinical practices is a challenge best met by having access to a pool of counseling techniques. Because counseling techniques are not developed in isolation, but in support of a theory of human behavior, it is important for clinicians to become familiar with a variety of counseling theories. Exposure to various counseling theories and techniques (a) reinforces clinician confidence, (b) expands intervention options, and (c) demonstrates that current audiological counseling approaches are based on accepted practice.

Cognitive psychoanalytic theory encompasses those counseling approaches which postulate that thought, emotion, and behavior are interrelated. Individuals respond, emotionally or behaviorally, to events based on the beliefs they hold. When beliefs are expressed in absolute terms (Ellis & Dryden, 1987) or as inviolate rules of living (Beck, 1976; Wessler, 1984) individuals may fail to see alternatives for responding to events. Cognitive counseling seeks to provide clients

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with alternative ways of thinking by teaching them to recognize and challenge their faulty beliefs and attitudes about life circumstances, themselves, and/or others.

Several authors have recommended cognitive counseling for use in communication and vestibular rehabilitation (Abrahamson, 1991; Luterman, 1991; Sweetow, 1986; Trychin, 1986) particularly with regard to the negative thoughts and unrealistic expectations about difficult listening environments which may contribute to avoidance and social withdrawal (Abrahamson, 1991). Trychin's (1985) experience suggests these beliefs can be challenged and replaced with a more positive perspective, thereby facilitating adjustment to hearing loss.

The purpose of the present article is to provide an introduction to Rational-Emotive Therapy (RET). RET is a cognitive counseling approach first proposed by Albert Ellis in 1955 (Ellis, 1977). The intervention process is based on the premise that although it is not always possible to change life circumstances, individuals can alter their irrational beliefs and their responses to those circumstances. Ellis (1977) defines "irrational beliefs" as self-defeating thoughts which precede inappropriate or unproductive behavior.

The theory and techniques forming the basis for rational-emotive therapy offer clinicians a number of options for understanding and assisting individuals with hearing-impairment. Rational-emotive therapy encourages expression of the emotions which accompany hearing loss. The theory recognizes that while it is normal for an individual to feel sadness with a loss of hearing, depression or sadness which interferes with the achievement of life goals requires intervention. This is done by examining which emotions the client is experiencing and determining what thoughts are associated with those emotions. Information gained during this process is used to develop positive coping strategies. The examination process helps the client understand how thought, emotion, and behavior are related. When understanding is accompanied by systematic behavioral change independence and acceptance of the hearing loss are promoted.

Rational-emotive therapy offers clinical audiologists the additional advantage of a format intended to foster change in a limited number of sessions. RET focuses on developing solutions for immediate client concerns using skills which clients can apply to a wide variety of situations. This is done within a systematic framework which encourages efficient use of time while maintaining focus on the issues most important to clients.

Critics of rational-emotive therapy point to its limited usefulness with severely emotionally disturbed populations, and with individuals who possess limited capability for reasoning (Burks & Stefflre, 1979). They suggest the high rate of success reported with RET may be due to a bias in the selection of clients who can be successful using RET techniques. It can be argued, however, that (a) audiologists deal with normal clients adjusting to life changes, and (b) all rehabilitative intervention is a process of selecting techniques which have the greatest possibility of success with a particular client.

Critics and proponents agree (Dryden, 1987b) that more research is needed

demonstrating RET effectiveness. While there is no evidence that any counseling approach is more effective than another (Luterman, 1991), a stronger research base would support the extensive case studies presently used to report its many applications.

THE RET MODEL

As previously noted, the rational-emotive therapy model is founded on the premise that a relationship exists between thought, emotion, and behavior. The interaction of these three can impede or assist the likelihood of achieving goals. Interaction can be viewed as a cycle which is triggered by some outside activating event. The activating event can be a noisy restaurant, a soft-spoken sales agent, or talking with the grandchildren. The clients' response or the "consequences" of the activating event can be internal (emotional), external (behavioral), or a combination of both. Anxiety accompanied by withdrawal is a common response to difficult listening situations. However, these internal and external consequences do not occur as a direct result of the activating event, but stem from underlying irrational beliefs. If the beliefs are irrational the behavioral or emotional consequences will reflect the irrational nature of those beliefs and will be inappropriate and/or unproductive. An irrational belief commonly associated with anxiety is "I must always do well." Individuals with hearing losses who become anxious at the prospect of missing parts of a conversation may be telling themselves they must understand or the world will realize they are fallible.

Clients can learn to recognize and dispute their irrational beliefs. When irrational beliefs are successfully disputed and replaced with rational beliefs the resulting consequences are more likely to facilitate goal achievement. The suggested rational substitute for "I must do well" is "I prefer to do well." Clients who are guided to the realization that they are fallible human beings may be less anxious about the possibility of misunderstanding and consequently less likely to avoid difficult listening situations.

Basic Categories of Irrational Beliefs

Ellis (1962) originally identified 11 irrational beliefs which have since been distilled into four common perceptions:

1. The individual indicates he/she cannot imagine circumstances being worse than they are. Situations are rated as being 100 or higher on a scale from 1 to 100.
2. The individual cannot envision being able to endure situations or being happy if conditions are not as he/she wants them to be.
3. The individual tends to be excessively critical of him/herself, others, or life conditions.
4. The individual tends to insist upon absolutes (e.g., I must succeed, I cannot fail, he/she must like me) (Dryden & DiGiuseppe, 1990).

Inflexibility is the common theme for all irrational beliefs. Consequently, irrational beliefs are often expressed in statements using such terms as "must,"

"have to," and "got to." When making absolute demands about the self, for example, statements such as "I must not make a mistake" or "I must do well" are likely. Emotions which may reflect irrational beliefs include anxiety, depression, and guilt (Dryden & DiGiuseppe, 1990).

Table 1 provides examples of irrational beliefs and emotional consequences which might occur when individuals with hearing loss encounter noisy environments. Possible client inferences about the responses of others are also listed. Inferences are defined as attempts to interpret action or intent without the benefit of complete information (Dryden, 1987a).

Table 1

Examples of Emotions, Inferences, and Irrational Beliefs
Which can Occur When Speech Understanding is Hampered

Emotion	Inference	Irrational Belief
Anxiety	If I miss something people will think I am stupid.	I must always do well.
	If I ask them to repeat they will become annoyed.	I must always be liked.
Depression	I am doing poorly at compensating.	I must always do well.
Hurt	People are avoiding me because it is hard to talk to me.	Others must treat me well.
Anger	People are not willing to help me communicate.	Others must treat me well.
	I am missing out.	Life must always go smoothly for me.

Clinicians unfamiliar with the distinction between irrational beliefs and inferences often confuse the two and attempt to alter clients' inferences. There are two limitations to disputing inferences. First, it is possible for inferences to be true (Ellis, 1992). Some people *do* become annoyed with repeated requests for repetition or believe individuals with hearing loss are less capable. To dispute an inference which has a basis in truth reduces clinicians' credibility and may serve to make clients doubt themselves and their perceptions of others. Disputing clients' correct interpretation of events may erode self-confidence for individuals who already lack faith in their ability to cope with difficult communication situations. Second, even when an inference is true, it may only apply to a particular situation, and therefore alterations of perceptions and inferences may not generalize easily to other circumstances (Ellis, 1992). It is important to distinguish between clients' inferences and irrational beliefs so that irrational beliefs are disputed first. If disputing irrational beliefs proves unsuccessful, clinicians can then compromise by focusing on inferences (Dryden, 1991). This may produce change in at least some of the desired circumstances.

COUNSELING STEPS USING RET

Ellis (1973) suggests humans have an innate capacity for irrational thinking. The degree to which irrational thinking is manifested results in part by the extent to which it is reinforced by circumstances in the environment (Ellis, 1984). Because individuals have the capacity to choose how they think and react they can learn to recognize irrational beliefs, the situations which trigger them, and alternatives for coping with them more effectively. Facilitating these changes is the basis of intervention with rational-emotive therapy. Table 2 summarizes Dryden and DiGiuseppe's (1990) rational-emotive therapy steps which can be used to guide beginning clinicians. The first goal is to identify client concerns and to help the client select a problem for further analysis. Clinicians should assess the strength of emotional responses and the extent to which they interfere with expressed goals. It is normal to feel sadness when the presence of a hearing loss is confirmed or to experience some annoyance during difficult listening situations. When the level of emotion is appropriate for life circumstance, the most important service a clinician can offer is a safe outlet for the client to express themselves. If, however, the emotions expressed are extreme and/or result in behaviors which are counter productive to the rehabilitation process the clinician should consider playing a more active role in promoting change.

Once the clinician understands the problem he/she can then move from teaching the relationship between cognition and behavior to the process of identifying and challenging irrational beliefs. A worksheet such as the one provided in the Appendix is helpful for tracking progress through the steps of RET and serves as a record of the counseling session.

Secondary Emotional Responses

The suggested counseling sequence assumes the problem presented by clients represents the most significant barrier to initiating more effective behavior. It

Table 2

Steps Used in Conducting a Rational-Emotive Counseling Session

1. Ask about the problem.
2. Define and agree upon a target problem.
3. Clarify specific event(s) proceeding unwanted consequences.
4. Obtain a better understanding of consequences.
5. Identify and assess secondary emotional problems.
6. Teach the relationship between irrational beliefs and consequences.
7. Determine which irrational beliefs are the basis for consequences.
8. Relate the client's irrational beliefs to consequences.
9. Dispute the client's irrational beliefs.
10. Encourage practice of rational beliefs by assigning homework.

Note. Adapted from *A primer on rational-emotive therapy* by W. Dryden and R. DiGiuseppe, 1990, Champaign, Research Press.

is not uncommon for individuals to experience strong emotional reactions when further challenged by difficult situations. For example, clients may feel guilt before feeling angry, or be fearful about feeling anxious in social situations when speech recognition is hampered. These reactions are called secondary emotional problems (Dryden & DiGiuseppe, 1990). Because secondary emotional problems can be an even greater barrier to a client's well-being than the primary emotional problem it may first be necessary to deal with secondary emotional problems before focusing on the problem initially associated with the client's concern.

A common type of secondary emotional problem is an unwillingness to face the emotional or physical discomfort induced by change. In RET this is called low frustration tolerance (Dryden, 1987a). The client has habituated to his/her present state and views the process of change as being less tolerable than the present discomfort, even if the change will ultimately reduce the difficulties s/he is experiencing. The concept of low frustration tolerance (LFT) is particularly useful for understanding resistance to amplification.

Clinicians regularly deal with adults who have adapted to their hearing loss using methods which are inconvenient to themselves and frustrating to family members. These same individuals avoid using amplification even when some degree of benefit is realized. LFT results from the belief that "I must always be comfortable" (Dryden, 1987a). Audiologists may be able to deal with this through a highly successful trial period with amplification, but this person will return the hearing aid unless the underlying belief can be successfully challenged.

The Roles of Clinician and Client in Therapy

The primary role of the counselor in rational-emotive therapy is one of a supportive teacher. However, practitioners of RET differ in method of implementation. Ellis suggests counselors become very active in therapy sessions. He recommends a style which is directive and forceful when a point needs to be emphasized (Ellis & Dryden, 1987). In contrast, Wessler (1984) feels flexibility with clients is important for promoting change. His approach is less directive and endorses frequent use of techniques for conveying empathy within the RET structure.

The client's role in RET is to actively engage in the process of disputing his/her irrational beliefs and to practice new behaviors. Involvement promotes client responsibility and more rapid change. As alternative beliefs and behaviors are substituted and practiced, there is a gradual shift in role, and the client becomes his/her own counselor/teacher, recognizing and disputing irrational beliefs in novel situations.

SUMMARY

The preceding article summarized the major principles of rational-emotive therapy with accompanying examples of applications to hearing loss manage-

ment. RET has a well established theoretical foundation in cognitive psychotherapy. The principles can be presented succinctly to both graduate students and clients. RET also represents a possible theoretical basis for research into the factors contributing to acceptance of hearing loss. As previously noted, low frustration tolerance offers a plausible explanation for some clients' rejection of amplification. Documenting cognitive factors associated with unsuccessful and successful management of hearing loss may prove useful for developing more effective rehabilitation programs.

The advantages of incorporating RET into clinical practice are (a) time efficiency, (b) a focus on issues important to the client, (c) emphasis on client responsibility, (d) the use of assignments to promote carry over, and (e) the option to incorporate compensatory communication strategies into assignments so that cognitive and behavioral goals are mutually reinforced. While not all clinicians will be comfortable with the process of disputing irrational beliefs or inferences, for many clinicians, rational-emotive therapy represents a viable alternative for counseling individuals with hearing loss.

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APPENDIX

RATIONAL-EMOTIVE SESSION WORKSHEET

Client Name: J. Doe Date: --/--/--

1. "C" – Client's Concern(s):
   a. Has difficulty hearing her grandchildren.
   b. Becomes anxious in social situations and is thinking of withdrawing from her volunteer group.
   c. Is frustrated when spouse tries to talk to her from the next room.

2. "A" – Client Activating Event(s):
   a. Monthly visit to daughter's home.
   b. Potluck dinners following weekly meetings of the foodbank volunteers.
   c. Fixing dinner while spouse is watching T.V.

3. Client Selected target: Anxiety in social situations.

4. Inferences associated with target:
   a. I will inconvenience them if I ask them to repeat or turn toward me while speaking.
   b. I do not want to appear as if I was bored and not listening.
   c. They get frustrated when I do not understand.

5. "B" – Belief(s) associated with target concern:
   a. I must always do well.
   b. I must always be liked.

6. Methods and statements used to dispute:
   Socratic Style of disputing –
   a. Do you always do everything without ever making any errors?
   b. Does your belief prevent you from making mistakes?
   c. If your belief does prevent you from making mistakes, how does it help you?

7. Rational substitutes for irrational beliefs.
   a. I prefer to do well. But if I make a mistake it is all right.
   b. I am a fallible human.

8. Homework assignment:
   a. Jane will spend fifteen minutes before her next meeting using a worksheet to dispute her belief.
   b. She will use at least four alternative styles for requesting repetitions when she misses information.