REBT for Depression - Reflective Essay

Introduction

The subject of this essay's critical and reflective review is a form of cognitive therapy and its function in the management of depression. Rather than relying on pharmaceutical interventions, cognitive behavioural therapy (CBT) is based on the idea that changes in one's way of thinking might alleviate symptoms of mental illness (Beck, 2020). Seminal research (Beck 2002; Ellis 1962) was considered the second wave of the CBT movement. According to Field et al. (2015), cognitive therapies like the Ellis ABCDE model underlie the primary role that cognition plays in addressing emotion, behaviour and physiological response. Rational emotive behavioural therapy (REBT), based on the Ellis model, has been proven in empirical research to address clinical depression (David et al., 2019). This essay begins with a comparison of the theoretical basis for CBT through discussion of the Ellis ABCDE approach and applied REBT as a form of CBT to treat depression. The essay also presents a reflective component where there is discussion on how CBT as a practice has been reflected through different methods.

Choice of Model: Ellis Model (ABCDE Strategy) and REBT for Depression

Maladaptive cognition is considered a primary determinant of emotional distress and behavioural problems. Through CBT, it is possible to modify this maladaptive cognition and address the core problems. According to Ellis (2014), the ABCDE model performs a stepwise evaluation of an individual within the external environment. Ellis (1962) concluded that emotional distress and behavioural dysfunctions evolve when there is an activating event (A) within the environment, also referred to as a trigger or a precipitant. The individual may respond to this precipitant or activating event on the basis of the belief (B) that they already have towards the event. Such beliefs are characterised as thoughts or cognition (David, 2004). If these beliefs are considered to be irrational, then they can create potential emotional distress which, in turn, can cause behavioural consequences (C) which are considered to be dysfunctional (Ellis, 1962). Ellis (1986) acknowledged that to prevent such dysfunctional consequences, an individual can be taught steps to help identify and dispute these irrational beliefs (D). Through such disputing, it is possible to create an emotional and behavioural response (E) which is more rational in nature. Sahin and Acar (2019) concluded that such modification of the individual's

irrational belief can help address underlying emotional distress and dysfunction. This results in new and more rational emotional and behavioural responses (E). The goal of counselling, according to Ellis (1962), is to modify a person's irrational beliefs to prevent emotional distress or dysfunctional behaviour. There is support for the Ellis model as a cognitive therapy approach that can help address patients' mental health needs (Bennett and Turner 2017). According to Turner (2016), the Ellis model is therefore based on the idea that irrational belief causes emotional and behavioural challenges, requiring a change in thinking, while the Beck (1979) model of cognitive therapy is focused on the identification and correction of distorted thought and belief.

The REBT approach was established on the basis of the Ellis ABCDE model (Turner, 2016). REBT uses the core elements of the Ellis model by considering the need to change irrational belief into rational thought with the goal of changing a person's dysfunctional emotions and maladaptive behaviours to decisions which are functional and adaptive (Bennett and Turner, 2017). According to Ruggiero et al. (2018), the REBT protocol can be compared to other CBT models, including the cognitive therapy (CT) protocol. A difference between REBT and CT, however, is that REBT focuses on evaluative beliefs rather than inferential or descriptive beliefs.

There is empirical evidence to support the effectiveness of the REBT model for anxiety and depression. For example, in their cross-sectional study, Oltean et al. (2017) concluded that REBT has a significant positive impact on reducing symptoms of anxiety and depression. Others have compared REBT with treatment options. David et al. (2008) conducted research comparing REBT, CT and pharmacotherapy for 170 patients with major depressive disorder. The findings showed that compared with pharmacotherapy, REBT and CT had a larger effect on depression rating on the Hamilton scale for depression at six months follow-up. Similarly, Iftene et al. (2015), in their comparison of REBT/CBT against pharmacotherapy or REBT/CBT plus pharmacotherapy, contended that group based REBT/CBT had the most impact on addressing youth depression. Ellis (2005) concluded that the REBT approach is more effective than other CBT methods as it helps people achieve unconditional acceptance of self, life and others. In a meta-analysis of REBT therapy in the outpatient setting, David et al. (2021) concluded that there was a significant

improvement in patient functioning with a medium effect size effect after three sessions of psychotherapy.

Reflective Assessment

This section of the essay presents a reflective assessment of my experience with REBT and its relevance in treating depression. I use the Driscoll (2007) reflective model to conduct this reflective analysis by evaluating our classroom experience of role play-based REBT training. According to Driscoll (2007), any experience can be evaluated on the basis of three questions: what, so what, and now what?

As seen in Figure 1, I used a staged ABCDE model approach as part of the role play exercise to question the client.

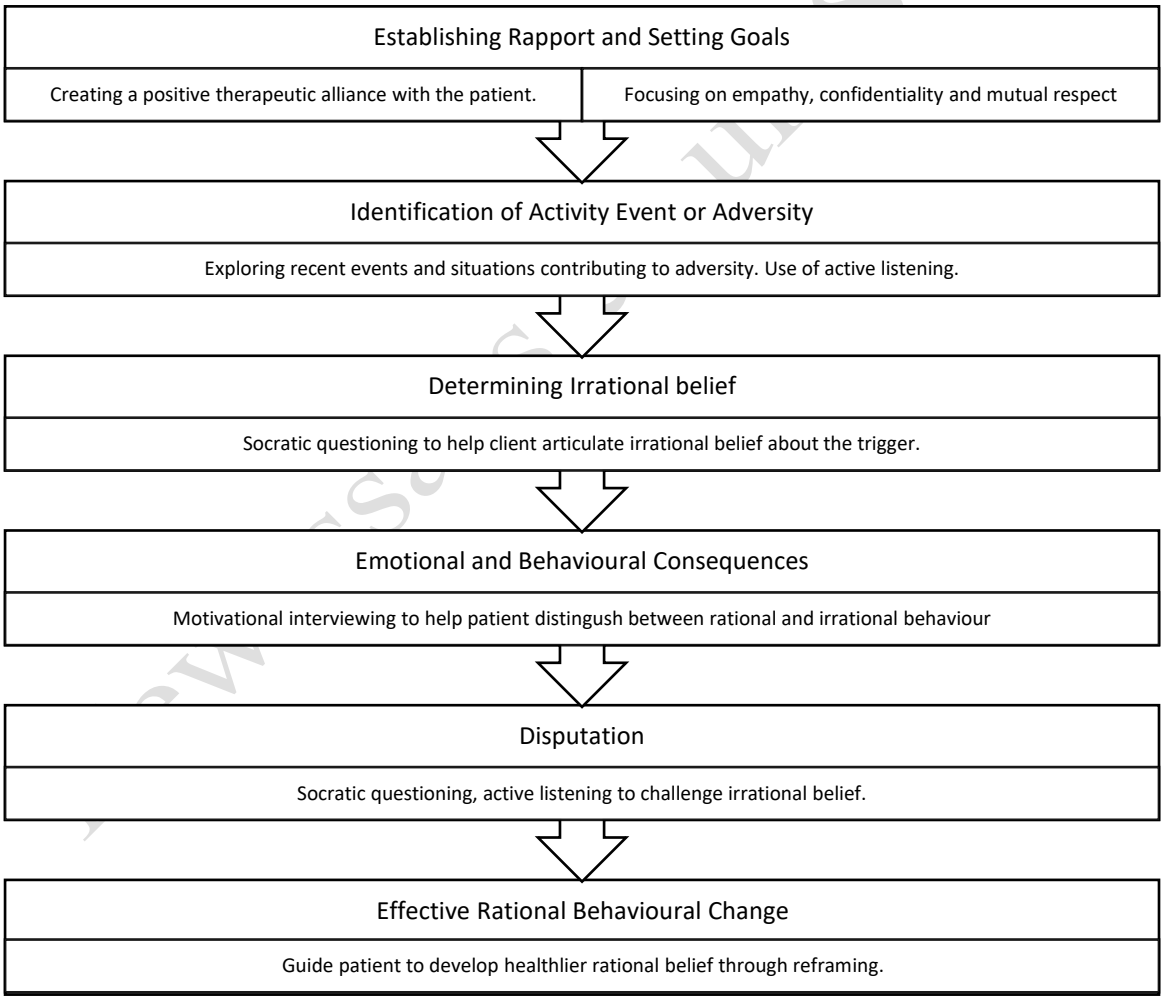

Figure 1. ABCDE model used as part of a role play exercise for case formulation.

In the initial phase of the model, the learner is required to recollect events in an unbiased and factual manner. As a component of our educational process, we engaged in role play exercises to enhance our comprehension of the practical implementation of psychotherapy in a clinical setting. Marriott et al. (2022) stated that the primary objective of psychotherapy training is to equip trainees with the necessary skills to use therapeutic interventions effectively in patient treatment. This is achieved through a combination of academic knowledge and practical application. Role play is a practical intervention technique. During our role play experience, I recognised that actively interacting with the service user is a crucial aspect of applying REBT in a therapeutic setting. The objective of engagement is to establish a strong therapeutic bond to facilitate the effective application of REBT (Dryden, 2021). The therapeutic alliance refers to the cooperative and emotional connection formed between the therapist and the client, and it plays a crucial role in determining successful therapy results (Penedo et al., 2021). By engaging in role play, I found that establishing a positive alliance with the client not only increases their motivation to actively engage and strive towards therapeutic objectives and outcomes, but also facilitates the process of defining the agenda. As stated by Dryden (2019), a crucial aspect of REBT is jointly establishing a plan for the patient's rehabilitation. This technique entails the identification and prioritisation of negative thoughts and beliefs, followed by their replacement with sensible ones. This practice helps the therapist and the client to maintain focus on their objectives. While participating in a role play, I discovered that in order to interact effectively with the client and create the objectives, it was necessary to build a connection with them, employ active listening and open-ended questions to exchange ideas, and solicit feedback from them regarding their preferences for the session.

As part of the role play process, Socratic questioning was used for different stages of the ABCDE model. Overholder and Beale (2023) contended that Socratic questioning can be collaborative in guiding clients to discover irrational beliefs and logical flaws in their thinking. I believe that when implementing REBT, the therapist is expected to guide the client to examine their irrational belief and potential triggers for the belief and to identify an alternative, more rational belief. For example, during my approach to the role play scenarios, I, as a therapist, asked the client to re-enact a situation or a trigger. As part of the re-enactment, I asked questions like ‘Is there a

different way to look at this situation?' or 'How does the situation make you feel now?' According to Wharne (2022), the therapist's skill in Socratic questioning will help the client reflect on and identify negative automatic thoughts which can challenge catastrophic or absolutist patterns that are contributing to depressive thoughts and feelings. As part of the role play exercise, I also focused on active listening. Active listening can help concentrate on the patient's needs, identify their perspective, and respond empathetically. In the context of REBT, active listening is used to assess language, tone and non-verbal behavioural cues which may influence maladaptive behaviour.

I saw that the person was experiencing multiple instances of rejection which were leading to the emergence of negative and self-deprecating ideas, such as feelings of melancholy and worthlessness. Intense emotions can cause noticeable alterations in both appetite and energy levels. The person was exhibiting social withdrawal and actively avoiding potential future possibilities. Motivational interviewing was considered as a way to effect behavioural change. According to Fulford et al., (2020), motivational interviewing helps in resolving issues regarding choice of treatment. For example, through motivational interviewing, an individual's willingness to confront their illogical thoughts, openness to getting support and treatment, future goals and expectations were discussed through motivational interviewing. The use of motivational interviewing (MI) provided a non-confrontational approach to help the patient feel that their views are understood and respected. As part of the treatment process, I suggested using cognitive restructuring and behavioural activation techniques. Ezawa and Hollon (2023) defined cognitive restructuring as a methodical and cooperative therapy technique that equips individuals experiencing distress with the necessary skills to recognise and assess the pessimistic beliefs that contribute to their depression. Through the process of cognitive restructuring, we successfully confronted and reframed negative thoughts around rejection, leading to the development of a more balanced and realistic viewpoint. In addition, I employed behavioural activation (BA) to target the patient's results. Stein et al. (2021) identified the fundamental features of BA as directing attention towards the circumstances that contribute to negative experiences; encouraging the adoption of alternative behaviours to cope with negative thoughts or actions; and, most importantly, acknowledging the connection between behaviour and the surrounding situation.

Using behavioural activation, I motivated the patient to participate in manageable and attainable tasks to combat their social isolation, such as joining in working lunches and socialising with friends.

In the Driscoll (2007) approach, the second phase involves learners examining patterns or moments of significance. I believe that the efficacy of the REBT role play session was intricately tied to collective action. Collaboration underscores the need for the therapist and the client to engage in a joint effort. According to Candea et al. (2018), one of the main objectives of REBT is to help patients transcend stoicism and cultivate a logical alternative to their illogical beliefs. Collaboration necessitates the establishment of a rapport, honesty, and the expression of empathy. As an illustration, I often asked the patient whether the therapy objectives were adequately addressing their requirements and if there were any changes in their preferences. In addition, while working together, I delved further into their personal background and present sources of stress in order to discover and understand the factors contributing to their depression. As part of collaborative practice, I should also learn more about the integrated care system within the NHS. NHS England (2019) called for multi-agency engagement and cooperation with stakeholders. As part of collaborative care, I need to be able to understand how effectively I can work with other caregivers within the patient's care plan to improve quality of care.

Normalisation can also help the learner understand areas of significance in learning clinical applications. According to Josefowitz and Myran (2021), normalisation helps the client understand that they are not alone in their problems and that their challenges are not unique. The purpose of normalisation is to reduce the perceived internal stigma that a client may face. To normalise the needs of the patient, I engaged in psychoeducation—i.e. sharing common patterns of cognitive distortion that contribute to patient distress. Normalisation also helps in the formulation or conceptualisation of outcomes. According to Barton and Armstrong (2018), when the client is willing to be proactive about seeking help through normalisation, it is possible to develop a shared understanding of the thinking, emotions and behaviours that contribute to their challenge. Through collaborative action and normalisation, I discovered that the client held negative beliefs about their worth and their abilities, these having been triggered by the recent rejections. Once successful formulation

was carried out, the next step was to ensure the assessment and management of risks that may contribute to patient outcomes. According to Townend and Grant (2008), risk assessment involves determining any immediate and long-term risks that may be linked to the client's behaviour. For example, in the role play exercise, potential risks included self-harm or suicide.

The final step of the Driscoll (2007) model is to encourage the learner to transfer their new knowledge to future situations and contexts. As part of this stage, the goal is to identify areas for improvement and ensure that the learner becomes a reflective practitioner. As part of the risk assessment, I should have conducted an in-depth risk analysis. While I discovered risks linked to self-harm and suicidality, I should also have evaluated other elements like social or functional impairment. Extant literature acknowledges that the maintenance of depressive symptoms can contribute to increased risk of social isolation and functional impairment, including in relation to self-care and work (Saris et al., 2017). A comprehensive safety plan should have been developed, including coping strategies and emergency contacts to manage the risks.

Another area for improvement that I would like to reflect on is setting homework. Beckwith and Crichton (2014) concluded that successful homework setting requires setting tasks that clients can work on as part of their everyday life in between sessions to reinforce specific therapeutic strategies. I should have tailored homework assignments to the client's own goals. For example, though the importance of cognitive restructuring was discussed, I should have asked the client to keep a record of their thoughts. According to McManus et al. (2012), a thought record can help determine the frequency and stressors leading to negative thoughts and can provide targeted strategies for cognitive restructuring. Similarly, as part of behavioural activation, we introduced social goals. However, I should have developed a schedule of activities, including routine responsibilities balanced against relaxing tasks.

As part of improvement, development goals for a student nurse can also be recognised. There are some areas of development that need to be acknowledged. For example, though the importance of collaborative actions is recognised, learning from peers (i.e., other student nurses) has not been considered as an opportunity for

future growth. I believe that I should look at peer-led education and look to identify peer groups who can provide practical insights and help bridge the gap that I currently face between academic and non-academic activities (Davis and Richardson, 2017). I need to develop communication skills to help coordinate CBT treatment against other needs of the patient. For example, working with other mental health professionals, psychologists and psychiatrists is important.

There are some limitations of CBT that need to be acknowledged as part of reflective practice. For example, Skillbeck et al., (2020) contended that the CBT is predominantly client driven. Therefore, it is largely dependent on the insights that are made by the client regarding their own thoughts and behaviour. If the client does not have the capability to engage in self-reflection, it can lead to limited impact of the therapy. Additionally, CBT is dependent on cognitive processes, and if the individual's depression is linked to interpersonal relationships or concerns then it may not effectively bring out the required outcomes (Dobson and Dobson, 2018).

There are some challenges linked to effective clinical use of cognitive therapies for depression. For example, I found that there can be difficulty setting the right self-endorsed goals for the client. As Urbanoski and Wild (2012) concluded, the Socratic questioning method requires creating a dialogue wherein sequenced discovery-oriented questions can be posed to arrive at cognitive restructuring goals. Another area that I should focus on to address the challenges of psychotherapy is maintaining the focus of the REBT sessions. During the role play, I discovered that the client had difficulty remaining focused. In such a case, I should be able to balance between flexibility and focus. The case formulation should ensure that the focus is on the end goals for the patient.

Finally, I understood that there can be challenges in meeting clients' unwillingness to do homework. According to Chu et al. (2015), one way to address homework incompletion is to discuss why clients did not complete the homework. I understood that it is important to understand why the client did not complete the homework and if they felt it was distressing, vague or difficult.

Conclusion

This essay intended to choose a specific type of CBT treatment option. The Ellis (2005) ABCDE model was chosen and its application the REBT approach was identified. The steps or the core essence of the model and its clinical significance and relevance was highlighted. Following this, the essay also presented a reflective evaluation of clinical skills and applications of CBT. The role play sessions provided evidence on how I can build my clinical experience as a psychotherapist. The use of evidence-based practice will help address this challenge. As a reflective practitioner, I believe that I should work on building a therapeutic alliance as it will help address most challenges linked to CBT adoption.

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