

Using Rational Emotive Behavior Therapy Techniques to Cope with Disability

Albert Ellis

I have had multiple disabilities for a long number of years and have always used Rational Emotive Behavior Therapy (REBT) to help me cope with these disabilities. That is one of the saving graces of having a serious disability—if you really accept it, and stop whining about having it, you can turn some of its lemons into quite tasty lemonade.

I started doing this with my first major disability soon after I became a practicing psychologist in 1943, at the age of 30. At age 19 I began to have trouble reading and was fitted for glasses, which worked well enough for sight purposes but left me with easily tired eyes. After I read or even looked steadily at people for no more than 20 minutes, my eyes began to feel quite fatigued, and often as if they had sand in them. Why? Probably because of my pre-diabetic condition of renal glycosuria.

Anyway, from 19 years onward I was clearly handicapped by my chronically tired eyes and could find no steady release from it. Today, over a half-century later, it is still with me, sometimes a little better, sometimes a little worse, but generally unrelieved. So I stoically accepted my tired eyes and still live with them. And what an annoyance it is! I rarely read, especially scientific material, for more than 20 minutes at a time—and I almost always keep my eyes closed when I am not reading, working, or otherwise so active that it would be unwise for me to shut them.

My main sight limitation is during my work as a therapist in the world. For at our clinic at the Institute for Rational Emotive Behavior Therapy in New York, I usually see individual and group clients from 9:30 am to 11:00 pm—with a

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couple of half hour breaks for meals, and mostly for half hour sessions with my individual clients. So during each week I may easily see over 80 individual and 40 more group clients.

Do I get tired during these long days of working? Strangely enough, I rarely do. I was fortunate enough to pick high-energy parents and other ancestors. My mother and father were both exceptionally active, on-the-go people until a short time before she died of a stroke at the age of 93 and he died, also of a stroke, at the age of 80.

Anyway, for more than a half century I have conducted many more sessions with my eyes almost completely shut than I have with them open. This includes thousands of sessions I have done on the phone without ever seeing my clients. In doing so, I have experienced some real limitations but also several useful advantages. Advantages? Yes, such as these:

1. With my eyes shut, I can focus unusually well on what my clients are telling me and can listen nicely to their tones of voice, speech hesitations and speed-ups, and other aspects of their verbal communications.
2. With my eyes closed, I can focus better, I think, on what my clients are telling themselves to make themselves disturbed: on their basic irrational meanings and philosophies that are crucial to most of their symptoms.
3. When I am not looking at my clients I am quite relaxed and can easily avoid bothering myself about how well I am doing. I avoid rating myself and producing ego problems about what a great therapist and noble person I am—or am not!
4. My closed eyes and relaxed attitude seem to help a number of my clients relax during the session themselves, to open up to concentrating on and revealing their worst problems.
5. Some of my clients recognize my personal disabilities. They see that I refuse to whine about my adversities, work my ass off in spite of them, and have the courage to accept what I cannot change. They therefore often use me as a healthy model and see that they, too, can happily work and live in spite of their misfortunes.

Do not think, now, that I am recommending that all therapists, including those who have no ocular problems, should often shut their eyes during their individual therapy sessions. No. But some might experiment in this respect to see what advantages closing their eyes may have, especially at certain times.

Despite the fact that I could only read for about 20 minutes at a time, I started graduate school in clinical psychology in 1942, when I was 28, finished with honors, and have now been at the same delightful stand for well over a half century—still with my eyes often shut and my ears widely open. I am handicapped and partially disabled, yes—but never whining and screaming about my disabilities, and always forging on in spite of them.

In my late sixties my hearing began to deteriorate, and in my mid-seventies I got two hearing aids. Even when working in good order, they have their distinct

limitations and have to be adjusted for various conditions, and even for the voice loudness and quality of the voices of the people I am listening to. So I use them regularly, especially with my clients, but I am still forced to ask people to repeat themselves or to make themselves clearer.

So I put up with all these limitations and use rational emotive behavior therapy to convince myself that they are not awful, horrible, and terrible but only a pain in the ass. Once in awhile I get overly irritated about my hearing problem—which my audiologist, incidentally, tells me will definitely get a little worse as each year goes by. But usually I live very well with my poor auditory reception and even manage to do my usual large number of public talks and workshops every year, in the course of which I have some trouble in hearing questions and comments from my audiences but still manage to get by. Too bad that I have much more difficulty than I had in my younger years.

I was diagnosed as having full-blown diabetes at the age of 40, so that has added to my disabilities. Diabetes, of course, does not cause much direct pain and anguish, but it certainly does lead to severe restrictions. I was quickly put on insulin injections twice a day and on a seriously restricted diet. I, who used to take four spoons of sugar in my coffee in my prediabetic days, plus half cream, was suddenly deprived of both. Moreover, when I stuck with my insulin injections and dietary restrictions, I at first kept my blood sugar regularly low but actually lost 10 pounds off my usually all-too-thin body. After my first year of insulin taking, I became a near-skeleton!

I soon figured out that by eating 12 small meals a day, literally around the clock, I could keep my blood sugar low, ward off insulin shock reactions, and maintain a healthy weight. So for over 40 years I have been doing this and managing to survive pretty well. But what a bother! I am continually, day and night, making myself peanut butter sandwiches, pricking my fingers for blood samples, using my blood metering machines, carefully watching my diet, exercising regularly, and doing many other things that insulin-dependent diabetics have to do to keep their bodies and minds in good order.

When I fail to follow this annoying regimen, which I rarely do, I naturally suffer. Over the many years that I have been diabetic, I have ended up with a number of hypoglycemic reactions, including being carried off three times in an ambulance to hospital emergency wards. And, in spite of my keeping my blood sugar and my blood pressure healthfully low over these many years, I have suffered from various sequelae of diabetes and have to keep regularly checking with my physicians to make sure that they do not get worse or that new complications do not develop. So, although I manage to keep my health rather good, I have several physicians whom I regularly see, including a diabetologist; an internist; an ear, nose, and throat specialist; a urologist; an orthopedist; and a dermatologist. Who knows what will be next? Oh, yes: Because diabetes affects the mouth and the feet, my visits to the dentist and podiatrist every year are a hell of a lot more often than I enjoy making them. But, whether I like it or not, I go.

Finally, as a result of my advancing age, perhaps my diabetic condition, and who knows what else, I have suffered for the last few years from a bladder that is easily filled and slow to empty. So I run to the toilet more than I used to do, which I do not particularly mind. But I do mind the fact that it often takes me much longer to urinate than it did in my youth and early adulthood. That is really annoying!

Why? Because for as long as I can remember, I have been something of a time watcher. I figured out, I think when I was still in my teens and was writing away like a demon, even though I had a full schedule of courses and other events at college, that the most important thing in my life, and perhaps in almost everyone else's life, is time. Money, of course, has its distinct value; so does love. But if you lose money or get rejected in your sex-love affairs, you always have other chances to make up for your losses, as long as you are alive and energetic. But are poor, you can focus on getting a better income; if you are unloved and unwanted, you can theoretically get a new partner up until your dying day. Not so, exactly, with time. Once you lose a few seconds, hours, or years, there is no manner in which you can get them back. Once gone, you can in no way retrieve them. *Tempus fugit*—and time lost, wasted, or ignored is distinctly ir retrievable.

Ever since my teens, then, I have made myself allergic to procrastination and to hundreds of other ways of wasting time, and of letting it idly and unthinkingly go by. I assume that my days on earth are numbered and that I will not live a second more than I actually do live. So, unless I am really sick or otherwise out of commission, I do my best to make the most of my 16 daily hours; and I frequently manage to accomplish this by doing two or more things at a time. For example, I very frequently listen to music while reading and have an interesting conversation with people while preparing a meal or eating.

This is all to the good, and I am delighted to be able to do two things at once, to stop my procrastinating and my occasional day dreaming and, instead, to do something that I would much rather get done in the limited time that I have to be active each day and the all too few years I will have in my entire lifetime. Consequently, when I was afflicted by the problem of slow urination in my late seventies, I distinctly regretted the 5 to 15 minutes of extra time it began to take me to go to the toilet several times each day and night. What a waste! What could I effectively do about saving this time?

Well, I soon worked out that problem. Instead of standing up to urinate as I had normally done for all my earlier life, I deliberately arranged for most of the times I went to the john to do so sitting down. While doing so, I first settled on doing some interesting reading for the several minutes that it took me to finish urinating. But then I soon figured out that I could do other kinds of things as well to use this time.

For example, when I am alone in the apartment that I share with my mate, Janet Wolfe, I usually take a few minutes to heat up my regular hot meal in our microwave oven. While it is cooking, I often prepare my next hot meal as well as

put it in a microwave dish in the refrigerator, so that when I come up from my office to our apartment again, I will have it quickly ready to put in the oven again. I therefore am usually cooking and preparing two meals at a time. As the old saying goes, two meals for the price of one!

Once the microwave oven rings its bell and tells me that my cooked meal is finished, I take it out of the oven, and instead of putting it on our kitchen table to eat, I take it into the bathroom and put it on a shelf by the side of the toilet, together with my eating utensils. Then, while I spend the next 5 or 10 minutes urinating, I simultaneously eat my meal out of the microwave dish that it is in and thereby accomplish my eating and urinating at the same time. Now some of you may think that this is inelegant or even boorish. My main goal is to get two important things—eating and urinating—promptly done, to polish them off as it were, and then to get back to the rest of my interesting life. As you may well imagine, I am delighted with this efficient arrangement and am highly pleased with having efficiently worked it out!

Sometimes I actually can arrange to do tasks while I am also doing therapy. My clients, for example, know that I am diabetic and that I have to eat regularly, especially when my blood sugar is low. So, with their permission, I actually eat my peanut butter and sugarless jelly sandwiches while I am conducting my individual and group sessions, and everyone seems to be happy.

However, I still have to spend a considerable amount of time taking care of my physical needs and dealing with my diabetes and other disabilities. I hate doing this, but I accept the fact that I have little other choice. So I use rational emotive behavior therapy (REBT) to overcome my tendencies toward low frustration tolerance that I may still have. I tell myself whenever I feel that I am getting impatient or angry about my various limitations,

Too damned bad! I really do not like taking all this time and effort to deal with my impairments and wish to hell that I didn't have to do so. But alas, I do. It is hard doing so many things to keep myself in a relatively healthy condition, but it is much harder, and in the long run much more painful and deadly, if I do not keep doing this. There is no reason whatsoever why I absolutely must have it easier than I do. Yes, it is unfair for me to be more afflicted than many other people are. But, damn it, I should be just as afflicted as I am! Unfairness should exist in the world—to me, and to whomever else it does exist—because it does exist! Too bad that it does—but it DOES! (Ellis, 1979, 1980)

So, using my REBT training, I work on my low frustration tolerance and accept—yes, really accept—what I cannot change. And, of course, barring a medical miracle, I cannot right now change any of my major disabilities. I can live with them, and I do. I can even reduce them to some extent, and I do. But I still cannot get rid of them. Tough! But it is not awful.

REBT, as you may or may not know, posits that there are two main instigators of human neurosis: First, low frustration tolerance (e.g., I absolutely must have what I want when I want it and must never, never be deprived of anything

that I really, really desire). Second, self-demigration (e.g., when I do not perform well and win others' approval, as at all times I should, ought, and must, I am an inadequate person, a retard, a no-goodnik!).

Many disabled people in our culture, in addition to suffering from the first of these disturbances, suffer even more seriously from the second. People with serious disabilities often have more performance limitations in many areas (e.g., at school, at work, and at sports) than those who have no disabilities. To make matters worse, they are frequently criticized, scorned, and put down by others for having their deficiencies. From early childhood to old age, they may be ridiculed and reviled, shown that they really are not as capable and as "good" as others. So not only do they suffer from decreased competence in various areas but also from much less approval than more proficient members of our society often receive. For both these reasons, because they notice their own ineptness and because many of their relatives and associates ignore or condemn them for it, they falsely tend to conclude, "My deficiencies make me a deficient, inadequate individual."

I largely taught myself to forgo this kind of self-deprecation long before I developed most of my present disabilities. From my early interest in philosophy during my teens, I saw that I did not have to rate myself as a person when I rated my efficacy and my lovability. I began to teach myself, before I reached my mid-twenties, that I could give up most of my feelings of shame and could unconditionally accept myself as a human even when I did poorly, especially at sports. As I grew older, I increasingly worked at accepting myself unconditionally. So when I started to practice REBT in 1955, I made the concept of unconditional self-acceptance (USA) one of its key elements (Balter, 1995; Dryden, 1995; Ellis, 1973, 1988, 1991, 1994, 1996; Hauck, 1991).

As you can imagine by what I stated previously in this article, I use my REBT-oriented high frustration tolerance to stop myself from whining about disabilities and rarely inwardly or outwardly complain about this. But I also use my self-accepting philosophy to refrain from ever putting myself down about these handicaps. For in REBT one of the most important things we do is to teach most of our clients to rate or evaluate only their thoughts, feelings, and actions and not rate their self, essence, or being. So for many years I have followed this principle and fully acknowledged that many of my behaviors are unfortunate, bad, and inadequate, because they do not fulfill my goals and desires. But I strongly philosophize, of course, that I am not a bad or inadequate person for having these flaws and failings.

I must admit that I really hate growing old. Because, in addition to my diabetes, my easily tired eyes, and my poor hearing, old age definitely increases my list of disabilities. Every year that goes by I creak more in my joints, have extra physical pains to deal with, slow down in my pace, and otherwise am able to do somewhat less than previously. So old age is hardly a blessing!

However, as I approach the age of 82, I am damned glad to be alive and to be quite active, productive, and enjoying. My brother and sister, who were a few

years younger than I, both died almost a decade ago, and just about all my close relatives are also fairly long gone. A great many of my psychological friends and associates, most of whom were younger than I, unfortunately have died, too. I grieve for some of them, especially for my brother, Paul, who was my best friend. But I also remind myself that it is great that I am still very much alive, as is my beloved mate, Janet, after more than 30 years of our living together. So, really, I am very lucky!

Do my own physical disabilities actually add to my therapeutic effectiveness? I would say, yes—definitely. In fact, they do in several ways, including the following:

1. With my regular clients, most of whom have only minor disabilities or none at all, I often use myself as a model and show them that, in spite of my 82 years and my physical problems, I fully accept myself with these impediments and give myself the same unconditional self-acceptance (USA) that I try to help these clients achieve. I also often show them, directly and indirectly, that I rarely whine about my physical defects but have taught myself to have high frustration tolerance (HFT) about them. This kind of modeling helps teach many of my clients that they, too, can face real adversities and achieve USA and HFT.

2. I particularly work at teaching my disabled clients to have unconditional self-acceptance by fully acknowledging that their deficiencies are unfortunate, bad, and sometimes very noxious but that they are never, except by their own self-sabotaging definition, shameful, disgraceful or contemptible. Yes, other people may often view them as horrid, hateful people, because our culture and many other cultures often encourage such unfair prejudice. But I show my clients that they never have to agree with this kind of bigotry and can actively fight against it in their own lives as well as help other people with disabilities to be fully self-accepting.

I often get this point across to my own clients by using self-disclosure and other kinds of modeling. Thus, I saw a 45-year-old brittle, diabetic man, Michael, who had great trouble maintaining a healthy blood sugar level, as his own diabetic brother and sister were able to do. He incessantly put himself down for his inability to work steadily, to maintain a firm erection, to participate in sports, and to achieve a good relationship with an attractive woman who would mate with him in spite of his severe disabilities.

When I revealed to Michael several of my own physical defects and limitations, such as those I mentioned previously in this article, and when I showed him how I felt sad and disappointed about them but stubbornly refused to feel at all ashamed or embarrassed for having these difficulties, he strongly worked at full self-acceptance, stopped denigrating himself for his inefficacies, shamelessly informed prospective partners about his disabilities, and was able to mate with a woman who cared for him deeply in spite of them.

In this case, I also used REBT skill training. As almost everyone, I hope, knows by now, REBT is unusually multimodal. It shows people with physical problems how to stop needlessly upsetting themselves about their drawbacks. But it also teaches them various social, professional, and other skills to help them minimize and compensate for their hindrances (Ellis, 1957/1975, 1988, 1996; Gandy, 1995). In Michael's case, in addition to teaching him unconditional self-acceptance, I showed him how to socialize more effectively; how to satisfy female partners without having perfect erections; and how to participate in some sports, such as swimming, despite his physical limitations. So he was able, although still disabled, to feel better and to perform better as a result of his REBT sessions. This is the two-sided or duplex kind of therapy that I try to arrange with many of my clients with disabilities.

3. Partly as a result of my own physical restrictions, I am also able to help clients, whether or not they have disabilities, with their low frustration tolerance (LFT). As I noted earlier, people with physical restrictions and pains usually are more frustrated than those without such impediments. Consequently, they may well develop a high degree of LFT. Consider Denise, for example. A psychologist, she became insulin dependent at the age of 30 and felt horrified about her newly acquired restrictions. According to her physicians, she now had to take two injections of insulin and several blood tests every day, give up most of her favorite fat-loaded and salt-saturated foods, spend a half-hour a day exercising, and take several other health-related precautions. She viewed all of these chores and limitations as "revolting and horrible," and became phobic about regularly carrying them out. She especially kept up her life-long gourmet diet and gained 20 extra pounds within a year of becoming diabetic. Her doctors' and her husband's severe criticism helped her feel guilty, but it hardly stopped her in her foolish self-indulgence.

I first worked with Denise on the LFT and did my best to convince her, as REBT practitioners often do, that she did not need the eating and other pleasures that she wanted. It was indeed hard for her to impose the restrictions her physical condition now required, but it was much harder, I pointed out, if she did not follow them. Her increased limitations were indeed unfortunate, but they were hardly revolting and horrible; I insisted that she could stand them, though never necessarily like them.

I at first had little success in helping Denise to raise her LFT because, as a bright psychologist, she irrationally but quite cleverly parried my rational arguments. However, using my own case for an example, I was able to show her how, at my older age and with my disabilities greater than hers, I had little choice but to give up my former indulgences or die. So, rather than die, I gave up putting four spoons of sugar and half cream in my coffee, threw away my salt shaker, stopped frying my vegetables in sugar and butter, surrendered my allergy to exercise, and started tapping my fingers seven or eight times a day for blood tests. When Denise heard how I forced my frustration tolerance up as

my pancreatic secretion of insulin went down, and how for over 40 years I have thereby stayed off the serious complications of diabetes that probably would have followed from my previous habits, and from her present ones, she worked on her own LFT and considerably reduced it.

Simultaneously, I also helped Denise with her secondary symptoms of neurosis. As a bright person and as a psychologist who often helped her clients with their self-sabotaging thoughts, feelings, and behaviors, she knew how destructive her own indulgences were, and she self-lambasted and made herself feel very ashamed of them, thereby creating a symptom about a symptom: self-downing about her LFT. So I used general REBT with her to help her give herself unconditional self-acceptance (USA) in spite of her indulging in her LFT. I also specifically showed her how, when I personally slip back to my pre-disability ways and fail to continue my antidiabetic exercise and other prophylactic routines, I only castigate my behavior and not my self or personhood. I therefore see myself as a goodnik who can change my no-goodnik actions, and this USA attitude helps me correct those actions. By forcefully showing this to Denise, and using myself and my handling of my disabilities as notable examples, I was able to help her give up her secondary symptoms—self-deprecation—and go back to working more effectively to decrease her primary symptom—low frustration tolerance.

I have mainly tried to show in this article how I have personally coped with some of my major disabilities for over 60 years. But let me say that I have found it relatively easy to do so because, first, I seem to be a natural born survivor and copier, which many disabled (and nondisabled) people are not. This may well be my innate predisposition but also may have been aided by my having to cope with nephritis from my 5th to my 8th years and my consequent training myself to live with physical adversity. Second, as noted earlier, I derived an epicurean and stoic philosophy from reading and reasoning about many philosophers' and writers' views from my 16th year onward. Third, I originated REBT in January 1955 and have spent the great majority of my waking life teaching it to clients, therapists, and members of the public for over 40 years.

For these and other reasons, I fairly easily and naturally use REBT methods in my own life and am not the kind of difficult customer (DC) that I often find my clients to be. With them, and especially with DCs who have disabilities and who keep complaining about them and not working too hard to overcome and cope with them, I often use a number of cognitive, emotive, and behavioral techniques for which REBT is famous and which I have described in my book, *How to Cope With a Fatal Illness* (Ellis & Abrams, 1994) and in many of my other writings (Ellis, 1957/1975, 1985, 1988, 1994, 1996).

Several other writers have also applied REBT and cognitive behavior therapy (CBT) to people with disabilities, including Rochelle Baker (1995), Warren Johnson (1981), Rose Oliver and Fran Bock (1987), and J. Sweetland (1991). Louis Calabro (1991) has written a particularly helpful article showing how the

anti-awfulizing philosophy of REBT can be used with individuals suffering from severe disabilities, such as those following a stroke, and Gerald Gandy (1995) has published an unusual book, *Mental Health Rehabilitation: Disputing Irrational Beliefs*.

The aforementioned writings include a great many cognitive, emotive, and behavioral therapy techniques that are particularly useful with people who have disabilities. Because, as REBT theorizes, human thinking, feeling, and acting significantly interact with each other, and because emotional disturbance affects one's body as well as one's physical condition affects one's kind and degree of disturbance, people who are upset about their disabilities often require a multifaceted therapy to deal with their upset state. REBT, like Arnold Lazarus' (1989) multimodal therapy, provides this kind of approach and therefore often is helpful to people with disability-related problems.

Let me briefly describe a few of the cognitive REBT methods that I frequently use with my clients who have disabilities and who are quite anxious, depressed, and self-pitying about having these handicaps. I bring out and help them dispute their irrational beliefs (IBs). Thus, I show these clients that there is no reason why they must not be disabled, although that would be distinctly desirable. No matter how ineffectual some of their behaviors are, they are never inadequate persons for having a disability. They can always accept themselves while acknowledging and deploing some of their physical and mental deficiencies. When other people treat them unkindly and unfairly because of their disabilities, they can deplore this unfairness but not damn their detractors. When the conditions under which they live are unfortunate and unfair, they can acknowledge this unfairness while not unduly focusing on and indulging in self-pity and horror about it.

Preferably, I try to show my disabled clients how to make a profound philosophical change and thereby not only minimize their anxiety, depression, rage, and self-pity for being disadvantaged but to become considerably less disturbable about future adversities. I try to teach them that they have the ability to consistently and strongly convince themselves that nothing is absolutely awful, that no human is worthless, and that they can practically always find some real enjoyment in living (Ellis, 1994, 1996; Ellis & Abrams, 1994). I also try to help them accept the challenge of being productive, self-actualizing, and happy in spite of the unusual handicaps with which they may unfortunately be innately endowed or may have acquired during their lifetime. Also, I point out the desirability of their creating for themselves a vital absorbing interest, that is, a long-range devotion to some cause, project, or other interest that will give them a real meaning and purpose in life, distract them from their disability, and give them ongoing value and pleasure (Ellis, 1994, 1996; Ellis & Harper, 1975).

To aid these goals of REBT, I use a number of other cognitive methods as well as many emotive and behavioral methods with my disabled clients. I have described these in many articles and books, so I shall not repeat them here. Details can be found in *How to Cope With a Fatal Illness* (Ellis & Abrams, 1994).

Do I use myself and my own ways of coping with my handicaps to help my clients cope with them? I often do. I first show them that I can unconditionally accept them with their disabilities, even when they have partly caused these handicaps themselves. I accept them with their self-imposed emptysema from smoking or with their 100 extra pounds of fat from indulging in ice cream and candy. I show them how I bear up quite well with my various physical difficulties and still manage to be energetic and relatively healthy. I reveal some of my time-saving, self-management, and other discipline methods that I frequently use in my own life. I indicate that I have not only devised some sensible philosophies for people with disabilities but that I actually apply them in my own work and play, and I show them how I have survived my handicaps for many years and damned well intend to keep doing so for perhaps a good number of years to come.

CONCLUSION

I might never have been that much interested in rational or sensible ways of coping with emotional problems had I not had to cope with a number of fairly serious physical problems from the age of 5 years onward. But rather than plague myself about my physical restrictions, I devoted myself to the philosophy of remaining happy in spite of my disabilities, and out of this philosophy I ultimately originated REBT in January 1955 (Ellis, 1962, 1994; Wiener, 1988; Yankura & Dryden, 1994). As I was developing REBT, I used some of its main principles on myself, and I have often used them with other people with disabilities. When I and these others have worked to acquire an anti-awfulizing, unconditional self-accepting philosophy, we have often been able to lead considerably happier and more productive lives than many other handicapped individuals lead. This hardly proves that REBT is a panacea for all physical and mental ills. It is not. But it is a form of psychotherapy and self-therapy especially designed for people who suffer from uncommon adversities. It points out to clients in general and to physically disadvantaged ones in particular that however much they dislike the harsh realities of their lives, they can manage to make themselves feel like the healthy negative emotions of sorrow, regret, frustration, and grief while stubbornly refusing to create and dwell on the unhealthy emotions of panic, depression, despair, rage, self-pity, and personal worthlessness. To help in this respect, it uses a number of cognitive, emotive–evocative, and behavioral methods. Its results with disabled individuals has not yet been well researched with controlled studies. Having used it successfully on myself and with many other individuals, I am of course prejudiced in its favor. But controlled investigations of its effectiveness are an important next step.

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