CHAPTER- II

REVIEW OF LITERATURE
Introduction

For the purpose of this study an extensive literature review was carried out in order to understand different concepts, opinions, theories and approaches presented by various thinkers and investigators in dealing with the aspects related to the subject of the present study. Also this part provides prevision research findings regarding to the effectiveness of Rational Emotive Behaviour Therapy Rational Emotive Behaviour Therapy (REBT) interventions on self-esteem, aggression and depression which were done individually or in the group. Further the interrelationship between the variables such as self-esteem and aggression, self-esteem and depression, aggression and depression were reviewed.

Therefore this review of literature has provided adequate theoretical basis for the present study and has helped the researcher plan the design of the study.

2.1 Psychotherapy

Psychotherapy is used to mean the learned and planned application of techniques resulting from recognized psychological principles, by persons skilled through training and experience to comprehend these principles and to apply these techniques with the purpose of assisting individuals to adjust such personal characteristics as feelings, values, attitudes and behaviour which are adjudicated by the therapist to be maladaptive and maladjusted (Meltzoff & Kornreich, 2007).

2.2 Cognitive Behavior Therapy

Cognitive Behavior Therapy, which is a form of psychotherapy, was introduced into the West in the late fifties (Free, 1999). Pioneers in the development of Cognitive Behavior Therapy include Albert Ellis (1913- 2007) who developed Rational Emotive Behaviour Therapy (REBT), and Aaron T. Beck (1921) whose Cognitive Therapy (CT) has been widely used for depression and anxiety (Free, 1999).
According to Cognitive Behavior Therapy, what determines individuals’ moods and subsequent behaviors is the way that they structure and interpret experiences. Seeing and perceiving negatively are purported to cause negative feelings and debilitative behaviors. Cognitive Behavior Therapy changes this way of seeing and perceiving (James & Gilliland, 2003).

From cognitive behavior therapists’ point of view, people have the capacity to be rational or irrational, erroneous or realistic in their thinking. In fact, the way of thinking about their experiences determines how they feel about those experiences, and what they will do. In general, as Palmer and Gyllensten (2008) have cited, Cognitive Behavior Therapy “proposes that dysfunctional thinking is prevalent in psychological disturbance” (Palmer & Gyllensten, 2008, p. 39).

Cognitive Behavior Therapy is used in treating of a large number of psychological problems such as depression, anxiety, dysfunctional attitudes, phobias (James & Gilliland, 2003), mood disorders, anger management, schizophrenia (Free, 1999), and so on.

2.3 The Most Well Known Cognitive Behavior Therapy Approaches

2.3.1 Albert Ellis’ Rational Emotive Behavior Therapy (REBT)

Rational Emotive Behaviour Therapy (REBT) which is one of the cognitive behavioral approaches to counseling and psychotherapy (Dryden, 2006), was established in the mid-1950s by Albert Ellis (Dryden & David, 2008). Ellis (1913-2007) derived Rational Emotive Behaviour Therapy (REBT) theory mainly from the ancient Asian philosophers such as Gautama Buddha, Lao Tsu, and Confucius; the Greeks and the Romans such as Epictetus, Marcus Aurelius, Epicurus, and Seneca; and from several modern constructivist philosophers, such as Kant, Russel, Dewey, and Wittgenstein (Overholser, 2003).

According to Ellis (2002), the philosophers found that human beings, who are natural constructivists, largely disturb themselves about adversities because they choose to add to these adversities their own irrational beliefs. Ellis added to this, that the nature of persons is such that when they think, they also feel and behave; when they feel, they also think and behave; and when
they behave, they also think and feel. Their thoughts, feelings, and behaviors strongly include and interact with each other.

Ellis used this philosophy at first, from the age of 16 onwards, to combat his own anxiety (Overholser, 2003). He pointed out that Epictetus said two thousand years ago: “People are disturbed not by events that happen to them, but by their view of these events” (Ellis, 2004a, p. 74). Then he added: “This was a revelation to me, which I took seriously, and with which I trained myself to be much less anxious about many things” (Ellis, 2004a, p. 74). Ellis has emphasized the negative role of dysfunctional cognitions in human beings’ lives and “posited that if people could be prevented from indulging in irrational thoughts and beliefs, they would improve their ability to direct their energy toward self-actualization” (Sherin & Caiger, 2004, p. 227).

According to Ellis (2003a), “The central theory of Rational Emotive Behaviour Therapy (REBT) says that people largely disturb themselves by thinking in terms of absolute imperatives–shoulds, oughts, and musts (p. 247). Therefore, thinking in terms of absolute imperatives is the reason for disturbance and maladaptive behavior. Albert Ellis started to create Rational Emotive Therapy in 1953, and then started using it in 1955. Then therapies of Aaron T. Beck, Albert Bandura, Donald Meichenbaum, and so forth began to be often practiced (Ellis, 2004b).

What needs to be mentioned is that in Rational Emotive Behaviour Therapy (REBT), behavior is and always has been an essential part of the theory (James & Gilliland, 2003). Also, Ellis has emphasized that his approach is the most comprehensive of the many existing behavior therapies (Ellis, 2004b).

Although Ellis had practiced various forms of psychoanalytic treatment, from the late 1940s to the early 1950s, he became dissatisfied with the effectiveness and efficacy of both classical analysis and psychoanalytic psychotherapy. Ellis believed that Freud was correct in his opinion that irrational forces keep neurotics troubled, but he was coming to believe that irrational forces were not unconscious conflicts from early childhood (Prochaska & Norcross, 1999).

In general, Rational Emotive Behaviour Therapy (REBT) is an approach which is problem-focused, goal-directed, structured and logical in its practice, educational-focused, primarily present-centered and future-oriented, skills-emphasized and having largely active and directive therapists (Dryden, 2006).
2.3.1.1 Therapeutic Goals in Rational Emotive Behaviour Therapy (REBT)

According to Ellis as cited by Corey (2005), we have a robust propensity not only to evaluate our acts and behaviors as “good” or “bad,” “worthy” or “unworthy,” but also to evaluate ourselves as an entire individual according to our performances. These assessments provide one of the central sources of our emotional disturbances. Therefore, the greatest Rational Emotive Behavior Therapists (REBT) have the overall aim of teaching clients how to distinguish between the assessment of their behaviors and the assessment of themselves—their essence and their whole—and how to accept themselves in spite of their inadequacies. The numerous roads taken in Rational Emotive Behaviour Therapy (REBT) lead in the direction of the terminus of clients reducing their emotional disturbances and self-defeating behaviors by obtaining an additional realistic and workable philosophy of life. The process of Rational Emotive Behaviour Therapy (REBT) includes a collaborative work on the part of both the therapist and the client in selecting realistic and self-enhancing therapeutic aims. The therapist’s duty is to assist clients distinguish between realistic and unrealistic aims and also self-defeating and self-enhancing aims. A preliminary goal is to teach clients how to change their dysfunctional emotions and behaviors into healthy ones.

Ellis states that three of the central aims of Rational Emotive Behaviour Therapy (REBT) are to support clients in the process of attaining unconditional self-acceptance (USA) and unconditional other acceptance (UOA), unconditional life-acceptance (ULA) and to realize how these are interconnected. As clients develop more ability to accept themselves, they are more probable to unconditionally accept others (Corey, 2005).

2.3.1.2 Rational Emotive Behaviour Therapy (REBT) Group Therapy

According to Ellis and Dryden (1997), Rational Emotive Behavior Therapy Rational Emotive Behaviour Therapy (REBT) and Cognitive Behavior Therapy (CBT) lend themselves particularly well to use in group settings. Ellis (2002) as cited by Terjesen and Esposito (2006), stated: Rational Emotive Behavior Therapy (REBT) and Cognitive Behavior Therapy (CBT) are efficient kinds of group therapy because they involve people who regularly meet together with a leader in order to work on their psychological problems; they focus on the members’ thoughts,
feelings and behaviors and they encourage all the participants to help each other change their cognitions, emotions and actions.

The small-scale group Rational Emotive Behaviour Therapy (REBT’s) main goals are similar to those for individual therapy, but also utilize the group process as a means to educate and elucidate about change. Ellis and Dryden (1997) reported that Rational Emotive Behaviour Therapy (REBT) groups try to teach the group members:

(1) To understand the basis of their emotional and behavioral problems and to use this understanding to overcome their current symptoms and function better;

(2) To understand the difficulties of other group members and be of some therapeutic help to these others;

(3) To minimize their (and the others’) basic disturbability so that for the rest of their lives they will tend to feel and respond appropriately, rather than inappropriately, emotional;

(4) To achieve not only a behavioral but also a pronounced philosophic change, including accepting (though not necessarily liking) unpleasant reality; relinquishing self-sabotaging thinking; discontinuing from awfulizing about life’s misfortunes; taking full responsibility for their own emotional difficulties; and stopping all forms of rating and, instead, learning to fully accept themselves and others as fallible and error prone humans.

In Rational Emotive Behaviour Group Therapy, the therapist actively shows group participants who are bringing up their emotional problems that they are largely creating these problems themselves by inventing and rigidly holding on to irrational beliefs (IBs), vigorously questions and challenges these beliefs, and encourages and persuades all the group members to look for and dispute the irrational beliefs of the other members. All group participants are taught to use the scientific method to empirically counter the upsetting cognition of themselves and other members. Rational Emotive Behaviour Therapy (REBT) groups include a number of role playing and behavior modification methods such as assertion training, in vivo risk-taking, and behavioral rehearsal— that can be done during individual therapy sessions but may be more effective in group. Rational Emotive Behaviour Therapy (REBT) group members get practice in talking other group participants out of their irrational beliefs (IB’s) and
thereby consciously and unconsciously begin to talk themselves out of their own self-defeating irrationalities (Ellis & Dryden, 1997).

2.3.1.3 Stages of Group Rational Emotive Behaviour Therapy (REBT)

One of the leading theories in the field of counseling which is widely used in group counseling is Rational Emotive Behaviour Therapy (REBT). In group Rational Emotive Behaviour Therapy (REBT), the leader teaches members to focus on changing their feelings by changing their beliefs. According to Jacobs, Masson, Harvill, and Schimmel (2011), these are the following stages in group Rational Emotive Behaviour Therapy (REBT):

1. Clarifying the event, person, or situation (A)
2. Clarifying the feelings and/or behavior (B)
3. Clarifying the negative self-talk (C)
4. Clarifying the feelings by changing the self-talk.

2.3.1.4 Therapeutic Processes

Considering the ABC theory of Rational Emotive Behavior Therapy, there are four main steps involved in the therapeutic process when applying the concept of Rational Emotive Behaviour Therapy (REBT). According to Watson (1999), the first step involves pointing out to the client that he/she has irrational beliefs. The second step is built on the awareness achieved in the previous step. The third step involves disrupting the pattern and discontinuing the cycle of irrational beliefs. By collaborative effort, both the therapist and the client modify the client’s thinking and begin to move away from the irrational beliefs and setting new rational beliefs. This moves into the fourth step of the process. After identifying irrational beliefs, the therapist by using cognitive, affective and behavioral techniques, challenges them in order to develop rational beliefs. In Freud’s theory, conscious thoughts and beliefs provide clues to the inner working of the unconscious mind, but, in cognitive behavior therapy conscious beliefs are important in themselves (Nairne, 2009). Thus, in Rational Emotive Behaviour Therapy (REBT), developing an insight into the role of irrational beliefs in inducing psychological and physical problems is important.
Also, in Rational Emotive Behaviour Therapy (REBT), the therapeutic process is to identify the irrational beliefs that cause emotional problems (Blum & Davis, 2010; Coon & Mitterer, 2009), to dispute them vigorously, and then to replace them with more rational beliefs (Blum & Davis, 2010). Rational Emotive Behaviour Therapy (REBT) considers thinking, feeling, and behaving as an integrated process. Therefore, a large number of cognitive, emotive, and behavioral methods are used in this therapeutic approach (Ellis, 1999, 2002, 2003a).

Ellis (2004) emphasized the importance of his therapeutic approach and that “Rational Emotive Behaviour Therapy (REBT) seems to be more comprehensive than most other behavior therapies in that it strives for its clients getting better and not merely feeling better” (p. 88). In general, according to Rational Emotive Behaviour Therapy (REBT), emotional difficulties are caused when the individual’s cognitions are irrational. Rational Emotive Behaviour Therapy (REBT) corrects these self-defeating beliefs, and replaces them with rational beliefs (Gelso & Fretz, 2001).

### 2.3.1.5 Therapeutic Relationship

In Rational Emotive Behaviour Therapy (REBT) the therapist is active and directive (Dryden, 2006). This means that in Rational Emotive Behaviour Therapy (REBT), therapists have empathy and unconditional positive regard. Nonetheless, they “do not believe a warm relationship between client and therapist is a necessary or a sufficient condition for effective personality change. On the contrary, Ellis suggests that too much personal warmth and empathic understanding may foster client dependent, and the need for the therapist approval” (James & Gilliland, 2003, p. 241).

### 2.3.1.6 Cognitive Techniques of Rational Emotive Behaviour Therapy (REBT)

Cognitive techniques of Rational Emotive Behaviour Therapy (REBT) deal with clients’ cognitions. Counselors by using these techniques help clients to change their beliefs. According to Ellis (2002), some of them are as follows:

**(1) Disputing Irrational Believing-Emoting-Behaving:** At first, counselors might show clients their irrational beliefs by asking questions such as: Where is the evidence for your beliefs? Why is this so terrible? These kinds of questions raise the consciousness in clients and help them to
begin thinking on a more rational level. Clients can be asked, for example, “Where is the evidence that I should not have any problem in my life?” Typical answer would be: There is no evidence that I should not have any problem in my life. Gradually, clients are able to see that things are not as bad as they make them out to be. Clients would be taught to do logical disputing of their irrational beliefs. For example: Does it logically follow that if I cannot solve my problems alone, I am an inadequate person? Typical answer would be: No, if I were an inadequate person, I would fail at practically everything, and that, of course, is not true. Clients would be taught to do pragmatic or heuristic disputing of their irrational beliefs. For example: What results will I get if I think that I must solve my problems alone, and that I am not a good person if I do not? Typical answer would be: It will help me make myself very anxious and depressed;

(2) **Rational Coping Self-Statement:** Clients repeat rational coping self-statements such as “I am never a failure or a loser but just a fallible human who fails some of the time”;

(3) **Positive Visualization:** By this technique, counselors help clients in reaching their achievement-confidence or self-efficacy;

(4) **Modeling:** By this technique counselors help clients see that other people they know have similar problems, but do not awfulise about them. Moreover, clients can model themselves after those people;

(5) **Psychoeducational Methods:** Clients can be encouraged to read Rational Emotive Behaviour Therapy (REBT) self-help materials;

(6) **Cognitive Distraction:** By using cognitive distraction such as reading, watching TV, meditation and yoga, clients temporarily block out some of their anxietising;

(7) **Practical Problem-Solving Techniques:** Counselors can help their clients to use more practical methods of tackling their problems such as assertiveness training, social skills training and decision making.

2.3.1.7 Emotive Techniques of Rational Emotive Behaviour Therapy (REBT)

Emotive techniques help clients to imagine themselves in different situations. According to Ellis (2002), some of these techniques are as follows:

(1) **Unconditional Self-Acceptance:** Counselors make the client familiar with the ways in which he/she could accept himself/herself unconditionally as a person;
(2) **Unconditional Other-Acceptance:** At first, counselors would give their clients examples of other-acceptance, and that they are accepted. Then, they will help them to see how others can be accepted as worthwhile human beings;

(3) **Shame Attacking Exercises:** In order to achieve unconditional self-acceptance, counselors help clients to remove their guilt and self-damning;

(4) **Rational Emotive Imagery:** By this technique clients could be shown how to imagine some terrible things happening. This technique helps clients to train themselves to feel healthy disappointment instead of unhealthy anxiety;

(5) **Strong Rational Coping Statements:** These kinds of statements help clients undo their anxious reactions. For example: I am not a miracle-maker and can only do my best;

(6) **Humor:** Since anxious clients take things too seriously, therapists might encourage clients to use their sense of humor.

### 2.3.1.8 Behavioral Techniques of Rational Emotive Behaviour Therapy (REBT)

By using behavioural techniques clients are encouraged to do some activities that help them overcome their anxieties. According to Ellis (2002), some of the behavioural techniques are as follows:

(1) **Reinforcement:** Clients might be encouraged to reward themselves with some pleasurable activities only after they took some risks they commonly avoided;

(2) **Penalisation:** If clients refused to change their thinking, feeling, and behaving, then they might be encouraged to take some real penalties to discourage their resistance. For example, doing some very unpleasant tasks;

(3) **Skills Training:** Counsellors might work with their clients’ assertiveness. They also might encourage them to use assertiveness training workshops.

### 2.3.2 Beck's Cognitive Model of Depression

As Free (1999) has cited, Beck’s theory of depression, possesses four major cognitive components. They relate to internal events that the person may be aware of, but which are not directly observable by other people. These four components are as follows:
(1) “Automatic thoughts are a transient phenomenon. They include sentences and phrases that occur in the stream of consciousness, and images of various kinds. They only exist as long as the thought is in consciousness” (Free, 1999, p. 11).

(2) “Schemas on the other hand are permanent structures in the person’s cognitive organization which act as filters, templates or stereotypes to summarize the individual’s experience of the world and enable him or her to organize their behavior” (Free, 1999, p. 11).

(3) “Logical errors are errors in the process of reasoning, such that a distorted conclusion or inference is drawn from the facts. Examples are making a general conclusion on the basis of insufficient data, or deciding that an event has a totally negative meaning on the basis of a lack of positive meaning” (Free, 1999, p. 11).

(4) “The cognitive triad is concerned with the content of thoughts. Both automatic thoughts and schemas have content, and logical errors act to bias this content to make it more extreme. In depression, the content is mostly negative, and is about the self, the world, and the future. The result is extremely negative automatic thoughts and schemas concerning oneself, the world, and the future that are derived from logical errors in interpreting sensory data” (Free, 1999, p. 12).

Unrealistic and distorted thoughts disturb clients. Therefore, in therapy clients will be helped to identify the thinking errors which lead to negative moods and behavior. Most common thinking errors are as follows:

1. All or nothing thinking. In this type of thinking the client evaluates self, other people, situations, and the world in extreme categories; this thinking is absolutist, and does not allow for ambiguity. For example, the young mother who regards herself as entirely bad because she is frustrated with her young child, and regards other mothers as always being patient with their offspring. Hence, she takes the unrealistic viewpoint of seeing other mothers as all good, and herself as all bad (Curwen, Palmer & Ruddell, 2000).

2. Personalization and blame. This is a thinking error in which one totally blames oneself for everything that goes wrong and relates this to some inadequacy in oneself. The person assumes personal responsibility for an event which is not entirely under his or her control. For example, a trainee who believes the trainer is rude because she made an error and overlooks the role of others
and disregards the possibility that she may have added to what happened, but was not entirely at fault. The opposite is blaming others for one’s problems or circumstances and not believing one has a part in the problem. An example is the wife who totally blames her spouse for their divorce (Curwen et al., 2000).

3. Catastrophizing. In catastrophizing, the person predicts the future negatively, and thinks everything will turn bad. This thinking error is usually associated with anxiety problems; clients tend to mull on the worst possible outcomes of the situation. For example, a manager asked to do a presentation for his company becomes preoccupied with the possibility that he will make a mess of it, get fired and become poor (Curwen et al., 2000).

4. Emotional reasoning. This is where one draws conclusions about an event based only upon feelings and ignoring any contrary evidence. For instance, the young man who has been waiting half an hour for his new girlfriend to arrive, feels rejected and thinks he has been ditched and does not consider other reasons for his partner’s delay such as missing the bus or having a flat tire (Curwen et al., 2000).

5. Should or must statements. This is where the person has a rigid idea of how she, others, or the world “must” or “should” behave. Preferences are turned into rigid demands. When these demands are unmet the person feels emotionally distressed and overestimates how bad it is when the expectations remained unsatisfied. For example, the gymnast doing a tough move degrades herself for making many mistakes. This leads to feelings of frustration so she avoids practice for days (Curwen et al., 2000).

6. Mental filter. This is where the person does not view the picture as a whole and concentrates on the one negative aspect. For instance, a woman receives many positive comments about her new hairstyle from friends, but one friend says she does not like that particular hair style. Therefore, she has this comment on her mind for a long time and wears a hat (Curwen et al., 2000).

7. Disqualifying or discounting the positive. This is where the person ignores the positive aspects of situations. For instance, a man produces very good meals on most occasions, but does not give himself any praise. He thinks of himself as being an awful cook (Curwen et al., 2000).
8. Overgeneralization. The person thinks that because an unpleasant event happened once, it will always happen. He makes sweeping generalized conclusions on the basis of one event. For example, a person who attended a job interview but did not get the position believes that he would be rejected for every job (Curwen et al., 2000).

9. Magnification and minimization. This is where the person who makes this thinking error when evaluating herself, other people or situations pays attention to the negative components and minimizes or plays down the positive aspects. When being appraised at work she pays attention to the areas where change is needed and pays little attention to a considerable range of positive aspect. Therefore, she concludes that this shows how inadequate she is (Curwen, et al., 2000).

10. Labeling. This is where the individual labels herself as a bad person. For instance, the mother we referred to in item 1, might label herself as a bad mother. When this thinking error is applied to others a client dislikes or disagrees with, he may say to himself, he is bad. The person will see others as globally bad, and may then feel angry with them. A person who makes an error at work may label herself as a totally stupid person (Curwen et al., 2000).

11. Jumping to conclusions. A person having this thinking error infers that a particular outcome will be negative, without having any evidence or even if the evidence points to a positive outcome. There are two main types of this thinking error: (1) mind reading. The person thinks she knows what others are thinking and does not consider other more plausible or likely possibilities. An example would be the client with social anxiety who thinks her work colleagues see her as inadequate person; (2) fortune telling. A person predicts that events in the future will turn out negatively. For instance, a person attending a routine chest X-ray assumes he has an important illness (Curwen et al., 2000). From Beck’s point of view, predisposing factors for a disorder may be genetic, or may be learnt in the person’s developmental years. Therefore, Beck’s theory of depression emphasizes this reality that “children exposed to a number of negative influences and judgments by significant figures would be prone to extract such negative attitudes and incorporate them into their cognitive organization” (Free, 1999, p. 12). Also, individuals who have negative interpretation of developmental experiences, shape negative schemas. These negative schemas relate to themselves, the world, and the future. The experiences may have been objectively negative. The schema may be conditional or absolute, as in ‘if I fail at something important’, ‘I am worthless’. Depression is then precipitated when an event occurs that is relevant to the schema and
therefore, activates it. For example, this could be failure experience in an activity seen as important (Free, 1999).

2.3.2.1 Therapeutic Process

In Beck’s approach, once a warm and empathic therapeutic relationship is established, the therapist uses some cognitive techniques in order to help clients to identify negative forms of thinking (James & Gilliland, 2003). An important part of the therapy is giving homework assignments. Between sessions, therapists ask clients to record their automatic thoughts and emotions they experience during the day. They are then asked to write rational responses to those thoughts and emotions (Nairne, 2009). This part of the therapy is “aimed at helping clients see and correct dysfunctional thoughts, assumptions, and behaviors” (Gelso & Fretz, 2001, p. 355).

According to Prochaska and Norcross (1999), in Beck’s cognitive approach, therapists ask these three questions:

(1) What's the evidence?

(2) What's another way of looking at it?

(3) So what if it happens?

In fact, by this approach clients will discover how irrational their assumptions are, and then realign their way of thinking.

2.3.2.2 Therapeutic Relationship

Due to the specific role of the therapist in Beck’s approach which is helping clients to discover their own faulty way of thinking, “rather than directly confronting clients with their irrational beliefs, Beck suggests it’s more therapeutic for clients to identify negative forms of thinking themselves” (Nairne, 2009, p. 498). Therefore, in Beck’s approach the first and the most important strategy is to develop a trustful and collaborative relationship through accurate empathy, warmth and genuineness. This kind of relationship enables the counselor to assess the client’s expectations regarding therapeutic success (James & Gilliland, 2003).
2.3.3 Mcmullin’s Cognitive Restructuring Therapy

According to Free (1999), Mcmullin has cited that “a single theory underlies all cognitive restructuring techniques that employ countering. This theory states that when a client argues against an irrational thought, and does so repeatedly, the irrational thought becomes progressively weaker” (p. 20). Although as Free (1999) has mentioned, much of the theory underlying Cognitive Restructuring Therapy is derived from RET, there are some important differences. Cognitions such as ‘I must be perfect’, and ‘I am worthless’ are neither inherently nor invariably painful, the trauma elicited by irrational ideas is itself derived by means of direct or vicarious conditioning. This contention immediately provides a link with therapeutic approaches such as systematic desensitization that are derived from classical conditioning models of emotion. It implies that deconditioning of conditioned emotional reactions may be a necessary adjunct to cognitive therapy (p. 20).

2.4 Effects of Rational Emotive Behaviour Therapy (REBT) on Self-esteem

Roghanchi, Mohamad, Mey, Momeni, and Golmohamadian (2013) studied the result of integrating Rational Emotive Behavior Therapy and Art Therapy on self-esteem and resilience. The study was an experimental type in which pre and post-test design were used. Participants were 24 Iranian university students who were randomly divided into two groups (experimental and control). The experimental group received 10 sessions of therapy. The results presented that the integration of Rational Emotive Behaviour Therapy (REBT) and art therapy increased the self-esteem and resilience of university students.

Min (2011) examined the efficacy of a community-based depression prevention program by evaluating depression, self-esteem, and quality of life on community people. The theoretical framework supporting the program was Ellis’s Rational Emotive Behavior Therapy (REBT). Design of the study was nonequivalent control group pretest-posttest. Participants were divided into experimental group (n=14), and control group (n=15) from 29 community residents. 6 weeks (a twelve-session) depression prevention program, made up of music activity, bibliotherapy, and cognitive behavior therapy was conducted. Data was gathered before and after the program and 3
months later for follow-up analysis. The results indicated that depression prevention (based on Rational Emotive Behavior Therapy) programs are effective in reducing depression and increasing self-esteem in people suffering from depression symptoms.

Lim et al. (2010) studied the efficiency of a cognitive-behavioral program for nursing student's career attitude maturity, decision making style, and self-esteem in Korea. Participants were 40 nursing students from one college located in Gyeonggi Province. Participants were randomly divided into an experimental group (n= 20) and a control group (n=20). 8 sessions (each session 60 minute) of cognitive-behavioral therapy were conducted. The results revealed that cognitive-behavioral therapy had a positive impact on enhancing self-esteem for nursing students in Korea.

The study by Valizadeh and Emamipoor (2007) inspected the effect of Rational Emotive Behavior Therapy on the self-esteem of blind female students. For this purpose, twelve participants were carefully chosen and divided into experimental and control groups equally. The results showed that Rational Emotive Behavior Therapy raises the overall, family and social self-esteem of the subjects. But, physical and educational self-esteem didn’t have significant changes by the therapy.

Larkin and Thyer (1999) evaluated the effectiveness of cognitive behavioral group counseling presented to behaviorally disruptive elementary school children. Cognitive behavioral group counseling was conducted for fifty-two referred children. Students were randomly divided into two groups- immediate (IT) group counseling and delayed treatment (DT). The two groups were unevenly homogenized on most demographic and result measures at the first valuation. After group counseling, the IT groups’ self-esteem, perceived self-control, teacher, and teacher aide grades of classroom comportment were meaningfully enhanced, whereas the same measures of the DT children did not noticeably change. The DT children then received the equal group program the IT group was subjected to three months earlier, and when group counseling was completed (third assessment), the DT group gained enhancements similar to those gained by the IT group. In inference, for behaviorally disruptive elementary school students, cognitive behavioral group work can be an efficient intervention.
Ngai and Min (1998) investigated the efficacy of REE group programme for adolescents who have low self-esteem. The 40 adolescents were put into treatment and control groups according to their preferences. These adolescents aged 12 to 14 came from a band one Government school. The treatment programmes consisted of 6 weekly sessions of one to one hour thirty minutes duration that were held at the school. They were either conducted after school or during lunch hours. Students in both groups were measured by quantitative and qualitative methods to evaluate the efficacy of REE. SDQ and MESSY questionnaires were used as pre-tests and post tests for quantitative measurement and semi structured interviews were conducted to collect qualitative data. The results showed that the students in the treatment groups who received REE showed significant increase in their self-esteem, this is only the qualitative results. The quantitative results showed no significant differences between the treatment and the control groups.

Warren, McLellarn, and Ponzo ha (1988) “compared the relative effectiveness of “preferential” rational emotive therapy (RET) and general cognitive behavior therapy (CBT) in the treatment of low self-esteem and related emotional disturbances. 33 subjects were randomly distributed in to RET, CBT, and waiting-list control (WLC) groups. 8 week therapy group sessions were conducted. Results indicated that at posttest, both the RET and CBT groups changed significantly more than the WLC group on all measures: self-esteem, depression, general and social-evaluative anxiety, anger, and rational thinking. On the self-esteem and self-efficacy measures, the CBT group changed significantly more than the RET group. At a six-month follow-up, both the RET and CBT groups maintained their gains, and there were no significant differences between groups on any measure”.

2.4.1 Summary of Findings

Enormous literature review supported the hypotheses that Rational Emotive Behavior Therapy (REBT) has positive impact on increasing self-esteem.

2.5 Effects of Rational Emotive Behavior Therapy (REBT) on Aggression
Dawoodi (2013) investigated the effectiveness of Rational Emotive Behavior Therapy on adolescents who had conduct disorder. The sample for the study comprised 1142 students of different schools and colleges at Mysore, Karnataka, India. The participants were asked to complete the Youth Self Report (YSR) Achenbach and Rescorla (2001) forms. Following this, adolescents with conduct disorder were selected. From 1142 students 200 students (100 girls and 100 boys) were selected for the sample. They were divided into control group (50 girls and 50 boys), experimental group (50 girls and 50 boys). 7 sessions of Rational Emotive Behavior intervention was given over seven weeks. The samples were divided into groups of 10. The participants learned about Rational Emotive Behavior Therapy (REBT) and how to use it on their problems. Post-test was taken after one month to find the differences between pre-test and posttest. Repeated measure ANOVA was used for analysis of data. Results showed that after intervention a significant reduction was shown in the conduct disorder symptoms and other emotional and behavioural problems among adolescents.

Moral (2011) attempted to find out an effective treatment in treating anger. The study highlights efficiency of alternative methods such as Homeopathy in medicine, Rational Emotive Behaviour Therapy (REBT) in psychotherapy, and Yoganidra in yoga for the treatment of anger. The results showed that Rational Emotive Behaviour Therapy (REBT) with its cognitive behavioural approach helped the patient to correct their irrational beliefs and change them into rational ones.

Liu, Ho, and Song (2011) “examined the association between online and real-world aggressive behavior among primary school students. Also, investigated the effects of an online rational emotive curriculum on decreasing the inclination of students to show aggression online and in the real-world”. The results revealed that after online rational emotive curriculum, students with strong hostile tendencies showed less aggressive behavior.

The study by Kumar (2009) examined the effect of Rational Emotive Behaviour Therapy (REBT) on adolescent students with conduct disorder. 100 boys and 100 girls participated in this study in Mysore city. Rational Emotive Behaviour intervention was conducted on an experimental group, in seven weeks. The results of the study showed that Rational Emotive Behaviour Therapy (REBT) has a positive impact on conduct disorder and other emotional and behavioural disorders co-morbid with conduct disorder experienced by adolescents.
Barekatain, Taghavi, Salehi, and Hasanzadeh (2006) examined the efficacy of Rational Emotive Behavioral versus Relaxation group therapies in treatment of aggression of offspring of veterans with post-traumatic stress disorder. The study exposed that aggression behavior among male adolescents of war veterans with PTSD were less in intervention groups compared to control group.

Sharp (2003) examined anger management group training program based on Rational Emotive Behaviour Therapy (REBT). The results suggested that anger management group training may be effective in teaching children the principles of Rational Emotive Behavior Therapy (REBT). Such knowledge may lead to an increase in the use of these principles for anger management, thus reducing aggressive behavior.

Morris (1993) examined the effects of a twelve-week treatment program, based on Rational emotive Therapy (RET). The samples for the study were twelve adolescents with conduct disorders (CD) and twelve adolescents with attention-deficit hyperactivity disorders (ADHD). The first two weeks of the rational emotive therapy intervention concentrated on assessment, relationship building and personal matters of students. In the following eight weeks, learning how to deal with self-defeating thoughts that navigated to emotional disturbance was the principal point. Special attention was paid to anger and depression. The results of the study indicated that response to the rational emotive therapy was different between adolescents with conduct disorders and adolescents with attention-deficit hyperactivity disorders. Irrational thinking, depression and symptoms of anger decreased significantly among adolescents with conduct disorders but these dependent variables didn’t reduce after intervention among adolescents with attention-deficit hyperactivity disorders. Morris concluded that thinking in adolescents with attention-deficit hyperactivity disorders may be connected to biological/physiological factors inherent in these adolescents. So, adolescents with attention-deficit hyperactivity disorders ascribed their behavior to a chemical imbalance.

Lochman (1992) studied the impact of cognitive-behavioral intervention with boys who have aggression. After three years, the control group (boys who did not received any treatment) was compared to the boys who had received an anger coping (AC) program. Results showed that rates of drug and alcohol involvement were less among the experimental group (AC boys) than among the control group. Also levels of self-esteem and social problem-solving skills were higher
in AC boys. At follow-up, the AC boys were similar to previously nonaggressive boys on these variables.

Hajzler and Bernard (1991) reviewed published studies and published doctoral dissertations on the effectiveness of rational emotive education for youth and found a decrease of irrationality in over 88% of the studies, and increase in the internal locus of control in 71% of the studies, a decrease in anxiety in 80% of the studies, and effectiveness in increasing self-esteem and decreasing behavior problems in over 50% of the studies.

Lochman, Lampron, Gemmer, Harris, and Wyckoff (1989) compared the impacts of two versions of the Anger Coping program to an untreated control situation. Cognitive-behavioral and social problem-solving training was conducted for Anger Coping conditions and one of the conditions involved an adjunctive teacher consultation component, planned to improve teachers' facilitation of their students' problem solving skills. Eleven boys received Anger Coping programme. For thirteen boys Anger Coping plus teacher consultation programme was conducted. Eight boys belonged to untreated controls. The average age of participants was about eleven. The results indicated that the boys who received treatment showed development in their disruptive-aggressive off-task classroom behavior and in their perceived social competence and they also showed decreases in their teachers' assessments of their aggressiveness.

Lochman (1985) investigated the impact of different treatment lengths in cognitive behavioral interventions with boys who have aggression. The results of the study showed that the length of treatment had an important impact on the result of cognitive behavioral treatment of aggressive boys. Therefore by conducting a quasi-experimental design, a longer eighteen session intervention showed more significant changes in classroom behavior compared to a twelve session intervention.

Lochman, Burch, Curry, and Lampron (1984) examined the treatment and generalization effects of cognitive–behavioral and goal-setting interventions with aggressive boys. Sample for the study were seventy-six males (9–12 years). Participants were divided into anger-coping, goal-setting, anger–coping plus goal-setting, or no-treatment groups. Anger-coping interventions were school-based secondary prevention attempts that used social problem-solving and cognitive-
behavioral techniques. After one month follow up was done; aggressive behavior in the classroom and at home was reduced and self-esteem was increased among the anger-coping treatment group.

Block (1978) studied 11th and 12th grade Black and Hispanic failure-and misconduct-prone students. The intervention was carried on for five weeks of rational emotive education group sessions. When compared with alternative treatment groups and non-treatment controls, the treatment groups showed less incidents of disruptive behavior over an extended period of time, as well as improved GPA and fewer incidents of cutting class.

2.5.1 Summary of Findings

Rational Emotive Behaviour Therapy (REBT) provides an effecting model for treating aggressive children. It is an integrative therapy that incorporates many interventions to accomplish its goal. Rational Emotive Behavior Therapy (REBT) involves strategies for learning to control dysfunctional emotions. It can be used to treat aggressive children in two ways: by teaching children to control the underlying angry emotions that lead to aggression and by teaching parents to control their disruptive emotions that interfere with effective parenting skills (Digiepepe & Kelter, 2006).

2.6 Effects of Rational Emotive Behavior Therapy (REBT) on Depression

Flanagan, Allen, and Henry (2009) investigated the “effect of Anger Management Treatment (AMT) and Rational Emotive Behavior Therapy (REBT) in a Public School Setting on Social Skills, Anger Management, and Depression”. Participants were received Anger Management Treatment (AMT) or Anger Management (AMT) plus Rational Emotive Behaviour Therapy (REBT). Samples were completed Social Skills Rating System, the Children’s Depression Inventory and the Children’s Inventory of Anger. The outcomes indicated that combined Anger Management Treatment (AMT) and Rational Emotive Behavior Therapy (REBT) resulted in alleviating anger as well as depression and enhancing social skill.

Sava, Yates, Lupu, Szentagotai, and David (2009) compared Cognitive Behaviour Therapy (CBT), Rational Emotive Behavior Therapy (REBT) and Fluoxetine for major depressive
disorder in a randomized clinical trial with a Romanian sample of 170 clients. Each intervention was conducted for 14 weeks, plus three booster sessions. Beck Depression Inventory (BDI) scores were obtained before the intervention, 7 and 14 weeks following the start of intervention, and 6 months were following completion of intervention. The results showed significant development for all three treatments at 6 months’ follow-up. Cognitive Behaviour Therapy (CBT), Rational Emotive Behaviour Therapy (REBT), and Fluoxetine did not differ significantly in changes in the BDI, depression.

David, Szentagotai, Lupu, and Cosman (2008) observed the comparative efficacy of Rational Emotive Behaviour Therapy (REBT), Cognitive Therapy (CT), and Pharmacotherapy in the treatment of 170 outpatients with nonpsychotic major depressive disorders. One of the treatments- 14 weeks of Rational Emotive Behavior Therapy (REBT), 14 weeks of Cognitive Therapy (CT), or 14 weeks of Pharmacotherapy (fluoxetine) was randomly given to the patients. Hamilton Rating Scale for Depression and the Beck Depression Inventory were used to measure the nonpsychotic major depressive disorders. The result indicated that no differences among treatment conditions at posttest were detected. A larger effect of Rational Emotive Behavior Therapy (REBT) (significant) and Cognitive Therapy (CT) (nonsignificant) over Pharmacotherapy at 6 months’ follow-up was noted on the Hamilton Rating Scale for Depression only.

Horowitz, Garber, Ciesla, Young, and Mufson (2007) examined the efficacy of intervention programs for preventing depressive symptoms in adolescents. 380 high school students were randomly received 8 sessions involved 90 minutes weekly Cognitive Behavioral Program (CB), an Interpersonal Psychotherapy Adolescent Skill Training Program (IPT-AST) or a no-intervention control. Results indicated that both Cognitive Behavioral Program (CB), an Interpersonal Psychotherapy Adolescent Skill Training Program (IPT-AST) were effective for reducing depression than did those in the no intervention group.

The study by Habib and Seif El Din (2007) evaluated the effectiveness of Cognitive Behaviour Therapy (CBT) for 12-14 years old school children. 198 boys and 136 girls were participated in the study. Child Depression Inventory and the Coopersmith Self-esteem Inventory were distributed among subjects. 32 children with depression were received Cognitive Behaviour Therapy. Results showed the effectiveness of Cognitive Behaviour Therapy in reducing depressive symptoms.

Marcotte (1997) evaluated the efficacy of Cognitive Behavioural Therapy on adolescent depression. The outcomes indicated that short-term group Cognitive Behavioural Interventions are effective with early and late adolescents.

The study by Borkovec and Andrews (1987) compared Relaxation plus Cognitive Therapy and Relaxation plus Nondirective Therapy in reducing depression. The subjects were 30 volunteers who met depressive symptoms. 12 sessions of training in progressive Muscular Relaxation were conducted on them. 16 of them were given Cognitive Therapy during ten of those sessions and the remaining 14 received Non directive Therapy. The Results indicated that both groups shows reductions in depressive symptoms and daily self-monitoring although Relaxation plus Cognitive Therapy produced significantly greater improvement than Relaxation plus Nondirective Therapy on several pre-therapy, post-therapy comparisons.

In the study by Reynolds and Coats (1986) 30 moderately depressed high school students were randomly assigned to Cognitive Behavioral Treatment, Relaxation Training, or a Wait-list control condition. The Beck Depression Inventory, the Rosenberg Self-Esteem Scale, and the State-Trait Anxiety Inventory were distributed among subjects. Treatment was conducted for 10 sessions each session 50-minute in a high school setting. The results showed that the Cognitive-Behavioral and Relaxation Training groups were superior to the Wait-list control group in the reduction of depressive symptoms at both posttest and 5-wk follow-up assessments.

2.6.1 Summary of Findings

Rational Emotive Behavior Therapy (REBT) is currently one of the most broadly practiced forms of cognitive behavioral psychotherapy (Ellis & Dryden, 1997). A huge number of psychotherapy outcome studies confirm the effect of this form of therapy with a wide range of clinical disorders such as depression (DiGiuseppe, Miller, & Trexler, 1977; Haaga & Davison, 1993; Kendall et al., 1995).
2.7 Self-esteem and Aggression

Understanding the relationship between self-esteem and aggression is a recent debate. Teachers, parents, therapists, and others have concentrated efforts on increasing self-esteem, on the hypothesis that high self-esteem will cause many positive results and welfare (Baumeister, Campbell, Krueger, & Vohs, 2003). One longstanding view in psychology believes that low self-esteem is a cause of aggression. Having low self-esteem feels bad, whereas having high self-esteem feels good. Therefore it may seem logically to infer that having low self-esteem is associated with bad things, such as behaving aggressively (Thomaes, Bushman, & Thomaes, 2011). On the other hand, some studies discovered that high levels of self-esteem and/or narcissistic personality features lead to aggressive behavior but not directly. According to this view, people with big egos become aggressive when others threated their inflated egos, for example when someone gives a negative feedback to him/her)

A study by Zeigler-Hill, Enjaian, Holden, and Southard (2014) attempted to clarify the association between self-esteem and aggression by examining the possibility that self-esteem instability moderates the association that self-esteem level has with aggression. Perceived aggression was measured in 234 (34 men and 200 women) undergraduate participants. These participants were then evaluated by 1078 friends and family members. Self-esteem instability was understood to moderate the association between self-esteem level and aggression such that individuals with stable high self-esteem were viewed as being less aggressive than those with unstable high self-esteem or low self-esteem (regardless of whether their low self-esteem was stable or unstable).

Wang et al. (2013) examined the alterations in the level of self-esteem among adolescents with different characters in aggression involvement (aggression perpetrators, victims, perpetrator-victims and neutrals) with regard to gender. The results indicated that self-esteem in the adolescents who have different types of aggression is not the same as in those without involvement. In females, aggression victims had low self-esteem. However, there was no significant difference in self-esteem among perpetrators, perpetrator-victims, and neutrals. In males, victims and perpetrator-victims had lower self-esteem than in neutrals and perpetrators; however self-esteem between victims and perpetrator-victims or between perpetrators and neutrals was the same.
Zeigler-Hill and Wallace (2012) examined the psychological adjustment of individuals with stable and unstable forms of self-esteem across three studies. The sample for this purpose was undergraduate students. The first study (N=122) on undergraduates involved indicators of global distress and aggression; the second study (N = 199) concentrated on depression, hopelessness, anxiety, and rejection sensitivity; and the third study (N = 183) studied global distress, affect, and psychological well-being. The results showed that across each study, unstable self-esteem was understood to moderate the association between self-esteem level and psychological adjustment. The design of these results proposed that individuals with unstable low self-esteem are particularly probable to experience dejection, whereas those with unstable high self-esteem are probable to experience agitation.

A study by Bushman et al. (2009) reanimated the hypothesis that low self-esteem causes aggression. They reanalyzed the data from a preceding experiment and administered a new experiment to study direct physical aggression. They also administered a field study by using a measure of indirect aggression using the method of a consequential negative assessment. Results found high narcissist participants were more aggressive than other participants but only when triggered by insult or humiliation and merely toward the source of criticism. The composition of high self-esteem and high narcissism shaped the highest levels of aggression. These results confirm the view that aggression stems from threatened egotism and are contrary to the hypothesis that low self-esteem is the reason for either direct or indirect aggression.

(Locke, 2009) surveyed aggression, narcissism, self-esteem, and the imputation of desirable and humanizing traits to self-versus others. 156 undergraduates completed the questionnaire on aggression, self-esteem, and narcissism. The results indicated that self-esteem and narcissism had opposite effects on aggression and performed as mutual suppressors: Controlling their shared variance bolstered self-esteem’s negative association with aggression and narcissism’s positive association with aggression.

Thomaes, Bushman, Stegge, and Olthof (2008) examined how self-views effect shame-induced aggression. Narcissism and self-esteem questionnaire were completed by one hundred and sixty-three adolescents. They lost to a simulative rival on a competitive task. In the shame situation, they were told that their rival was bad, and they saw their own name at the lowest of a ranking list. In the control situation, they were told nothing about their rival and did not see a ranking list. Following this, members could blast their rival with noise (aggression measure). Aggression was
more among narcissistic children, but only after they had been shamed. Outcomes established that low self-esteem did not lead to aggression. In fact, narcissism in composition with high self-esteem led to remarkably high aggression.

Donnellan, Trzesniewski, Robins, Moffitt, and Caspi (2005) discovered the controversial connection between global self-esteem and externalizing problems such as aggression, antisocial behavior, and delinquency. Self-esteem and externalizing problems based on self-report, teachers’ ratings, and parents’ ratings were measured in three studies for contributors from different nationalities such as the United States and New Zealand and different age groups such as adolescents and college students. The results indicated that the effect of self-esteem on aggression was independent of narcissism, and a significant discovery given recent claims that individuals, who are narcissistic, not low in self-esteem, are aggressive.

D’zurilla, Chang, and Sanna (2003) studied the relationships between self-esteem, social problem-solving ability, and aggression. The samples were 205 college students. For the study, the Social Problem-Solving Inventory-Revised was used to measure five different dimensions of social problem-solving ability (viz., positive problem orientation, negative problem orientation, rational problem solving, impulsivity/carelessness style, & avoidance style), and the Aggression Questionnaire was used to measure four different dimensions of aggression (viz., physical aggression, verbal aggression, anger, & hostility). Self-esteem and social problem-solving ability were measured at the same time, whereas aggression was measured six to seven weeks later. The results indicated that low self-esteem was related to anger and hostility, and several specific problem-solving dimensions were found to be related to anger, hostility, and physical aggression.

Bushman and Baumeister (1998) measured, in two studies, both simple self-esteem and narcissism, and then the contributors were given a chance to be aggressive towards someone who had insulted them or praised them or against an innocent third person. The results indicated that self-esteem proved irrelevant to aggression. The combination of narcissism and insult in a person led to remarkably high levels of aggression in the direction of the source of the insult.

The study by Perez, Vohs, & Joiner (2005) examined the two opposite theories- that high self-esteem is accountable for aggression and that low self-esteem is accountable for aggression. The participants’ self-esteem and self-reported physical aggressions were assessed; moreover, the participants’ roommates described their esteem for the target. The findings suggested that both
theories may be right. In agreement with both theories, self-esteem was related to aggression in a curvilinear fashion, showing that probably physical aggression among people who have very low or very high self-esteem was more in contrast to the people who have moderate self-esteem. This phenomenon was somewhat qualified by interpersonal setting; specifically, contributors who thought about themselves more positively than their roommates thought of them as well as contributors who thought less affirmatively of themselves than their roommates thought of them described higher levels of physical aggression. Participants whose low or high self-esteem corresponded to the roommates’ esteem of them did not report physical aggression.

O’Moore and Kirkham (2001) elucidated further understanding of the association between self-concept and bullying behaviour. From the rapidly increasing literature on bullying, it is progressively recognized that peer relationship difficulties such as being bullied are related to low self-esteem.

However, the literature on self-esteem in relationship to children who bully others is erratic. Documents from a nationwide research of bullying behaviour conducted in Ireland during 1993-1994 have been studied. The pertaining outcomes from 8,249 school children aged between 8 to 18 years are reported. The research studied the global and dimensional nature of self-esteem and how it connects to children and adolescents who either have been victimized or bullied others. “Pure victims,” “pure bullies,” and children and adolescents who were both bullied and who bullied others were dividing into different groups. The participants who were bullied and bullied others were subdivided further into victims who bully occasionally, sometimes, and frequently and bullies who are victimised occasionally, sometimes, and frequently. The outcomes indicated that global self-esteem was low in children of both primary and post-primary age who were involved in bullying as victims, bullies, or both and had meaningfully lower global self-esteem than did children who had neither bullied nor been bullied. However, the pure bullies, in contrast to the pure victims, located the same value on their physical attractiveness and traits and on their popularity as did their peers who had not bullied others or been bullied. Bully-victims groups reported the lowest self-esteem. Also, the children who were victimised or bullied others, had lower global self-esteem. The typology and occurrence of recurrence of bullying and the age of the children when they were preoccupied in bullying influence the position of the specific domains of self-esteem. The results indicated that high self-esteem defends children and adolescents from participation in bullying.
2.7.1 Summary of Findings

The majority of research supports a relationship between self-esteem and aggression. An enormous volume literature suggests that low self-esteem is a source of aggression. Analyses of aggression and violent acts have concentrated on perpetrators with low self-esteem.

2.8 Self-esteem and Depression

Cognitive vulnerability models of depression attempt to identify risk factors that increase the likelihood of disorder onset and maintenance. Common across models is the salient role of a negative self-view construct (e.g., self-esteem, self-concept) that stems from the negative inferential style that is characteristic of depression (Sutton et al., 2011). During early adolescence, self-views become more negative as the positivity bias that is present during childhood decreases (Baumeister & Tice, 1986), and identity confusion peaks (Erikson, 1968). Therefore, decreased levels of self-esteem during the identity confusion phase may increase vulnerability for depression in adolescents. One prominent mental health disorder during adolescence is major depressive disorder (MDD) (Wittchen, Nelson, & Lachner, 1998), and lifetime prevalence rates by the age of 18 are 5.5% and 11.2%, respectively. Adolescent MDD increases the risk of more severe depression symptoms in adulthood, as well as suicidal behavior (Pine, Cohen, Gurley, Brook, & Ma, 1998; Wittchen, Stein, & Kessler, 1999; Zisook et al., 2007).

Previous cross-sectional studies have consistently observed lower self-esteem in those with relatively higher levels of depression, both in adults (Ginsburg, La Greca, & Silverman, 1998; Hammond & Romney, 1995) and adolescents (Jong, Sportel, Hullu, & Nauta, 2012; Moksnes, Moljord, Espnes, & Byrne, 2010). A recent meta-analysis of 95 longitudinal studies (77 on depression, 18 on anxiety) suggests that low self-esteem was predictive of both symptoms of depression and anxiety (Sowislo & Orth, 2013). Although Sowislo and Orth (2013) found age not to be a moderator of the effect size in the relationship between self-esteem and symptoms of depression, it is also important to acknowledge that findings observed in adulthood and late adolescence might not be observed in a younger adolescent sample, particularly since several
studies argue that adulthood depression and anxiety differ etiologically and neurologically from adolescent and child depression and anxiety (Kaufman, Martin, King, & Charney, 2001).

While the vulnerability model in the current context suggests that relative decreases in self-esteem increases risk for later symptoms of psychopathology, a longitudinal relationship could also, theoretically, occur in the opposite direction. The “scar hypothesis” refers to residual negative cognitions following a depressive episode (Lewinsohn, Steinmetz, Larson, & Franklin, 1981). In the current context, a model based on the scar hypothesis would suggest that self-esteem is lowered as a consequence of depression (Zeigler-Hill, 2011). In the meta-analysis by Sowislo and Orth (2013), a significant reciprocal relationship was observed where prediction of self-esteem by depression was weaker than the prediction of depression by self-esteem.

Steiger, Allemand, Robins, and Fend (2014) examined how decreasing self-esteem during adolescence predicts adult depression two decades later. The results demonstrated that both level and change in self-esteem served as predictors for adult depression. Individuals who entered adolescence with low self-esteem, and/or whose self-esteem declined further during the adolescent years, were more likely to exhibit symptoms of depression 2 decades later as adults; this pattern held both for global and domain-specific self-esteem.

Orth, Robins, Widaman, and Conger (2014) observed the relationship between low self-esteem and depression by using longitudinal data. Participants of the study were 674 Mexican-origin early adolescents’ with ages ranging between 10 and 12 years. The outcomes agreed with the vulnerability model, which explained that low self-esteem is a potential risk factor for depression. Furthermore, the outcomes recommended that the vulnerability effect of low self-esteem is determined, for the most portion, by general assessments of worth (i.e., global self-esteem), rather than by domain-specific assessments of academic capability, physical appearance, and capability in peer relationships.

The longitudinal study by Tuijl, Jong, Sportel, de Hullu, and Nauta (2014) aimed to test the association between implicit and explicit self-esteem and symptoms of adolescent depression and social anxiety disorder. Two complementary models were tested: the vulnerability model and the scarring effect model. Method: the participants were 1641 first and second year pupils of secondary schools in the Netherlands. The Rosenberg Self-Esteem Scale, Self-esteem Implicit
Association Test and Revised Child Anxiety and Depression Scale were used to measure explicit self-esteem, implicit self-esteem and symptoms of social anxiety disorder (SAD) and major depressive disorder (MDD), respectively, at baseline and at two year follow-up. The findings indicated that explicit self-esteem at baseline was associated with symptoms of major depressive disorder and implicit self-esteem was not associated with symptoms of major depressive disorder in either direction.

Zheng, Wang, Yu, Yao, and Xiao (2014) examined a 6-month longitudinal study on how self-esteem forecasts symptom dimensions of depression. 659 participants from the University of Hunan Province, China participated in the baseline and the 6-month follow-up study. Low self-esteem, depressive symptoms, and the occurrence of daily hassles were measured by participants. The contributors afterwards completed measures assessing daily hassle and depressive symptoms once per month for 6 months. The outcomes of the study recommended that low self-esteem plays an eminent role in the etiology and course of depressive symptoms that progress in response to exposure to daily hassles.

Pavlickova, Turnbull, and Bentall (2014) examined the discrepancies between explicit and implicit self-esteem and their relationship to symptoms of depression and mania. Thirty children of parents with bipolar disorder and 30 offspring of control parents completed the Hamilton Rating Scale for Depression, the Bech-Rafaelson Mania Scale, the Self-esteem Rating Scale and the Implicit Association Test. The results showed that no differences between groups were revealed in levels of explicit or implicit self-esteem. However, the bipolar offspring showed increased levels of symptoms of depression and mania. Furthermore, depressive symptoms were associated with low explicit self-esteem, whilst symptoms of mania were associated with low implicit self-esteem. When self-esteem discrepancies were examined, damaged self-esteem (i.e. low explicit but high implicit self-esteem) was associated with depression, whilst no associations between mania and self-esteem discrepancies were found.

Benony, Elst, Chahraoui, Benony, and Marnier (2006) verified the connection between depression and academic self-esteem in gifted children. 58 students subdivided into two groups (gifted children and adolescents versus control children and adolescents). From these 58 participants who took part in the measures, 8 were removed either because of their outcomes on the "lie" scale of the self-esteem scale (score greater than or equal to 5) or because of their age. In
effect, a high score on this scale implies that the subjects want to show themselves in a better light than is actually correct. It is then explained that the participants had sought the examiner's endorsement by showing the best probable image of themselves. 23 gifted children aged between 9 and 13 years participated in the study. The participants who had greater than or equal to 130 score on Weschler tests (WPPSI or WISC III depending on age) were attending private schools (20) and schools in the state education system (3). The outcomes showed that the gifted children in the study demonstrated a lack of self-esteem, and in particular a lack of academic self-esteem, combined with depressive symptoms.

Kreger (1995) examined self-esteem, stress, and depression among graduate students. In a study of 25 graduate students self-ratings of stress correlated with low scores on self-esteem but were not related to an objective indicator of actual stress. The results indicated that low self-esteem scores were related to scores on depression with a weak interaction effect.

Workman and Beer (1989) studied self-esteem, depression, and alcohol dependency among high school students. 123 participants underwent the short form of the coppersmith Self-esteem inventory- school form and its lie scale, Beck’s Depression Inventory, and an Alcohol dependency scale. The results showed that significant and negative correlations were between self-esteem scores and depression, but self-esteem and lie scores values were significant between depression and alcohol dependency scores.

Battle (1987) examined the relationship between self-esteem and depression among children. 62 boys and girls from fourth to ninth grade participated in the study. The correlations were significant and ranged from (.44 to .83) between scores on all facets of a modified version of Beck’s depression inventory and the culture free self-esteem inventory for children.

Battle (1980) determined the relationship between self-esteem and depression in high school students. 26 participants, males and females 15 to 18 years participated in the study. Each participant underwent a self-esteem checklist and two measures of depression. The results indicated that there was a significant correlation (.34 to .75) between self-esteem and depression for both measures of depression.
2.8.1 Summary of Findings

The majority of studies supporting a relationship between self-esteem and depression agree with Cognitive vulnerability models of depression. According to this model, a relative reduction in self-esteem increases the risk for later symptoms of psychopathology; a longitudinal relationship could also, theoretically, happen in the contradictory direction.

2.9 Aggression and Depression

Prima facie, there appears to be little resemblance between depression and aggression (see for example, Zuravin, 1989). Depression connotes lethargy and sluggishness, making a person too listless to be aggressive. The Diagnostic and Statistical Manual of Mental Disorders DSM-IV-TR (2000) lists the following as criteria for a Major Depressive Episode: “feelings of sadness, diminished interest in activities, fatigue and diminished ability to think or concentrate, indecisiveness, recurrent thoughts of death” (APA, 2000, p. 366).

A number of studies have reported increased likelihood of aggression in samples reporting depression.

A study by Dervic et al. (2015) investigated the distinguishing features between bipolar I, II and unipolar depression, and impulsivity/aggression traits in particular. Six hundred and eighty-five (n = 685) patients in a major depressive episode with lifetime Unipolar (UP) depression (n = 455), Bipolar I (BP-I) disorder (n = 151), and Bipolar II (BP-II) (n = 79) disorder were compared in terms of their socio-demographic and clinical characteristics. The results showed that BP-I and BP-II depressed patients had higher lifetime impulsivity, aggression, and hostility scores. With regard to bipolar subtypes, BP-I patients had more trait-impulsivity and lifetime aggression than BP-II patients whereas the latter had more hostility than BP-I patients.

Nantel-Vivier, Pihl, Côté, and Tremblay (2014) described and predicted the combined development of prosocial behaviour with externalizing and internalizing problems (physical aggression, anxiety and depression) from 2 to 11 years of age. The results indicated that maternal depression increased the probability of moderate aggression.
Dutton and Karakanta (2013) studied a critical review on Depression as a risk marker for aggression. Empirical studies indicated that depression is a risk marker for several forms of aggression. Most studies reviewed did not assess aggression temporally following depression, and attributions of cause for depression become diffused under strong emotion, also, isolation, alcohol use, rumination and impulsivity linked depression and aggression.

Kaltiala-Heino, RimpelÄ, Rantanen, and RimpelÄ (2000) examined bullying and victimization in relation to psychosomatic symptoms, depression, anxiety, eating disorders and substance use. A number of Finnish adolescents 14 to 16 years old participated in the School Health Promotion Study (n=8787 in 1995, n=17643 in 1997). The results indicated that among bully-victims group and bullies and victims group anxiety, depression and psychosomatic symptoms were most frequent. In adolescence bullying should be considered as an indicator of risk of various mental disorders.

A study by Bjork, Dougherty, and Moeller (1997) investigated a positive correlation between self-ratings of depression and laboratory-measured aggression. In order to study this relationship researcher used an objective measure of aggression; the samples were normal controls 42 women and 23 men. The findings display that there was a significant positive correlation between the level of aggressive responses and the level of depressive symptoms in women but not in men.

Slee (1995) inspected the relationship between three dimensions of children’s peer relations, namely, the tendency to be victimized, to bully and to be prosaically and depression. Questionnaires were directed to 353 primary school students assessing various dimensions of peer relations and depression. Results specified that the tendency to be victimized was found to be significantly associated with depression. Excitingly there was also a significant association between depression and the tendency to bully.

Weiss and Catron (1994) scrutinized 350 public school children; the results found a significant relationship between depression and aggression. In fact, researchers found a significant positive correlation between externalizing (consisting of hyperactivity/attentional problems and aggression) and internalizing (depression and anxiety). They also concluded that the broadband
set of relationships found did not support the theory that depression directly causes aggression, but was more consistent with the theory that the consequences of aggression cause depression.

2.9.1 Summary of Findings

The majority of research support increased likelihood of aggression in samples reporting depression.

2.10 Rational Emotive Behavior Therapy (REBT) with Children and Adolescents

Flanagan, Povall, Dellino, and Byrne (1998) compared the efficacy of problem-solving and problem-solving plus Rational Emotive Behavior Therapy. The samples for the study were 44 (17 male, 27 female) public school youngsters aged 9-11 years. The participants were given a twelve-week group treatment to increase their social skills. Pretest-posttest design was used for the study. The samples were requested to complete the Social Skills Rating System and the Child-Adolescent Survey of Irrational Beliefs. The results showed that the participants who received problem-solving plus Rational Emotive Behavior Therapy were more improved in their social skills components than the group who received the problem-solving therapy.

Gossette and O'Brien (1993) reviewed comparisons of rational emotive education treatment, which is a form of RET used in schools to determine its effectiveness in forestalling future maladjustment through the early detection and eradication of irrational beliefs. 33 unpublished dissertations and 4 published reports found RET effective in about 25% of comparisons with wait list, placebo, and other treatment conditions. The major effects of RET were found to be more in scores on self-report measures of irrational beliefs and less on emotional distress. There was little or no change in behavior. Little justification was found for continued use of RET in schools.

Thorpe (1975) designed a study comparing the merits of rational emotive therapy (self-instructional training), systematic desensitization, behavior rehearsal, and a placebo control group, in increasing the assertiveness in college students. The students in the rational emotive therapy group were made aware of their irrational self-statements and rehearsed
more appropriate rational statements. In the systematic desensitization condition, the students were desensitized to making assertive responses via relaxation. The students in the behavioral rehearsal group observed the therapist model the appropriate responses, which they then rehearsed. In the placebo control group, the students discussed the etiology of non-assertiveness. The length of treatment was six sessions. Dependent measures included self-report, behavioral, and physiological ratings for a situational test in which the students had to respond assertively. Results indicated the general superiority of rational emotive therapy (self-instructional training).

Maultsby (1984) has developed a program with rational emotive therapy that is essentially designed for use in high schools and college classrooms. His goal was to teach students to utilize rational emotive therapy in analyzing their emotional upsets and to give them an effective method for solving their personal conflicts.

Maultsby, Knipping, and Carpenter (1974) investigated the efficacy of rational emotive therapy as a preventive measure. In a pilot study, two groups of emotionally disturbed high school students were used as the sample population. One group received the rational emotive therapy course and the other group served as a control group. The outcomes showed significant differences in the positive direction on all three measures in the group receiving the rational emotive course. A second study using college students again demonstrated that the group receiving the rational emotive course showed more pretest-posttest improvement on scales that were highly correlated with emotional adjustment.

Maultsby, Costello, and Carpenter (1974) attempted to validate the efficacy of rational emotive therapy as a preventing mental health program with college students. The sessions lasted for 75 minutes and met twice a week for 15 weeks. The instructor of the course was unaware of the nature of the hypotheses. A control group consisted of 30 students who were enrolled in an introductory psychology course taught by the same instructor. The dependent measure was a mental health adjustment scale. The results, as measured by the scores on the mental health adjustment scale, showed that the rational emotive therapy group yielded more positive results than the control group.

Since the elementary school environment may be an important setting for instituting preventive efforts, there has been increasing interest in developing mental health programs that
would increase emotional and behavioral adjustment (Spivack & Shure, 1974). In concordance with these views, Ellis has recommended that the principles of rational emotive therapy be taught to elementary school children. Rational emotive education is a direct extension of rational emotive therapy (Knaus, 1974). Children are taught many of the same principles of RET, including the common irrational beliefs that Ellis (1962) articulated, as well as the concepts of self-acceptance and mistake-making. In addition, specific lessons are designed to help children cope with disappointments and frustrations by teaching them to limit their “musts”, “should” and “demands”. Materials used in rational emotive education are simplified for easier understanding by children.

A meta-analysis was performed by Gonzalez et al. (2004) on 19 empirical studies on the effectiveness of Rational Emotive Behavior Therapy (REBT) with children and adolescents. Their findings suggest that Rational Emotive Behavior Therapy (REBT) is a valuable tool for treatment outcomes with children and adolescents, and it more favorably affects those with disruptive behaviors. There appears to be no difference between studies with high or low internal validity and the greatest impact was shown for those receiving longer durations of therapy.

Lyons and Woods (1991) in their meta-analysis reported which examined the efficacy of Rational Emotive Behavior Therapy (REBT). Results indicated that Rational Emotive Behavior Therapy (REBT) is beneficial treatment for a large range of clinical diagnosis and clinical consequences; Rational Emotive Behavior Therapy (REBT) is equally effective for clinical and non-clinical populations, for a large range between (9 to 70), and also for males and females.

### 2.10.1 Summary of Findings

Rational Emotive Behaviour Therapy (REBT) interventions in adolescents would generally be concerned with aiding adolescents understand three things: how their thought patterns affect their behaviour; how they can take control of these thought patterns and how they can apply interventions to effect behaviour change.