CHAPTER II

REVIEW OF LITERATURE

The review of literature reveals different concepts, opinions and approaches presented by various thinkers, methodologists and investigators in dealing with the research problems related to the subjects of the present study. The review helps a researcher in planning the specific study design for the problem at hand. It reinforces and supports the theoretical base for the study the review was done under the following categories:

2.1. Unemployment
2.2. Unemployment and Stress
2.3. Unemployment and Depression
2.4. Unemployment and Dysfunctional Attitude
2.5. Unemployment and Self-esteem
2.6. Unemployment and General health
2.7. Rational Emotive Behavior Therapy

2.1. Unemployment

Unemployment is one of the most dramatic aspects of the current economic crisis. It is also a growing social problem with serious financial consequences for the affected individuals and one of the most stressful of life events that lead to diminished social status, financial debt, disturbed social role patterns feelings of guilt and reduced self-esteem. International Labour Organization (ILO) estimated that global unemployment as 210 million in 2010. The World of Work report 2011 stressed that the current crisis has resulted in a global need to create 80 million new jobs over the next few years to restore pre-crisis employment rates (ILO, 2011; Ensminger & Celentano, 1988). The ILO (2008) reported that declining trend in youth unemployment has been found. The world unemployment rate of youth aged 15-24 rose from 10.9% in 1999 to a peak in 2004 of 12.6% and later years declined to 11.9 per cent by 2007 (ILO, 2008).

Unemployment is a multi-dimensional phenomenon that all countries including developing ones confront; it is an economic phenomenon showing imbalance in economic activity. It is considered social phenomenon because of its effects on the social structure of societies. The economic and social dimensions of the
unemployment increase its complexity and impose adopting extensive analysis to understand the causes and consequences and to identify the responses to such phenomenon. The economic growth is a goal of the main objectives of economic policy (either of monetary or of fiscal policy). The investment leads to achieving rate of sustained economic growth in the national economy and addressing the problem of unemployment. The greater the unemployment rate, the less opportunities to achieve high economic growth as well as the emergence of the negative social aspects (Ahmed, Kader, & Ahmed, 1996).

In addition to this, research studies show poorer mental health among the unemployed compared with employed persons (Vinokur et al., 1987; Dressler, 1986). Individuals who become unemployed experience or develop stress-related disorders or mental distress (Lindstro¨m, 2005; Theodossiou, 1998; Ensminger & Celentano, 1988).

Many studies have concluded the devastating effects of unemployment on individual health. Economists have emphasized on income and consumption consequences (Bentolila & Ichino, 2002; Browning & Crossley, 1998), and other researchers have stressed on the mental, physical and emotional consequences of unemployment (Frey & Stutzer, 2002; Argyle, 1999; Darity & Goldsmith, 1996; Clark & Oswald, 1994 & 2002).

Unemployment fear and feelings of uncertainty regarding career prospects have considerable psychological effects. The psychological impact of unemployment has been systematically studied since Jahoda’s study on the residents of Marienthal, an Austrian village where the most of the inhabitants became unemployed after the closure of the town’s textile industry in the early 1930s (Jahoda, Lazarsfeld, & Zeisel, 1971). A recent meta-analysis found that compared to employed people, rates of psychological problems were almost twice as high among unemployed. E.g., unemployed show more psychosomatic symptoms and anxiety, lower levels of self-esteem and life satisfaction as well as higher rates of depression (Paul & Moser, 2009; McKee-Ryan, Song, Wanberg, & Kinicki, 2005). Perceived job insecurity is shown to have similar psychological effects (De Witte, 2005; Sverke & Hellgren, 2002).

Studies available on the status of unemployment indicted that unemployment exerts various adverse effects on the psychological health of those who experience it. But the question that still remains unsettled is which of the two, whether one’s psychological
or physical health, is more affected. Literature reviews indicate that unemployment causes greater damage to psychological health than to physical health and there is no strong evidence that unemployment leads to ill-health of a primarily physical kind. Studies have also concluded that unemployment does not satisfy one’s need for income (manifest function), nor does it support one’s latent psychological functions such as wide social experience, time structure, identity-formation, involvement in collective purposes and activity, and thus ultimately renders one vulnerable to psychological problems (Fryer & Winefield, 1998; Winefield, 1995, 1997; Fryer, 1995a; Sabroe & Iversen, 1989; Verkleij, 1989; Iversen & Sabroe, 1988; Jahoda, 1988, Kieselbach & Svensson, 1988; Kieselbach & Wacker, 1985; Warr, 1985; Winefield & Tiggemann, 1985; Warr, 1984a,b,c).

Researchers in India have also found that prolonged involuntary unemployment is arguably more dangerous to psychological well-being than physical health (Kumari, 2001; Singh, Singh & Singh, 1995; Rani, 1993; Singh, 1990, 1994, 2001). There are some studies which are contrary to the above findings, wherein unemployment has been shown to be equally deleterious to physical and psychological health (Jin, Chandrakant & Svoboda, 1995; Wilson & walker, 1993; Arnetz at al., 1991; Martikainen, 1990; Brenner & starrin, 1988). Further, it is a fact revealed through common observation as well as empirical findings that unemployment results in an increase in poverty, leading to deficiencies in clothing, nutrition, and to some other harmful changes in life, causing reduced physical health (Jahoda, 1982, 1988).

In the light of the above, literature review concerning the topic of research is reviewed below.

2.2. Unemployment and Stress

2.2.1. Stress

Stress is a concept borrowed from the natural science. Derived from the Latin word “Stringere”, stress was popularly used in the 17th century to “mean hardship, strain, adversity or affliction. It was used in the 18th and 19th centuries to indicate pressure, force, strain or strong effort with reference to person or an object” (Pestonjee, 1992).

Mason (1979), reviewed literature on definition of stress and concluded that “the term stress has been approached in at least four different ways. (a) as a stimulus or external
force acting on the organism; (b) as a response or changes in the physiological functions; (c) as an interaction between an external force and the resistance opposed to it, (d) finally, as a comprehensive phenomenon encompassing all the three” (Mason, 1979).

The concept of stress was first introduced in the life sciences by Hans Selye in 1936. According to Selye (1956), any external event or any internal drive which threatens to upset the organism equilibrium is stress. Selye (1950) defined it “as the nonspecific response of the body to any demand”.

Stress has been defined in different ways over the years. Initially it was considered of as “pressures from the environment, then as strain within the person and as an interaction between the individual and the situation. It is the physical and psychological state that results when resources of the person are not sufficient to cope with the demands and pressures of the situation. Thus, more likely stress is in some situations and in some individuals than others. Stress can weaken the achievement of goals” (Michie, 2002).

It is difficult to define stress, as it means different meaning to different people. Some scientists see stress as any external stimulus that causes wear and tear, such as the pressure to perform at work. Competition and uncertainties of modern life, unemployment and job insecurity all such factors have made life increasingly stressful (Khokhar, 2003).

Stress is a universal phenomenon and is considered to be a condition in which people respond physiologically, psychologically, behaviorally and socially to life changes. These changes may be occurring through family of related experiences, education, and outcomes caused by a range of different events or circumstances (Manktelow, 2003).

Stress is “a common term describing the physical and psychological response to a stimulus that alerts the body’s equilibrium” (Lazarus & Folkman, 1984).

Stress is a state of tension created when an organism responds to demands and pressures of its internal and or external environments. Further it is proposed that stress is “a cumulative and additive process and stress is large subjective in nature” (Miller & Smith, 1987).
Ivancevich & Matteson, (1993) defines stress as “the interaction of the individual with the environment, an adaptive response mediated by the individual differences and/or psychological processes that is a consequence of any external (environmental) action, situation, or events that places excessive psychological and or physical demand upon a person”.

2.2.2. Studies related to Unemployment and Stress

Rayman (1981), reported that the unemployed experience a greater amount of stress in their life and also reported that as compared to the employed, the unemployed have a higher level of experienced strain and negative feelings, and a lower level of life satisfaction, happiness, experience of pleasure and positive feelings.

Stokes (1983), found that the apathetic outlook of the unemployed youth is a defensive reaction to a situation that produces worry and stress. He also indicated that the condition of unemployment eventually renders a person ineffective in his/her life and in the long run develops symptoms of psychiatric disorders.

O’Brien and Feather (1990), found that symptoms of stress are higher among those who subsequently become unemployed. Dooley, Rook and Catalano (1987), too, indicated perceived job insecurity as the most important predictor of all stress-related variables associated with symptoms of mild depression in general population.

Cobb and Kasl (1977), found that significantly higher physiological stress levels (of noradrenaline, uric acid and blood pressure) and altered health behavior in the phase of anticipation of job loss, which differs significantly from control group of employed persons and unemployed people (particularly in the initial phase), as also from those of others who succeed in getting themselves reemployed.

Madonia (1983), in his study of psychosocial reaction to chronic joblessness, found that unemployment affects self-esteem and gives rise to frustration, tension and worry- some of the significant symptoms of stress. Gold (1978), found that chronic joblessness among university graduates in the developing and developed nations is major cause of stress in them.

Lahelma and Kangas (1989) and Verkleij (1989), studies show that an increase in the duration of unemployment can lead to increase in the level of stress. However, Brinkmann (1984) has indicated a contrary results showing decrease in the level of
stress with the increase in the duration of unemployment and has supported the conclusion that the process of psychological deterioration does slow down with the increase in the duration of unemployment (Harrison, 1976).

Harrison (1976) has argued that prolonged unemployment would be especially stressful to those who are ambitious and have tasted success before. It has also been recorded that the unemployed having low qualifications (i.e., blue-collar workers either little or no occupational training) experience the highest level of stress (Brinkmann, 1984; Warr, 1984a, Wuggenig, 1985). Hepworth (1980) also found that unemployed people who have problems with structuring their time before they become unemployed demonstrate higher stress levels during unemployment.

Linn, Sandifer and Stein (1985), conducted a study to test the impact of stress on health of unemployed men (N=300). The results indicated that after unemployment, symptoms of somatization, anxiety and depression were significantly greater in the unemployed than employed. Further, study reports large standard deviations on self-esteem scores in the unemployed group indicated that some men coped better than others with job loss stress. Further, those with higher self-esteem had more support from family and friends than did those with low self-esteem. Even though the number of diagnoses in the two groups was similar, unemployed men made significantly more visits to their physicians, took more medications, and spent more days in bed being sick than did employed individuals.

Frost and Clayson (2006), conducted a study to assess the stress-related events, self-esteem, and locus of control among unemployed and employed blue-collar workers (N=562). The results indicate that unemployment increases the level of an individual’s stress by experiencing significant life change and does not decrease self-esteem and increase external locus of control orientation. A significant change with stress in conjunction with life event was found but mediated by numerous factors, including age and a non-significant correlation between time laid-off and stress level. Further it is suggested that an individual’s reaction to unemployment does not considerably affect their locus of control and self-esteem when compared to the employed.
2.2.3. Intervention studies on stress

Sharma et al., (2010), conducted a study to test the effectiveness of cognitive behavioral techniques on high school students’ academic stress (N=60) and found significant decrease in high school students’ academic stress and significant enhancement in their mental well-being.

Biabangard (2000) conducted a study and found that individual CBT intervention is effective in reducing stress of students. Smith (1989), conducted a study to examine the effectiveness of CBT on stress, locus of control and self-efficacy in students self-identified as test-anxious and found significant decreases on traits. Stoyva (2000), conducted a study and found that three types of meditation such as relaxed breathing response, paying attention to respiratory situations and mindfulness are effective in reducing the stress and anxiety in students.

Granath, Ingvarsson, Thiele, and Lundberg (2006), conducted a study to compare a stress management program based on cognitive behavioral therapy principles with a Kundalini yoga program. The results show that both yoga and cognitive behavior therapy are promising stress management technique and reduce stress related problems.

Gloria and Kelli (2002) conducted a study and found that relaxation response and CBT are effective in reducing psychological distress, anxiety and the perception of stress. Further they found a trend towards improvement for the intervention group on trait-anxiety and health-promoting life style profiles.

Verma (2001) conducted a study on women software professionals and results indicated that cognitive behavioral stress management (CBSM) program was efficacious in decreasing various types of stress outcome, burn out, reduced DAS and enhanced subjective wellbeing. Study also indicated that workshop module was effective in significantly reducing total somatic, emotional and cognitive stress responses.

Antoni, et al., (2000) conducted a study using randomized clinical trial comprising HIV+ men assigned to a Cognitive Behavioral Stress Management (CBSM) and wait-list control group in order to establish the efficacy of CBSM. Results indicated that CBSM reduced anxiety and urinary output of norepinephrine and buffered the long
term decline in T-cytotoxic / suppressor in HIV infected persons. Further study revealed that CBSM group showed reduced anxiety, anger, overall distress and perceived stress than controls after 10 week intervention period. Study also suggested that CBSM might work on endocrine and immunologic pathways through their ability to modulate stress response modify stress appraisals and improve mood in HIV+ infected people.

Talma and Ruth (1993) conducted a study using rational emotive therapy principles with industrial workers aimed at improving cognitive skills and assertiveness mainly focusing on irrational thought processes. Study indicated that assertiveness improved somatic complaints and irrational belief decreased in the short term. Cognitive weariness also reduced in follow up. Although other improvements were evident, they were not to the same extent as the short term effects.

Higgins (1986) conducted a study to evaluate the effectiveness of two different Stress Management Intervention (SMI) studies on Employees (N=54). First SM program involved systematic desensitization and JPMR, while other program involved instruction in assertive training, time management and rational emotive therapy. Result indicated that subjects in both programs had significantly decreased emotional exhaustion and personal strain relative to the control group and no significant difference was found between the two programs.

Bhalla (1980) conducted study to test the multidimensional SMI combining relaxation, cognitive restructuring and environmental restructuring. The program was delivered weekly through audio cassettes. He concluded that it was effective and superior to unimodal SM program. Bhandarkar and Singh (1986) reported that individuals can reduce stress by cultivating belief in self and positive habits based on interest like yoga, meditation, sports and breathing exercise. Dubey and Kumar (1986) also suggested that yoga, TM, auto-suggestion, relaxation, insight techniques and maintaining consistent value system were effective in reducing stress.

Thus, previous investigators have conducted studies on stress of various sample characteristics using cognitive behavioral therapy and other psychological interventions, but not particularly on the effect of REBT. No intervention studies have been reported on stress of unemployed. The present study adopts a novel strategy by applying REBT as an interventional strategy for managing stress.
2.3. Unemployment and Depression

2.3.1. Depression

Depression is one of the most commonly diagnosed mental disorders among adults. People’s understanding of the course and nature of depression has changed significantly in the last 20 years. Depression is now considered a chronic and lifelong illness. It is not only economically detrimental, but also engenders significant personal and interpersonal suffering alongside its societal impact (Johnson, Weissman, & Klerman, 1992).

Depression is “a state of low mood as well as aversion to activity that can affect a person's thoughts, feelings, behavior and physical well-being” (Salmans, 1997).

“Depression is naturally characterized by low self-esteem, low mood and loss of interest or pleasure in usually enjoyable activities”- DSM-IV-TR (2000).

Depression is a kind of psychological disorder which includes negative mood, loss of energy and interest, feeling of guilt, difficulty in concentration, reduction of appetite and thought of death and suicide. These symptoms lead to social, interpersonal and job dysfunction (Akiscal, 2005).

2.3.2. Studies related to Unemployment and Depression

Patton and Noller (1984, 1990) and Winefield and Tiggemann’s (1994) study shows increase in depression scores in the unemployed compared to the employed.

Feather (1983a), Feather and Davenport (1981), reported that depressive affect is more intense among those who see work as attractive and who have higher expectations with regard obtaining a job, and who hanker after it.

Feather and Barber (1983), found that low expectations of finding a job in the unemployed youth lead to low self-esteem, perceived lack of control, helplessness, depressive affect and an inclination towards self-blame in them.

Dooley, Rock and Catalano (1987), found that job insecurity is the most significant predictor of all stress-related variables associated with symptoms of mild depression in the general population.
Fryer (1995a, c), Tiggemann and Winefield, (1980, 1984) and Winefield (1995), found that the unemployed have greater depressive affect than the employed.

Berchick, Gallo, Maralani and Kasl (2012), examined the ways in which the association between job loss and depressive symptoms depends on five aspects of Socio Economic Status (SES): education, income, occupational prestige, wealth, and home ownership. Their findings indicate that higher SES prior to job loss is not uniformly associated with fewer depressive symptoms. Higher education and lower prestige appear to buffer the health impacts of job loss, while financial indicators do not. The results have so many implications for understanding the multidimensional role that social inequality plays in shaping the health effects of job loss.

Bolton and Oatley (2009) conducted a study to investigate depression and social support in unemployed men. 49 men were interviewed just after they had become unemployed, and compared with matched sample of 49 employed men. Result showed that unemployed men were significantly more depressed than those employed. When people lose a source of social interaction that is important to their sense of worth and has no alternative means of experiencing this worth, people become depressed.

2.3.3. Intervention studies on Depression

Comino et al., 2000 found that CBT is effective for anxiety and depression and is suitable for use with people who are unemployed because of the high rates of anxious and depressive symptomatology within this group.

David, Szentagotai, Lupu and Cosman (2008), investigated the relative effectiveness of rational-emotive behavior therapy (REBT), pharmacotherapy and cognitive therapy (CT) in the treatment of 170 outpatients with non-psychotic major depressive disorder through randomized clinical trial. The patients were randomly assigned to 14 weeks of REBT, 14 weeks of pharmacotherapy (fluoxetine) or 14 weeks of CT. The Hamilton Rating Scale for Depression and the Beck Depression Inventory were used as outcome measures. No differences among treatment conditions at post-test were observed. A larger effect of REBT (significant) and CT (non-significant) over pharmacotherapy at 6 months follow-up was noted on the Hamilton Rating.
Proudfoot et al., (2004), conducted a study to test the clinical effectiveness of computerized cognitive-behavioral therapy for depression and anxiety in primary care (N=274). Result indicates decreased depression, negative attributional style, work and social adjustment. It is concluded that computer-delivered CBT is widely applicable treatment for and/or depression in general practice. McCrone et al. (2004) conducted similar study and opined computerized CBT is cost effective.

Hedayati & Khazaei (2014), examined the relationship between depression, meaning in life and Hope among students (N=215). The results showed that there is a significant negative correlation between depression with meaning life ($r=-0.479, p < .01$), Presence meaning in life subscale ($r=-0.511, p < .01$) and Search meaning in life subscale ($r=-0.286, p < .01$). Also, the statistically significant correlation exist between depression and adult hope ($r=-0.484, p < .01$). It was found positive significant correlation between subscales of hope and meaning in life. Paying attention to these factors to minimize depression and to promote the society general health would be helpful.

Emmott (1992), conducted a study to examine effectiveness of cognitive group therapy on depression of HIV-infected people (N=32). The result showed a significant decline in depression.

Diane et al., (1997), examined the response to CBT for depression using depressed outpatients (N=53). Results indicate that there was a little support for the prediction of a difference in outcome between patients with or without pretreatment negative stressors and cognitive dysfunction.

Reynolds and Kevin (1986) conducted a study and found that CBT and relaxation training moderate the levels of depression in students. Findings demonstrated that short-term group administered therapies are effective in significantly decreasing stress and depression in adolescents.

Kelly et al., (1993), conducted a study to compare the effectiveness of brief CBT and social support group therapy on psychological distress of depressed HIV-infected men (N=68). Results indicated that both therapy groups, relative to the comparison group, experienced reduced distress.
Fava, Rafanelli, Grandi, Conti and Belluardo (1998), conducted a study using 40 patients with recurrent depression and they were assigned to one of two groups. They received drug treatment alone in the first group and both drugs and CBT treatment in the second group. The second group showed a greater reduction in symptoms.

Chen et al., (2006), conducted a study to evaluate the impact of cognitive behavioral group therapy (CBGT) on the self-esteem and depression of clinically depressed subjects (N=26). Results indicated that the subjects who received CBGT experienced greater cognitive improvements (i.e., self-esteem increase, depression relief) compared to the subjects of the comparison group.

Stice, Rohde, Gau, and Wade (2010), conducted a study using adolescents with elevated depressive symptoms (N=341) and Results indicated that initial symptoms and risk for future depressive episodes were reduced by Group CB intervention. Both CB bibliotherapy and supportive expressive therapy also produced effects that persisted long term.

Mulder et al., (1994), conducted a study to compare effectiveness of experiential group therapy and cognitive behavioral group therapy on HIV-infected men (N=39). Mulder found that both interventions, as compared with the control group, decreased distress and depression.

Thus, previous investigators have conducted studies on depression of various sample characteristics using cognitive behavioral therapy and other psychological interventions, but not particularly on the effect of REBT. Hence the study adopts a novel strategy by applying REBT as an interventional strategy for managing depression.

2.4. Unemployment and Dysfunctional Attitude

2.4.1. Dysfunctional Attitude

Dysfunctional attitude is defined as “a set of beliefs which demonstrate rigid and perfectionistic criteria on the evaluation of personal performance and self-value” (Kuiper et al., 1988). Dysfunctional attitudes arise from a set of stable cognitive schemata that are formed as a result of early life experiences. These schemata often involve exceedingly rigid and inappropriate belief about the self, others and the world. They function cognitively as filters, which allow an individual to interpret the vast
amount of information, gathered during their day-to-day interaction with the world. It is also a cognitive concept commonly used in clinical studies of depression (Beck, Rush, Shaw & Emery, 1979). The characteristics of dysfunctional attitudes, as described by Beck (Mendels, 1970), comprise “the concepts of arbitrary inference, magnification or minimization, selective abstraction, inexact labeling and overgeneralization”. Dysfunctional attitudes is operationally defined by Wiessman & Beck (1978), as “consisting of three factors such as vulnerability, referring to the pessimistic attitudes that tend to exaggerate negative consequences of an action; success perfectionism referring to the attitudes with the perfectionistic criteria that could not bear with any mistakes done in one’s actions; and social approval as dependency on others’ approval for a satisfactory life of one self”. Dysfunctional attitudes are “a stable marker of cognitive vulnerability to depression and they do not react according to changes in mood” (Meites, Deveney, Steele, Holmes, & Pizzagalli, 2008; Fresco, Heimberg, Abramowitz & Bertram, 2006; Brosse, Craighead, & Craighead, 1999). Often the depressogenic schemata are operationalized as sets of dysfunctional attitudes (Abela et al., 2009).

2.4.2. Studies related to Unemployment and Dysfunctional Attitude

Fatemi, Younesi, Azkhosh and Askari (2010), conducted a study to compare social adjustment and dysfunctional attitudes in infertile employed and unemployed females. Infertile females are faced with a variety of psychological problems and dysfunctional attitudes because of stress of infertility. Infertility problems lead females into maladjustment as well as disturbed interpersonal relationships. Results showed that dysfunctional attitudes were far more prevalent in infertile unemployed females than in infertile employed females. Social adjustment was better in employed infertile females than in unemployed infertile females. It was shown that higher the education level in employed infertile females lesser is dysfunctional attitudes in entitlements and relationships, whereas in unemployed infertile females had the most dysfunctional attitudes in terms of entitlements and relationships.

Senormanci et al., (2013), investigated the relationship between dysfunctional attitudes, depression and rumination response styles (RSS), using patients diagnosed with depression according to the DSM-IV-TR diagnostic criteria (N=60). Results showed that there was mild to moderate negative correlation between depression and
need for approval, the perfectionist attitudes, independent attitudes sub scores. Brooding sub score of Ruminative Responses Scale (RRS) was highly positively correlated with depression. As predictors of depression, high sub scores of RRS-short version brooding and RRS reflected increased risk for depression, whereas high sub scores of DAS perfectionist attitudes are assessed to be protective for depression. It was concluded that dysfunctional attitudes are not correlated positively with depression nor are they predictors of depression.

2.4.3. Intervention studies on Dysfunctional Attitude

Gumley et al., (2006), conducted a study to test the effect of CBT on negative beliefs/thoughts about psychosis and self-esteem of people with schizophrenia or a related disorder (N=144). Results indicate that CBT decreases negative appraisals of loss arising from psychosis and enhances self-esteem. Relapse is associated with the development of negative appraisals of entrapment and self-blame.

Jasmine (2010) conducted a study and found that CBT has a positive impact on reducing irrational beliefs, enhancing self-esteem, and self-acceptance, and reducing the level of depression among the late adolescents. Researcher reported that there was no significant difference between males and females in irrational beliefs, self-esteem, however, the difference between the males and females in depression scores was significant, and CBT has been found to be more effective in reducing irrational beliefs and depression in the females compared to that of the males.

Renner, Schwarz, Peters and Huibers (2014), conducted a study to test the effects of a best-possible-self mental imagery exercise on affect and mood ratings and dysfunctional cognitions following a sad mood induction in undergraduates (N=40). The result showed that the experimental had higher positive mood ratings and higher positive affect compared to the control group. It is reported that dysfunctional cognitions were decreased in the control group but remained unchanged in the experimental group.

Thus, previous investigators have conducted studies on dysfunctional attitude of various sample characteristics using psychological interventions, but not particularly on the effect of REBT. Hence the study adopts a novel strategy by applying REBT as an interventional strategy for managing dysfunctional attitude.
2.5. Unemployment and Self-esteem

2.5.1. Self-esteem

Self-esteem is an idea with many meanings. It has been one of the most widely studied hypothetical constructs. It is also one of the few psychological terms that are regularly mentioned in the popular media and used in conversations among the public. It is closely related to persistence and success across a range of achievement and health-related settings (Fox, 2000).

Self-esteem refers to “the way one evaluates herself or himself in general” (Brown & Marshall, 2006). It refers to “an individual’s overall view of herself or himself”. Self-esteem also referred to as “self-worth or self-image” (Santrock, 2006). The Dictionary of psychology defines self-esteem as “the degree to which one values oneself” (Reber & Reber, 2001).

Self-esteem is what we think about the self; it is the positive or negative evaluations of the self, as in how we feel about it (Smith & Mackie, 2007).

According to Huitt, self-esteem is “the affective or emotional aspects of self and generally refers to how we feel about or how we value ourselves” (Huitt, 2009). Baumeister et al., (2003), also support the same idea and accordingly it is defined by how much value people place on themselves (Baumeister et. al., 2003).

Self-esteem is generally described as the evaluating component of the self-concept. On a long-term cumulative basis, such self-evaluations may influence the development of cognitive and affective traits. In particular, there is widespread agreement that self-esteem is a crucial determinant of such psychologically important variables as coping ability and sense of well-being. The construct of self-esteem, at first glance, is deceptively simple. It is often assumed to be a general evaluative attitude towards oneself, ranging from extremely positive to extremely negative, that is stable and entirely subjective in nature (Anastasia, & Urbina, 1997). It simply means how you feel about yourself.

2.5.2. Studies related to Unemployment and Self-esteem

Perfetti and Bingham (1983) conducted a study to evaluate positive and negative attitude towards self and found that unemployed workers scored lower on self-esteem
than employed workers and re-employed workers scored between the employed and unemployed. This study also reported significant cross sectional differences between the employed and the unemployed.

Warr and Jackson (1983) conducted a study to examine positive and negative self-esteem of school leavers. The study was conducted before the sample left school in 1978 and continued on 3 occasions in 1979: at 8 months, 15 months and 31 months. The result showed that unemployed respondents were found to have significantly more negative self-esteem than those who had jobs.

Shams and Jackson (1994) conducted a study of unemployment among British Asians living in the North of England. The results indicated that the unemployed group had lower levels of self-esteem, psychological well-being and employment commitment with high external beliefs than the employed group. Length of unemployment was an important determinant of psychological well-being and people with a longer period of unemployment had a lower level of psychological well-being and self-esteem than those who had been unemployed for a shorter period.

Breakwell, Harrison and Propper (1984), conducted a study to examine the relationship between self-esteem and length of unemployment using unemployed people. The sample was drawn from the career office's register and consisted of 3 groups of subjects: those registered for less than 3 weeks, those registered for 3 to 9 weeks and those registered for 9 to 16 weeks. The results showed that young people unemployed for between 4 to 9 weeks suffered greater loss of self-esteem than those unemployed for longer or shorter periods. There were no significant sex differences in response to varying lengths of unemployment. The study showed that negative rather than positive aspects of self-esteem are sensitive to unemployment, indicating that the unemployed are more self-critical than the employed and less likely to praise themselves.

Waters and Moore (2002), investigated the Kasl’s (1982) proposal that positive psychological health particularly, self-esteem facilitates re-employment by assessing levels of cognitive appraisals, self-esteem and coping efforts among unemployed persons and relating these factors to their employment status six months later. 201 unemployed and 128 employed participated in the study. Comparison of baseline appraisals revealed that future re-employed participants rated their latent deprivation
lower and their internal locus of control higher than those continuously unemployed, and they also derived more internal meaning from leisure activities. Overall, the results supported Kasl’s reverse causation.

McIntyre, Mattingly, Lewandowski and Simpson (2014), conducted study on self-expansion, self-concept and self-esteem using employed and unemployed samples and results indicated that self-expansion predicts job satisfaction and commitment. They also examined the impact of losing a self-expanding job by sampling currently unemployed and results indicated that losing a self-expanding job results in lower amounts of self-concept clarity and self-esteem.

Creed, Bloxsome and Johnston (2001), investigated the immediate and long-term well-being, self-esteem and confidence outcomes for unemployed who attended community-based occupational skills/personal development training courses. Results for unemployed trainees were compared with an unemployed waiting-list control group. Researchers found that self-esteem and confidence levels at the end of the courses were associated with perceptions of the actual training environment.

2.5.3. Intervention studies on Self-esteem

Proudfoot et al., (1997), conducted a study to assess the efficacy of CBT programme with 134 long-term unemployed. The results showed that experimental group had significantly greater enhancement in job-seeking self-efficacy, self-esteem, attributional style, life satisfaction and motivation for work than a control group. Beneficial effect of CBT on employment was found with 34% of CBT participants achieving full-time employment compared with 13% of control group participants.

Roghanchi et al., (2013), investigated the effect of combined rational emotive behavior therapy (REBT) and the art therapy (engraving method) and its efficacy on improving self-esteem and resilience of students. Results indicated that the integration of REBT and art therapy increases the self-esteem and resilience of students.

Waite, McManus, and Shafran (2012), conducted a study to examine the effect of Cognitive behaviour therapy on low self-esteem in a primary care setting (N=22). Results indicate that the immediate treatment group showed significantly better functioning than the waitlist group on measures of low self-esteem.
Lim et al., (2010), conducted a study to examine the effectiveness of a cognitive-behavioral program for nursing student's self-esteem, decision making style and career attitude maturity in Korea (N=40). Results indicate that the experimental group significantly increased in the mean score for career attitude maturity and self-esteem compared to the control group.

Thus, previous investigators have conducted studies on self-esteem of various sample characteristics using cognitive behavioral therapy and other psychological interventions, but not particularly on the effect of REBT. Hence the study adopts a novel strategy by applying REBT as an interventional strategy for managing self-esteem.

2.6. Unemployment and General Health

2.6.1. General Health

The World Health Organization (WHO) defined health in its broader sense in 1946 that it is “a state of complete physical, mental, social and spiritual well-being and not merely the absence of disease or infirmity” (Taylor & Marandi, 2008).

“Health is the level of metabolic or functional efficiency of a living organism. In humans, it is the general condition of a person's mind and body, generally meaning to be free from injury or pain and illness” (as in "good health" or "healthy") (Dictionary – Health. Merriam-Webster. Retrieved 21 April 2011).

General health is a general condition of a person in all aspects. It is also a functional or metabolic efficiency of an organism, often implicitly human.

According to the WHO, worldwide changes may be found in the pattern of epidemiology of diseases in the next two decades. Infectious and communicable diseases may be replaced by Non-communicable diseases such as mental disorders as the leading factor for disability and premature death (Murray & Lopez, 1996).

2.6.2. Studies related to Unemployment and General Health

Studies reveal close relationship between unemployment and health problems. Unemployment is reported among different population subgroups. Usually, ethnic minorities and young people face the highest rates (US Dep. Labor, 1994). These include the school-leaver unemployment (Petersen & Mortimer, 1994; Winefield et
al., 1993) and unemployment among adults (Catalano, 1991; Arnetz et al., 1988; Jahoda, 1982). Research studies support the generally assumed negative effects of unemployment on well-being and physical and mental health.

Bartley (1994) examined the relationship between unemployment and ill health and mortality and concluded that there are four mechanisms need to be considered to understand this relationship namely social isolation and loss of self-esteem; the role of relative poverty; health related behaviour and the effect that a spell of unemployment has on subsequent employment patterns.

Eliason and Storrie (2009), examined the effect of unemployment on a number of non-fatal health events, which are severe enough which require hospital in-patient care. Using linked employee–employer register data, they identify the unemployment due to all establishment closures. They found that job loss significantly increases the risk of hospitalization due to alcohol-related conditions, among both women and men, and due to traffic accidents and self-harm, among men only. They found no evidence, however, that unemployment increased the risk of severe cardiovascular diseases such as myocardial infarction or stroke.

Mork, Sjogreny and Svalerydz (2014) studied health outcomes of Swedish children whose parents become unemployed. To this end they combined Swedish hospitalization data for 1992-2007 for children 3-18 years of age with register data on parental unemployment. They found that children of unemployed parents are 17% more likely to be hospitalized than other children. Study suggested effect of parental unemployment on child health.

Payne, Warr and Hartley (1984), investigated psychological health and the experience of being unemployed between 6 and 11 months in two social class groups: white-collar, managerial and professional workers, unskilled and semi-skilled workers. Information was obtained through interviews about financial and other problems, perceived threats associated with unemployment, depression, anxiety, ratings of general health and general psychological distress. It is found that medium-term unemployment appeared to have a homogenizing effect, with similarly poor health in both social class samples, although working-class respondents reported significantly greater financial problems and difficulties in filling the time.
Scutella and Wooden (2008), conducted a study to examine the effect on household joblessness on mental health. Results indicate that unemployment is associated with lower levels of mental health. However, there is no evidence for any additional disadvantage to the unemployed stemming from living in a jobless household.

Dooley, Fielding and Lennart (1996), conducted a study to examine the relationship between unemployment and health. Poor mental or physical health can lead, via poor work performance, to job loss. Findings revealed that there is a positive association between suicide rates and unemployment over time. At the individual level of analysis, study showed increased psychiatric problems such as depression and substance abuse and the adverse health effects of unemployment.

Giatti, Barreto, and Cesar (2010), conducted a study to examine the relationship between self-rated health and unemployment. Results confirmed the association between poor self-rated health and unemployment, regardless of the contextual or personal characteristics studied in this study. Bockerman & Illmakunnas (2009) in Finland study did not show negative effects of unemployment on self-assessed health.

In contrast, Browning et al., (2006), examined the effect of unemployment and found no causal effect of job loss on the possibility of entering a hospital due to symptoms caused by mental stress after four years with Danish register data.

Salm (2009) examined subjective and objective health measures of unemployment and found no effect on several objective and subjective health measures with data from the HRS.

Kuhn et al., (2009), examined the effect of job loss on public health and did not find short-run effects of job loss on public health costs associated with health care utilization. But, they did find that job loss increases hospitalizations for mental health reasons and prescriptions for antidepressants.

Axelsson and Ejlertsson (2002), conducted a study to investigate the connections between self-esteem, social support and self-reported health among unemployed youngsters aged 20-25 years (N=264). Mental health issue consisted of the symptoms of tearfulness, restlessness, dysphoria, irritability, sleeping disturbance and general fatigue. The unemployed youngsters had more mental problems than youngsters who are working or studying. Dysphoria and restlessness were significantly over-
represented in the unemployed youngsters among both sexes. The results indicated that good social support seemed to predict mental health. Support from parents was most important, particularly in males. Especially, youngsters with low self-esteem and poor parental support were vulnerable.

### 2.6.3. Intervention studies on General Health

Creed et al., (1999), conducted a study to assess coping behaviours and the wellbeing of long-term unemployed youth attending a CBT group intervention (N=43). After intervention, significant improvements in both coping behaviours and mental health were reported for the CBT group compared to control group.

Proudfoot et al., (1997), conducted a study to examine the effects of CBT programme on measures of job-seeking, mental health and job-finding among long-term unemployed (N=289). Results indicate that improvement on GHQ scores in the CBT group than in the control group. There were no significant differences between the groups in job-seeking activity during or after training, However CBT group had been more successful in finding full-time work by 4 months after completion of training. It is found that group CBT training improves mental health and produces tangible benefits in job-finding.

Creed, Machin and Hicks (1996), conducted a study on short-term mental health outcomes for long-term unemployed youngsters who attended 16 week occupational training programs. Outcomes for 30 participants were compared with 52 waiting-list control subjects. Researchers found significant improvements in self-esteem, but not reductions in psychological distress for participants. High pre-intervention levels of neuroticism were associated with poorer well-being in all participants.

Thus, previous investigators have conducted studies on general health of various sample characteristics using cognitive behavioral therapy and other psychological interventions, but not particularly on the effect of REBT. Hence the study adopts a novel strategy by applying REBT as an interventional strategy for managing general health.

From the above studies it is evident that poorer mental health among the unemployed compared with employed persons (Vinokur et al., 1987; Dressler, 1986). Individuals who become unemployed experience or develop stress-related disorders or mental distress (Lindstro¨m, 2005; Theodossiou, 1998; Ensminger & Celentano, 1988).
Studies also showed that compared to employed people, rates of psychological problems were almost twice as high among unemployed. E.g., unemployed show more psychosomatic symptoms and anxiety, lower levels of self-esteem and life satisfaction as well as higher rates of depression (Paul & Moser, 2009; McKee-Ryan, Song, Wanberg, & Kinicki, 2005). Perceived job insecurity is shown to have similar psychological effects (De Witte, 2005; Sverke & Hellgren, 2002).

Many studies have concluded the devastating effects of unemployment on individual health. Economists have emphasized on income and consumption consequences and other researchers have stressed on the mental, physical and emotional consequences of unemployment (Bentolila & Ichino, 2002; Clark & Oswald, 1994, 2002; Frey & Stutzer, 2002; Argyle, 1999; Browning & Crossley, 1998; Darity & Goldsmith, 1996).

Unemployment exerts various adverse effects on the psychological health of those who experience it. But the question, it seems, still remains unsettled as to which of the two, one’s psychological or physical health, is more affected. Literature reviews indicate that unemployment causes greater damage to mental or psychological health than to physical and there is no strong evidence that unemployment leads to ill-health of a primarily physical kind. Studies have also concluded that unemployment does not satisfy one’s need for income, nor does it support one’s latent psychological functions such as time structure, wide social experience, involvement in collective purposes, identity–formation and activity, and thus ultimately renders one vulnerable to psychological uprootedness.

Thus, unemployed in the age group of 20-40 years are affected a lot because it is a critical period to experience high stress which plays a major role in the individual’s life. Unsatisfactory solution to this crisis can lead to many psychological problems like stress, depression, dysfunctional attitude and will affect their self-esteem and general health. These are the individuals who are in definite need of psychological services.

2.7. RATIONAL EMOTIVE BEHAVIOR THERAPY (REBT)

2.7.1. Introduction

Cognitive behavior therapy (CBT), which is being used increasingly, has been put forward as one of the most effective and scientific therapies for people with
psychological problems. It is advocated as the treatment of choice for numerous psychological and mental health difficulties (Department of Health, 1999). CBT is not a single therapy, but is a generic term for over 20 different therapies (Neenan & Dryden, 1999). One of the main therapies incorporated under the umbrella term of CBT is “rational emotive behavior therapy (REBT) which is the first form of cognitive behavior therapy (CBT). This was developed by Ellis (1962, 1994). It considers that at the core of emotional disturbance lies a set of four irrational beliefs (demands, awfulising, low frustration tolerance, and self or other downing), that people hold about themselves, other people, and the world there are four corresponding rational beliefs (preferences, anti awfulising, high frustration tolerance, and self/other acceptance) that are at the core of psychological health. One of the central tenets of REBT is the evaluative beliefs mediate the view that people have about events and effect on the emotional, behavioral, and inferential reactions to these events. The fundamental premise of REBT is that people cause themselves distress and dysfunction due to their habitual irrational beliefs, and that these irrational thinking patterns can be changed, with resultant improvement in emotional states and functioning. Intervention involves training subjects in rational self-analysis to help them become aware of their thought patterns, followed by teaching them how to see their reactions in more constructive (i.e., rational) terms. Then they have daily relearning exercises during which they practice their new thinking patterns several times a day” (Rosner, 2011).

2.7.2. The origins of REBT

Ellis derived the basic principles of REBT from the writings of a number of ancient and modern philosophers. His philosophical influences were Greek and Roman stoics such as Zeno of Citium, Epicurus, Epictetus, and Marcus Aurelius. In addition to the stoics, Ellis adapted the ideas and philosophies of Asian thinkers, such as Confucius, Buddha, and Lao Tsu. Modern philosophers, Immanuel Kant, John Dewey, and Bertend Russell were influential in Ellis’s development of REBT as well (Ellis, 1994). The philosophic notion that the manner in which a person perceives and interprets a situation, directly affects his or her psychological welfare is the foundation for REBT. Through adopting and adapting these ancient ideas, Ellis derived a psychological theory and therapeutic method that has evolved into REBT (Ellis & Dryden, 1997).
Researchers have declared that the essence of REBT lie in the words of Epictetus, a Stoic philosopher from the first century A.D. Epictetus wrote, “Men are not disturbed by things, but by the views which they take of them.” REBT, in part, is a philosophical theory based on the premise that dysfunction is primarily a result of an individual’s perceptions, belief system, values, and interpretations of the world around him (Wallen, DiGiuseppe, & Dryden, 1992).

2.7.3. Models of REBT

There are three models proposed to describe the relationships among irrational beliefs and emotional distress:

(1) REBT-I Model proposed by Ellis and colleagues, argues that “demandingness leads to the other evaluative irrational beliefs, which, in turn, lead to emotional disturbances and associated automatic thoughts. In this case, awfulizing, low frustration tolerance and self-downing function as mediators in the relationship between demandingness and distress” (Ellis & Dryden, 1997; Ellis, 1994).

(2) The Cognitive Therapy Model, proposed by Beck (1976, 1995), suggests that “awfulizing, low frustration tolerance, and self-downing are intermediate or core beliefs which promote demandingness expressed in “rules of life” and behaviors” (e.g., Beck, 1995). In this case, demandingness is the proposed as mediating variable in the relationship between the intermediate/core beliefs and distress.

(3) REBT-II model proposed by DiGiuseppe (1996) suggests that “demandingness, awfulizing, low frustration tolerance, and self-downing can independently lead to automatic thoughts and related emotional disturbances. Here, mediation is not proposed; rather, each type of irrational beliefs makes unique contributions to emotional distress”.

Rational-Emotive Behavior Therapy (REBT) is based on Ellis’s ABCDE model of distress (Ellis, 1994,1962). According to this ABCDE model (David & Szentagotai, 2006; Ellis, 1994) often people experience undesirable activating events (A), about which they have rational and irrational beliefs or cognitions (B). These beliefs lead to emotional, behavioral, and cognitive consequences (C), (Rational beliefs (RBs) lead
to adaptive and healthy (i.e., functional) consequences, whereas irrational beliefs (IBs) lead to maladaptive and unhealthy (i.e., dysfunctional) consequences. Once generated, these consequences (C) can become activating events (A) themselves, producing secondary (Meta) consequences (e.g., meta-emotions: depression about being depressed) through secondary (meta-cognitions) RBs and IBs. Subjects who are trained in REBT are encouraged to actively dispute (D) (i.e., restructure) their IBs (Irrational beliefs) and to assimilate more efficient (E) RBs (Rational beliefs), to facilitate healthy, functional, and adaptive emotional, cognitive, and behavioral responses. The ABC(DE) model has been recently expanded by including the concept of unconscious information processing (David, 2003) More precisely, sometimes cognitions are not consciously accessible, in so far as they are represented in the implicit rather than the explicit memory system (David, 2003).

2.7.4. REBT Goals

“The goals of REBT are to help clients over their psychological disturbances; help them address their life dissatisfactions and help them become more psychologically healthy. The ideal of therapy, ‘philosophic change’ is achieved through strengthening rational beliefs and weakening irrational beliefs” (Dryden, 2001).

REBT theorists state that “problems for individuals are caused by the beliefs they hold and their goal is to help clients develop a more positive outlook and the maintenance of positive cognitions by restructuring the beliefs and irrational thoughts they hold. Another method used to combat these irrational goals is the tracking of cognitions so that the person may know when they start thinking irrationally and to take immediate action before these thoughts lead to maladaptive behavior, by schema restructuring” (Corey, 2012).

“REBT helps clients decide how to use their newly acquired knowledge in the future as opposed to becoming dependent and going to therapy every time things start going wrong in their lives” (Corey, 2009); which is in line with the APA (2002), notion of fostering autonomy in the client. “Other strength of REBT is that it is deemed to be the most effective form of Psychotherapy when combined with medication, in quite a number of clinical disorders and especially when it comes to treating depression” (Bennett, 2006).
REBT proposes that we have the ability to be both rational and irrational though, we are inclined to thinking irrationally (Corey, 2012). Therefore, “REBT therapists aim to change this self-talk which they believe will also change subsequent behavior and the emotions or feelings associated by both cognitions and behavior” (Mkangi, 2010). REBT proposes that emotional problems and self-defeating behaviors are learned maladaptive responses resulting from faulty thinking patterns.

“Ellis describes 11 types of irrational beliefs in his earlier works (Ellis, 1962) later developments suggest that they fall into 4 main categories: (1) Demandingness (DEM), (2) Awfulizing (AWF), (3) Low frustration tolerance (LFT), and (4) Global evaluation/self or other-downing (GE/SD). These four types of irrational beliefs cover various content areas (e.g. performance, comfort, affiliation) and can refer to ourselves, others, or life in general (David, David, Ghinea, Macavei, & Eva, 2005). The alternative rational beliefs are: (1) Preferences, (2) Antiawfulizing, (3) High frustration tolerance, and (4) Unconditional self/other acceptance. REBT also specifies the relationships among these beliefs (Ellis, 1994), namely that both rational and irrational beliefs consist of a primary and secondary belief. Whereas the former expresses the demanding or preferential nature of the belief, the latter conveys a personally meaningful context or theme” (Dryden & Branch, 2008; Mac Innes, 2004). An example would be: I must get a good job (primary belief—DEM), and I cannot stand it if I don’t (secondary belief—LFT).

2.7.5. Demandingness (DEM)

According to Ellis the behavioral consequences of demandingness that demands are commands on the universe to be the way you want it to be (DiGiuseppe, 1996). “As rigid assertions of desires, demands are beliefs characterized by a dogmatic insistence that a certain condition must or must not exist. Such absolutistic requirements are commonly expressed in the form of “must,” “ought,” absolute “shoulds,” “have to,” and so forth. Demands concern oneself, others, and life conditions. The rational alternatives of demands are full preferences, which are flexible assertions of what the person wants, coupled with the acceptance of the fact that we cannot insist absolutely that we get what we want; hence, the demanding element is negated” (David et al., 2009). Demandingness is viewed as the core (or root) irrational belief from which the other irrational beliefs stem (Ellis, 1994). However, David et al, (2005), DiGiuseppe
argue that this assumption is clinically derived, and has not yet received sufficient and definite empirical support. “In response to the lack of empirical investigation into the primacy of demandingness, Ellis (2003 a), often offers what is fundamental common sense: How can a derivative exist (Such as awfulizing, LFT, or selfdowning) in the absence of a demand? It is unlikely that these derivatives (e.g., awfulizing) would stem from a full preference. E. g., if people strongly prefer to be approved of by others but recognize that they cannot insist on or guarantee approval, then being disapproved of cannot be evaluated as a truly awful experience. What has been established, however, is the role of demandingness in generating a range of unhealthy negative (dysfunctional) emotions” (David et al., 2005; David et al., 2002). According to Ellis (2003 a), “there are three main types of demands that create problems for people: (1) demands that they should perform well, (2) demands that others must treat them nicely, and (3) Demands that living conditions must be free of hassles and that life should be fair. One can use this distinction in extracting the behavioral consequences of demandingness”.

And “demands on the behavior of the self (e.g. “I must achieve,” “I must be competent,” “I must act perfectly”) have been associated with self-defeating behaviors such as comfort eating, medication use, the tendency to engage in routine or repetitive behaviors” (Harrington, 2005) and reduced attempts to inhibit aggression (Bernard, 1998). Also, “behavioral demands are predictive of interpersonal behavioral difficulties such as relational problems, and social avoidance and isolation” (Watson, Sherbak, & Morris, 1998). Research studies have documented the link between a demand of self-oriented perfectionism and maladaptive behaviors such as disordered eating (Pearson & Gleaves, 2006; Sherry, Hewitt, Besser, McGee, & Flett, 2004); alcohol abuse (Hewitt & Flett, 1991): diminished task performance (Frost & Marten, 1990); problems in interpersonal interactions (Haring, Hewitt, & Flett, 2003); suicide (Blatt, 1995) and reduced willingness to discuss and share personal results on various tasks with others(Frost et al., 1995).

2.7.6. The Behavioral Consequences of Awfulizing

Awfulizing beliefs refer to “the extreme dichotomous evaluation of a negative event as worse than it absolutely should be. Awfulizing beliefs exaggerate the consequences of past, present, or future events, conceptualizing people or events as terrible,
horrible, or the worst thing that could happen” (MacInnes, 2004). A person who holds an awfulizing belief is unable to allow for the fact that there are worse possible present or future outcomes (Dryden, 2003).

REBT theory proposes that awfulizing derives from demandingness: when people do not get what they believe they are entitled to have job, they conclude that “it is awful” (Dryden & Branch, 2008; DiGiuseppe, 1996). “Anti-awfulizing beliefs are the rational counterparts of awfulizing. They refer to the evaluation that when people’s full preferences are not met, they conclude that the circumstances may be “bad” but not awful. This approach allows for the fact that worse outcomes are possible” (Dryden & Branch, 2008) and relies on a continuum of badness, rather than a dichotomous judgment of either awful or not bad at all.

The relationship between awfulizing and dysfunctional emotions has received extensive attention in the REBT literature (David et al., 2002) significantly less research has focused on the impact of awfulizing on overt behavior. The rational emotive behavior theory of emotions has traditionally tied awfulizing to the experience of anxiety (David, 2003), although clinical anecdotes suggest that awfulizing can pervade most if not all emotional problems, including unhealthy anger, depression, shame, guilt, and hurt (Dryden & Branch, 2008). “Ellis distinguishes between two major forms of anxiety: ego and discomfort anxiety (Ellis, 2003c), both of which have to do with awfulizing. Discomfort anxiety results when people feel that: (1) their comfort is threatened E.g., Not having secured life, financial insecurity. (2) They must get what they want (permanent job, secured life) and that it is awful or catastrophic when they do not get what they demand. In contrast, ego anxiety appears when people feel that: (1) their self or personal worth is threatened E.g., I am worthless (2) they must perform well and/or be approved by others (E.g., Do something which receives approval from others) and that is awful or catastrophic when they fail to perform well and/or are not approved by others. In Ellis’s opinion, these two constructs help explain several phenomena related to emotional disturbance, including a range of self-defeating behaviors (e.g., avoidance)” (Ellis, 2003c).

2.7.7. The Behavioral Consequences of Low Frustration Tolerance (LFT)

LFT beliefs emphasize the fact that one cannot tolerate or bear an event (E.g., Unemployment, Bachelor) or set of circumstances, thereby making a situation appear
to be intolerable (David et al., 2009). “As in the case of awfulizing, many REBT theorists hold that low frustration tolerance stem from demands (e.g., I must get job, I should get marry) when people do not get what they believe they must get, they conclude that the situation is intolerable and they cannot stand it (Dryden & Branch, 2008). On the other hand, high frustration tolerance beliefs (e.g., if I don’t get a job, nothing is going to happen, I can take up same self-employment entrepreneurship and give job to other unemployed youths) state that events may be difficult to tolerate, but they are not intolerable. REBT proposes that low frustration tolerance discourages people from contending with unpleasant circumstances, and short-circuits their ability to confront obstacles to goal-attainment. Alternatively, high frustration tolerance (e.g., Unemployed starting some self-employment) promotes active efforts to confront or eliminate obstacles to happiness and achievement” (Dryden & Branch, 2008).

2.7.8. The Behavioral Consequences of Global Evaluation or Self-Downing

“People exhibit a natural tendency to make global evaluations about themselves, others, and the world. This tendency is a result of the cognitive system’s innate ability to generalize rapidly from specific occurrences to facilitate learning or ensure safety, E. g., people tend to draw stable, global and more or less definite conclusions based on low-frequency behaviors or events (Attribution- Hopelessness theory: There are three critical dimensions on which attributions are made: (1) Internal/External (2) Global/Specific (3) Stable/Unstable. Pessimistic attributions for a negative event are internal, stable and global). Logical point of view, this process can yield erroneous inferences, so no firm and general conclusions can be drawn based on inductive reasoning” (David, 2006b).

Self-downing refers to “making global negative evaluations about oneself (The fact that I failed to get job proves that I am a failure). The person evaluates a specific trait, behavior, or action according to standards of desirability or worth and then applies the evaluation to himself or herself” (MacInnes, 2004). “When such negative overgeneralizations are applied to others or the world, it is called other-downing and world-downing, respectively. The rational correspondent of self-downing, other-downing, and world-downing is unconditional self-acceptance, other-acceptance, and world-acceptance. With regard to unconditional self-acceptance (e.g., I am an educated youth, among uneducated lot, I may not have been employed), a person
understands that although people do bad or stupid things, they cannot be globally rated as bad or stupid, and that people’s fallibility and foibles (including the self) must be accepted. REBT teaches that people are valuable in themselves, even though their behaviors may not always be laudable; however, unconditional self-acceptance does not mean that individuals do not strive to change or improve their behavior when it is called for (maladaptive behaviors)” (David et al., 2009).

According to Ellis and other REBT theorists (Dryden, 2003) self-downing (e.g., I am worthless because I am unemployed) results from demandingness (e.g., I must get a job, I must get marry). When people do not get what they believe they must get, and they attribute this failure to themselves, they will tend to engage in global self-condemnation, rather than disapprove of a specific behavior. “Self-downing (e.g., I am worthless; I am unemployed) is one of the irrational beliefs that exhibits the highest correlations with emotional disturbance and negative affect (e.g., Depression & low self-esteem)” (DiGiuseppe, 1996; DiGiuseppe et al., 1988). “Unconditional self-acceptance is positively correlated with life satisfaction and happiness and negatively correlated with dysfunctional emotions such as anxiety and depression” (Chamberlain & Haaga, 2001a).

2.7.9. Evaluation of REBT

REBT studies show its effectiveness, including cost effectiveness. Rosner (2011) concluded that “the effectiveness of REBT appeared to be comparable to both systematic desensitization and cognitive behavior therapy (CBT). Study reported that standard deviation of results as quite large, suggesting considerable variability among individuals in treatment response, raising an interesting question about what kind of person does best with this kind of treatment”. Sava et al., (2009) compared REBT, cognitive therapy and fluoxetine for major depressive disorder in a randomized clinical trial and found significant improvement and comparable results for all three treatments at 6 months follow-up. They addressed the issue of cost-effectiveness dividing the total cost by the number of depression-free days and quality-adjusted life years. The two psychotherapies were found to be more cost effective than pharmacotherapy.

According to Rosner (2011), “REBT was not used in isolation, but implemented along with a variety of other interventions involving relapse prevention, problem-solving,
assertiveness, relaxation and other techniques. The approach of REBT differs from other forms of therapy in that its goal is a new philosophical outlook, rather than just a different mode of interpreting life events. The main questions raised have to do with the validity of the assumptions underlying REBT; it is important to keep in mind that not all of these have not been tested and validated”. There is some evidence that irrational beliefs are related to psychological disturbance and maladaptive behaviors. Chang and Bridewell (1998), found a significant association between irrational beliefs and pessimism in college students. Zeigler and Leslie (2003), found empirical support for the ABC model underlying REBT by using a questionnaire to study college students. They found correlations between high scores on irrational thinking, awfulizing, and low frustration tolerance and the students’ reports of experiencing daily hassles (a marker for stress). “It is not very clear whether people who have only rational beliefs are more effective and happier than people who have both rational and irrational beliefs. Similarly, it simply is not true that all human emotional/psychological illness is unrelated to actual external events: physically traumatic brain injury, exposure to neuro-toxins, metabolic diseases, cerebro-vascular accidents, and brain tumors are all actual external events that have severe impact on emotional/psychological functioning” (Rosner, 2011).

2.7.10. The role of irrational beliefs in the rational emotive behavior theory of depression:

“Ellis (1994) specified a secondary theoretical principle, namely, that both rational and irrational beliefs consist of a primary and secondary belief. The first one expresses the preferential or demanding nature of the belief and the second one conveys a personally meaningful context or theme that is consistent with the functionality or dysfunctionality of the belief” (Ellis, 1994).

REBT is one of the most commonly practiced forms of cognitive behavioral psychotherapy (Ellis & Dryden, 1997). A large number of studies support the effectiveness of REBT with a wide range of clinical disorders (Kendall et al., 1995; Haaga & Davison, 1993). REBT practice is based on a model of change that has also undergone more extensive empirical investigation (Macavei, 2005). “According to this model, psychopathology is a result of people endorsing irrational beliefs that sabotage their goals and purposes. It is considered that at the basis of all human
disturbances lies the tendency of making devout, absolutistic evaluations of perceived events that come in the form of dogmatic ‘shoulds’ or ‘musts’” (Ellis & Dryden, 1997). “The major derivatives of these “musts” are awfulizing, low frustration tolerance and self-downing. Awfulizing occurs when an event is rated as being more than 100% bad. Low frustration tolerance means the person believes that no happiness is possible if the unwanted event actually takes place. Self-downing refers to the tendency of labeling oneself, other people or life as being “worthless” or “bad” if failure occurs” (Ellis & Dryden, 1997).

Earlier studies showed that the REBT model of depression has been effective in reducing both irrational beliefs and other treatment outcomes that could support the REBT theory of change (Lipsky et al., 1980). However evidence supporting the REBT theory of depression is limited which were addressed in a number of studies and led to conclusions supporting the hypothesis that clinically depressed people and depression-prone individuals significantly exceed controls in irrational beliefs (Solomon et al., 2003; McDermut et al., 1997). There is less evidence supporting the causal role of IBs in the case of depressive symptoms (Solomon et al., 2003).