Albert Ellis, a rational emotive behavior therapist, developed Rational Emotive Behavior Therapy (REBT). REBT is a form of psychotherapy based on the idea that human beings are "sign-, symbol-, and language-creating." Along with REBT, Ellis also developed the A-B-C Theory of Personality. In this theory, significant activating events (A) cause humans to create masturbatory belief systems (B) leading to emotional consequences (C) based on their beliefs. Following Ellis’s theories, I argue that youth smoking is a behavior that results from a dire need for social acceptance and approval. I then propose that REBT can be used to reduce rates of youth smoking. In this critical review, I initially provide a detailed biography of Albert Ellis and an overview of his theory of personality. Then, I demonstrate the negative effects of the media and personal relationships serving as significant activating events that cause the early onset of tobacco use. Finally, I propose my own solutions, based on Ellis’s cognitive, emotive-evocative, and behavioral therapies, to decrease youth smoking rates.

Introduction

In a report to the Board of Directors of Philip Morris (the world’s largest private tobacco company), Thomas Osdene, Director of Science and Technology, stated the following: “Smoking a cigarette for the beginner is a symbolic act … ‘I am no longer my mother’s child, I’m tough’ … As the force from the psychological symbolism subsides, the pharmacological effect takes over...” Osdene’s description of common marketing tactics used to promote youth smoking places emphasis on the mental aspect before the physical aspect of smoking. He stresses...
the importance of first controlling the mind and then dominating the body shortly after. Osdene’s marketing tactics closely mirrors Albert Ellis’s cognitive approach to psychology.

Albert Ellis is an American psychologist who founded Rational Emotive Behavior Therapy (REBT).[^2] Ellis suggested that human beings are “sign-, symbol-, and language-creating.”[^3] Human beings engage in evaluative thinking using four interrelated processes: perception, movement, thinking and emotion.[^3] Evaluative thinking gives rise to “self-talk,” which shapes thoughts and emotions.[^4] Ellis developed the A-B-C Theory of Personality, which suggests that human beings create musturbatory belief systems (B), consisting of absolute life philosophies, in response to significant activating events (A).[^5] Ellis proposed that human beings generate emotional consequences (C) based on their belief systems.[^5] Following Ellis’s theories, I argue that youth smoking is a harmful behavior that results from a dire need for social acceptance and approval prompted by the media and relationships. In short, the negative effects of youth smoking are what Ellis would term the emotional consequence (C) that results from a musturbatory belief system. In this context, a dire need for social acceptance and approval (B) is activated by the media and peer relations (A). I also propose that REBT can be used to reduce rates of youth smoking.

The Theory of Rational Emotive Behavior Therapy

Ellis suggested that human beings are “sign-, symbol-, and language-creating” individuals who use four interrelated processes: thinking, perception, movement, and emotion.[^3] He believed that thinking entails neurological processes (including learning and problem-solving) that are necessarily facilitated by perception, movement, and emotion.[^6] Similarly, emotions are a combination of related phenomena. Hence, cognitions, emotions, and behavior are consistently interactional.[^6][^7]

Based on the interconnectedness of the four fundamental processes, Ellis reasoned that emotional responses are akin to a form of “evaluative thinking.”[^6][^7] He hypothesized that thinking and emotion develop into a cause-and-effect relationship. One’s thinking becomes one’s emotion and vice-versa. This relationship eventually creates a form of “self-talk,” where internalized sentences shape cognitions, emotions, and behaviors.[^6][^7] In short, Ellis proposed that thought was necessary to sustain a specific emotional response.[^7] Hence, he believed that human beings have a tendency to create their own emotional consequences.[^2]

Human beings are innately inclined to seek happiness. Nevertheless, it is natural for individuals of all ages to foster irrational thoughts, unsuitable emotions, and harmful behaviors.[^7][^8] Although Ellis believed that interpersonal relations and social interest is important for “identity seeking,” he suggested that emotional disturbances are frequently associated with an unreasonable desire for others’ approval.[^7][^8] As a result, exaggerating the importance of societal acceptance often causes inappropriate emotions.

According to the A-B-C theory of personality, emotional consequences (C) that follow a specific activating event (A) are largely created by an individual’s belief system (B) rather than by the activating event itself.[^7][^8] For example, experiencing sadness (C) from receiving a poor grade (A) is caused by the belief that “I’m a dumb student” (B) rather than the evaluation itself. Hence, by disputing emotional consequences rationally and behaviorally, the emotional disturbances are minimized and greatly decreased.

Ellis elaborated on his theory by suggesting that a complex of thoughts and emotions are increasingly likely to become disturbed when specifically grounded in musturbatory belief systems consisting of absolute musts (E.g. “I absolutely must be loved by all.”)[^7][^8] Hence, recognizing and controlling absolute musts of a musturbatory belief system will likely reduce emotional disturbances.[^7][^8] Regardless, Ellis strongly believed that every individual must assume responsibility for his or her behavior.

Rational Emotive Behavior Psychotherapy

Unlike previous psychotherapists, Ellis was not concerned with understanding the causes of an emotional disturbance. In the case of smoking, his goal was not to remove the symptoms of pathological behavior but instead he hoped to encourage smokers to develop confident images of their self-worth.[^2] In REBT, clients are taught to recognize and concentrate on irrational thinking and inappropriate emoting by an active, directive, and “homework”-assigning therapist.[^2] As a result, smokers are likely to alter their symptom-creating beliefs.

REBT is often included in three other therapies including Cognitive, emotive-evocative, and behavioral therapy. First, cognitive therapy guides smokers to distinguish between rational and irrational thoughts by recognizing their musturbatory belief system.[^2][^7]
During sessions, the therapist actively offers information and strategies that encourage the client to explore his or her philosophy of life.[2-7] Second, emotive-evocative therapy utilizes psychodrama, role-playing, and humor to reduce emotional disturbances. The goal of this therapy is to convince smokers that they are accepted by others despite their own perceived flaws of themselves by highlighting the absurdity of their “shameful” emotions.[2,6-7] Third, behavior therapy aids clients in altering cognitive processes alongside maladaptive behavior patterns. REBT therapists often assign specific homework assignments to highlight a patient’s cognitive thought processes.[2] For instance, clients are often encouraged to deliberately fail at a relatively insignificant task, thereby learning that failures are not necessarily dangerous or harmful. Clients may be encouraged to complete regular mood diaries, create and follow lists, and engage in meditation or relaxation techniques.[2] Furthermore, smokers are instructed to establish penalties for failure to complete their assignments.[2]

Ellis recognized the importance of conducting empirical research to support the effectiveness of REBT. Concepts of REBT are difficult to measure because they are interdependent. However, outcome studies of Rational Emotive Therapy (RET) and REBT have been published on a number of occasions. McGovern and Silverman reviewed 47 RET outcome studies in 1984.[6] In 1989, Haaga and Davison conducted a detailed review of outcome studies of RET. The studies were organized according to stress reduction, headaches, assertiveness, stuttering, psychosexual disorders, antisocial behavior, and depression.[10] In 1989, Ellis stated that Haaga and Davison’s study “is probably the most comprehensive review of this area that has yet been done.”[11] A more recent review by Lyons et al. examined the efficacy of RET quantitatively.[11] The authors conducted a meta-analysis of 70 RET outcome studies, reporting 236 comparisons of RET to baseline, control groups, Cognitive Behavior Modification (CBM), and Behavior Therapy. The study found that RET is significantly effective over baseline and control group measurements. Furthermore, the study showed that therapist experienced the effectiveness of RET. However, the differences between RET and CBM or Behavior Therapy were not significant. Given the limitations of qualitative studies, the research conducted by Lyons et al. suggests that RET is an effective form of therapy.[11]

In recent years, REBT has been adapted for use with children, adolescents, and adults who suffer from a diverse set of psychological and behavioral illnesses and actions, including major depressive disorder, disability, aging, substance addictions, and terrorism.[2] Likewise, REBT is often integrated into family systems therapy. Ellis ultimately hoped that REBT would be incorporated into the schooling system as its format permits its use as an educational tool in workshops and classrooms.[2]

Application of Ellis’ Theories to Youth Smoking

Presently, REBT is a predominant technique associated with cognitive-behavioral therapy (CBT), but is distinguished by two central principles.[12] First, REBT asserts that emotional consequences are caused by an irrational belief system. Second, rational beliefs precede psychological health and wellness.[13] For example, REBT athletes who hold rational beliefs may be apprehensive prior to a competition because their preference for success may be thwarted (“I want to win”). Conversely, athletes with an irrational belief system may experience unusual levels of anxiety prior to competing because their demand for success may be thwarted (“I have to win”), ultimately affecting performance.[14] A study by Turner & Barker found that REBT significantly reduced cognitive-anxiety and irrational beliefs in elite youth cricketers. Furthermore, the shift from irrational to rational thinking was apparent to parents and coaches who noted that participants appeared less affected by peer expectations and judgments.[15] From these results, it is likely that REBT may be similarly successful in reducing the societal pressures faced by youth smokers.

The problems associated with youth smoking are physiological and behavioral. Thus, youth smoking is a major topic of concern for government organizations, academic institutions, and health care facilities. According to the 2008/9 Youth Smoking Survey (YSS), a Canadian project conducted by the University of Waterloo and funded by Health Canada, established smokers generally start experimenting with cigarettes between the ages of 10 and 18.[16] It was found that 33% of Canadian youth in Grades 6 to 12 have attempted cigarette smoking.[16] Also, 8% of youths surveyed reported being a current smoker who smokes a pack of cigarettes per month.[16] Statistics showed adults who started smoking before 15 years of age experience greater risks of respiratory and circulatory diseases.[18] Thus, long-term health effects worsen when regular smoking begins during adolescence.[17]
Psychologically, young smokers find it difficult to overcome the addictive effects of nicotine. They develop withdrawal symptoms that prevent them from attending school or contributing to society and ultimately reducing their quality of life. The YSS reported that youth smokers are generally influenced by peers or family, either directly via peer pressure or indirectly via role models. For instance, it was found that 95% of youth smokers have friends who smoke compared to 28% of non-smokers. Additionally, 76% of current smokers have family members who smoke compared to 45% of non-smokers.

Educational programs and community interventions have been implemented to control youth smoking. Youth programs that are focusing on the social influences of smoking and also teaching refusal skills to smoking have proven to be most effective. However, youth-targeted programs have not brought about a substantial decline in youth smoking.

In accordance with Ellis’ model, youth smoking can be explained in terms of activating events. Media messages may be activating events that create a strong desire for acceptance and approval leading to youth smoking behavior. For example, Wakefield et al. evaluated the impact of media messages on adolescent tobacco use. They found that children are avid consumers of movies, television shows, and music media. Within these forms of media, 30% of it depicts cigarette smoking in highly social settings. Furthermore, it was observed that fashion magazines with high youth readership frequently uses images that link successful personalities to cigarette smoking in an attempt to depict the habit as “attractive.” It was also noted that advertisement amplifies cigarette consumption by encouraging “social experimentation.” Hence, increases in youth smoking are associated with advertising campaigns that emphasize a link between tobacco use and teenage popularity.

Tobacco use in popular media may be a form of product placement utilized by corporations to promote brands. Hence, the depiction of smoking in broadcasting is often portrayed as a highly celebrated social norm. Youth often overestimate smoking prevalence, which results in “self-talk” that associates the habit with emotionally-charged thoughts of success and approval. Hence, youth misinterpret tobacco use as an “absolute must” for integration into society (“I must smoke to be a successful member of society”). They develop irrational beliefs such as the thought that by emulating celebrities they will impress peers and raise self-worth. Thus, this irrational belief leads to an increased disposition for smoking. Therefore, youth smoking is activated by false interpretations of the media.

In addition, interpersonal relationships formed at home and in school may be activating events that contribute to an absolutist need for acceptance, resulting in youth smoking.

At home, parents are generally a child’s first social influence, dictating moral and cultural norms. Studies by Eiser et al. and James White have found that children whose parents smoke are twice as likely to become smokers compared to children whose parents do not smoke. Ellis emphasized that human beings are social creatures who are eager to fulfill themselves by meeting the expectations of others. Young children are likely to imitate the smoking behaviors of their parents leading to the development of masturbatory belief systems that coincide with familial morals. Therefore, youth smoking may result when an adolescent believes that engaging in the habit is necessary to gain the approval and respect of his/her parents. This leads to the thought of “I must smoke to be accepted by my family.”

At school, peers affect youth smoking behavior. Allen et al. found that cigarette smoking serves as a form of peer-bonding. Many teenagers start smoking to belong to a specific social circle. Others lack the ability to refuse a cigarette offered by a peer. Children are likely to exaggerate the importance of peer acceptance, basing their self-worth on the approval of others. A dire need to be liked may result in youth smoking. This leads to the thoughts of “if I do not smoke, my friends will not accept me.” Hence, youth smoking is caused by illogical misperceptions of interpersonal relations.

Ellis’ model may present an effective smoking termination intervention for youth smokers. Ellis believed that human beings have a limited capability to alter their behavioral patterns. Still, he suggested that psychotherapy can help smokers recognize their self-worth and appreciate their “true identity.” Also, Ellis claimed that psychotherapy is most successful when smokers are given homework assignments. To reduce the occurrence of youth smoking, I believe that smokers must contradict their “self-talk” by acknowledging and disputing their need for societal acceptance and approval. By applying RETB via cognitive, emotive-evocative, and behavioral therapy, young smokers may be able to relinquish their need for cigarettes.
Cognitive therapy can help young smokers alter their masturbatory belief systems. It urges smokers to accept reality by focusing on irrational thinking. Schane et al. found that young smokers often deny personal nicotine addiction. Hence, it is crucial to change the behavior of young smokers by convincing them to recognize the harmful consequences of smoking. Therefore, I believe that smokers should assess the advantages and disadvantages of smoking by performing a cost-benefit analysis. In effect, young smokers will be forced to confront their behavior by analyzing their need for acceptance. They will be able to distinguish between rational and irrational beliefs by determining the emotional and physical costs of their actions. Therefore, they can develop a sense of reality that does not rely on absolutist philosophies. For example, smokers will relinquish their “if I do not smoke, my friends will not accept me,” philosophy and accept the fact that “true friends will accept me whether or not I smoke.”

Similarly, emotive-evocative therapy can also help young smokers alter their masturbatory belief systems. Since, emotive-evocative therapy uses role-playing and humor to emphasize the absurdity of harmful behaviors, young smokers can reenact situations that express their irrational beliefs. For example, a teenager smoker may admit that (s)he started smoking to gain the approval of his/her parents to an individual playing the role of said parent. If the individual demonstrates wholehearted support, an early-age smoker will be able to contradict “absolute musts” by realizing that others can accept him/her despite his/her differences. Instead of thinking, “I absolutely must smoke to be accepted by my family,” a patient can believe, “My family will love me whether or not I smoke.”

Likewise, behavior therapy can also help young smokers alter their masturbatory belief systems by assisting smokers to change self-defeating cognitive processes. I believe that young smokers should complete daily homework assignments that track their attempts to counteract their belief systems, which will allow them to monitor their progress. For instance, teenage smokers can be asked to deliberately refuse a cigarette offered by a peer. Eventually, young smokers will realize that their self-worth is not dependent on smoking behavior.

REBT is a hardhearted treatment. Therapists are often encouraged to form a non-friendly, strictly professional relationship with their clients. This approach is ideal for tough-minded individuals. Unfortunately, Ziegler (1990) noted that, “…the counseling profession attracts primarily tender-minded students, people who are warm, sensitive, and caring. Tender-minded counseling students are often threatened or alienated by a theory that espouses ‘life is often unfair.” Furthermore, REBT is a time-consuming intervention, requiring a strong commitment from clients. A final disadvantage to participating in REBT is its high cost. However, despite its drawbacks, REBT is still recognized as an effective therapy particularly for substance abuse disorders.

As Thomas Osdene suggested, smoking is a psychological activity. An application of Albert Ellis’s theories reveals that youth smoking results from activating events such as desires for social acceptance, media messages, and interpersonal relationships. Youth smoking rates may decline if young smokers distinguish between realistic and harmful beliefs. By completing active homework assignments, smokers can reduce disturbance-creating tendencies and recognize their true value.

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Keywords
Albert Ellis, Rational Emotive Behavior Therapy, Personality Theory, Youth, Smoking

References


Review of *Albert Ellis’ Theory of Personality and Its Influence on Youth Smoking: A Critical Review*

In the reviewed paper, the author attempts to understand youth smoking with respect to Albert Ellis’ A-B-C theory of personality and suggests Rational Emotive Behavior Therapy (REBT) as an intervention tool to curb youth smoking. The subject matter of the paper is important, given smoking represents the number one cause of preventable illness and premature death in most industrialized countries, and insight regarding effective intervention tools is valuable. Application of the A-B-C theory of personality to understand youth smoking is intriguing and REBT has the potential to be a useful intervention strategy, but there are nevertheless some critical concerns with this paper that are discussed in turn.

The first concern is that a stronger rationale could be provided regarding why youth smoking is considered critical. There is a large body of literature pertaining to youth smoking, which could be referred to in providing background information to the reader, and to substantiate the arguments put forward. For example, it would be helpful to state current smoking prevalence among youth and to clarify whether the context is applicable to Canada, the U.S., or elsewhere. Additionally, it would be useful to clarify what is typical smoking behaviour among youth (e.g., daily smoking, once per week), as well as what factors prompt youth to initiate smoking in the first place.

The author makes an important point in discussing the role of social norms (e.g., the influence of parents, peers, and social media) regarding youth smoking. Some of the arguments put forward regarding social norms are consistent with what the larger body of research has found (e.g., youth often overestimate smoking prevalence, tobacco representation in the mass media and its influence), yet other statements and arguments are highly questionable. For example, the author argues that “youth smoking results when an adolescent believes that engaging in the habit is necessary to gain the approval and respect of his/her parents (“I must smoke to be accepted by my family”). It is hard to believe, however, that many smoking parents approve or encourage their children to be smokers, especially given that most existing smokers regret their behaviour and would like to quit (studies indicate between 80% and 90% of smokers in the U.S.). It may be that youth, whose parents smoke, perceive smoking as permissible by their parents or that their smoking will be overlooked or ignored, but this should not be equated with smoking parents encouraging their children to smoke. In the U.S., research reveals that nearly 90% of parents (both smokers and non-smokers) believe that teenagers should be punished for smoking. This strong belief against youth smoking can be even more intensified in certain cultures (e.g., Korea). A more convincing argument seems to be that adolescents smoke to declare their independency and rebelliousness as cigarettes are seen as “forbidden fruits” that only adults can access (rather than being youths’ attempt to be approved and respected by their parents). It is highly recommended that the author review some key research papers to broaden his or her understanding of youth smoking before arguing how Ellis’ theory is applicable to understanding youth smoking and interventions.

The second concern is that it is unclear whether the author’s main interest is youth smoking prevention or cessation. The distinction between smoking prevention and cessation is very important, as intervention strategies would consequently be different. Traditionally, researchers and the public health community have given great attention to “youth” smoking and preventive measures; in the U.S., for example, it is known that smoking initiation typically takes place during early adolescence and if not smoking by 18 years old it is highly unlikely they will ever be smokers. However, there is an increasing interest in smoking cessation among youth, and also accounting for the stage at which addiction has become consequential. It appears that REBT, being a cognitive behavioural therapy, can be an effective cessation intervention to help youth quit smoking, but the paper does not specify whether the therapy is meant to have a prevention or cessation orientation.

The third concern relates to the paper’s analysis of the A-B-C theory of personality and REBT with respect to smoking. Research has already shown that a cognitive behavioural approach is an effective cessation strategy for youth. Based on my limited understanding of the A-B-C theory of personality, REBT is a cognitive
behavioural therapy. Consequently, is there any previous research showing whether REBT is in fact used to help smokers quit and whether or not it is effective? How is REBT different from other cognitive behavioural therapies? Once again, it would be helpful if the paper had a stronger foundation by presenting a more thorough overview of the relevant literature. Based on the review, an indication can be provided as to what has been done on the subject, what has been found, what we still do not know about the subject, and consequently what type of research is still needed.

The author uses terms such as “dysfunctional,” “inferiority,” and “patients” to describe the A-B-C theory of personality and REBT. It is understandable that these terms are used because REBT is applied in clinical settings, however caution is needed as such terms may be counterproductive when dealing with youth. Smokers, generally, are already likely to feel stigmatized with social norms against smoking prevailing more than ever before.

The title of the paper suggests that a “critical analysis” is put forward, thus it would be useful to also provide some potential drawbacks of REBT. For example, even though a cognitive behavioural approach is known as effective to curb youth smoking, a big drawback is the cost of such interventions. Many prevention and cessation programs are school and community based because they tend to be more cost-effective than individual based interventions. Having said this, REBT may be more cost-effective if it is used to target youth with other psychological and/or behavioural issues (e.g., depression, eating disorder).

The author suggests providing youth smokers with homework assignments as a part of REBT. It was not clear to me what kind of homework assignments. Please be clear on what kind and why this is important.

There are some minor issues.

1. The content of the abstract and opening paragraphs are too repetitive (i.e., statements repeated verbatim).
2. Please note that “product placement” is a marketing term and it is no longer allowable in the U.S. for tobacco products.
3. Some arguments are written as absolute and factual. For example, “youth smoking is activated by false interpretations of the media,” and “youth smoking is caused by illogical misperceptions of interpersonal relations.” Where is the evidence to support those claims? The author needs to be cautious about making such claims or provide appropriate citations for substantiation purposes.
4. Many cited papers are quite dated. I encourage the author to cite more up-to date papers.

Overall, the paper made for interesting reading. In summary, my suggestion is for the author to provide a more comprehensive and thorough overview of youth smoking, to think about whether REBT can be prevention or cessation focused, and to evaluate critically when REBT is likely to be effective and non-effective pertaining to youth smoking.

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