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## **Introduction**

The idea for this work was born in November 2005, when I was participating as ERASMUS Student at the Faculty of Pedagogia of the Universitat de Barcelona. During this scholarship I was an active participant of the class “Techniques Cognitivo-Conductuals de Modificacio de Conducta” of Isabel Paula. In this class I encountered for the first time of my life the “*Rational Emotive-Behaviour Therapy*” (REBT) by Albert Ellis. I realized that there are many similarities with the program of “*Motivierende Kurzintervention für Jugendliche*” (MOVE) developed by the german GINKO<sup>1</sup>. The experiences I made (and am making) during I was participating at the drug-harm-reduction-projects [www.eve-rave.de](http://www.eve-rave.de), [www.eclipse-online.de](http://www.eclipse-online.de) and [www.energycontrol.org](http://www.energycontrol.org) .

So first I translated MOVE into English<sup>2</sup>, second I compared it with the REBT concept. After this I selected the main aspects and correlating points of these concepts, always under drug-harm-reducing aspects<sup>3</sup>.

The work’s structure is designed the following way:

I will give a short overview of the two concepts (REBT and MOVE), each divided into the aspects “*a brief history*”, “*the general concept*”, “*objectives*” and “*Evaluation*”. The third part is the proper analyse of similarities and differences between these two concepts, that are “*the (psycho)pedagogic context, Target Groups and objectives*”, “*the detection of thoughts and attitudes*” and “*Techniques for Emotive-Behavioural Changes*”. Finally I will resume all and give some impulses for synergies and further investigations.

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<sup>1</sup> GINKO is the coordinating authority for addiction-prevention in the Western of Germany.

<sup>2</sup> This work seems to be, so far, the only translation of MOVE into another language.

<sup>3</sup> I am aware of the fact, that the quantity of each capital is fluctuating. This can be explained for the different availability of informations to each capital. The quality of the contents will not suffer.

## 1. REBT

### 1.1. A Brief History

REBT, the first of the modern cognitive behaviour therapies and a pioneering philosophy, was developed in 1955 by Albert Ellis in Eastern USA, in New York. Coming and strongly influenced by the perspective of a Freudian Sexual-Therapist Ellis is still modifying and updating his theory and methods even up to nowadays. Today REBT is used also for the treatment of personal disorders, posttraumatic stress and addiction.

The chronological development of REBT, following the activities of Ellis, can be resumed by the following way<sup>4</sup>:

- Presenting of the Rational-Therapy (RT) on a Conference in 1955. The emphasis lays on cognitive-behavioural aspects.
- Publication of his Rational-Emotive-Therapy (RET) in his book *“Reason and Emotion in Psychotherapy”* in 1962. Formulation of the ABC-model and pointing out the importance of emotions.
- *“Compulsion”* as a characteristic of irrational thinking and formulation of the 11 occidental irrational believes in the 1970ies.
- Extension of his model in *“Essence of RET”* in 1984. Irrational thinking is non-logic, non-objective, and absolutistic versus conditional compulsion.
- Publication of *“Expanding ABC of RET”* in 1985. Description of secondary disturbing symptoms (emotional problems beyond emotional disturbances).
- In 1993 Ellis proposes the new name *“Rational Emotive-Behaviour Therapy”* (REBT). Update of his book *“Reason and Emotion in Psychotherapy”* in 1994. Emphasizing of humanistic aspects of REBT (how to live a happy life and development of the human potentials).

A metaphor shows the main difference between the classical RET and the modern REBT programs:

*RET: Patient: “I need a table”. Therapist: “Here you got one.”*

*REBT: Patient: “I need a table”. Therapist: “Let’s make one together“*

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<sup>4</sup> (Lega, Caballo, Ellis 1997, p.34)

The actual REBT should be not understood as a pure therapy for personal disturbances, posttraumatic stress, restlessness, depression or addiction. Furthermore it is a constructivistic philosophy of life that can be used specifically and variably at every individual to reach a happy life.

There is no clear foundation of the REBT by Ellis. As the chronological progress shows the objectives and methods were developed permanently during a period of almost 40 years. But we can take the 11 irrational ideas (respective beliefs)<sup>5</sup> of the occidental civilisation that can cause emotional disturbances as basis that Ellis observed clinically:

- Irrational Idea No. 1: *It is a dire necessity for adult humans to be loved or approved by virtually every significant other person in their community.*
- Irrational Idea No. 2: *One absolutely must be competent, adequate, and achieving in all important respects or else one is an inadequate, worthless person.*
- Irrational Idea No. 3: *People absolutely must act considerately and fairly and they are damnable villains if they do not. They are their bad acts.*
- Irrational Idea No. 4: *The idea that it is awful and terrible when things are not the way one would very much like them to be.*
- Irrational Idea No. 5: *The idea that emotional disturbance is mainly externally caused and that people have little or no ability to increase or decrease their dysfunctional feelings and behaviours.*
- Irrational Idea No. 6: *The Belief that if something is or may be dangerous or fearsome one should be constantly and excessively concerned about it and should keep dwelling on the possibility of its occurring.*
- Irrational Idea No. 7: *The Belief that one cannot and must not face life's responsibilities and difficulties and that it is easier to avoid them.*
- Irrational Idea No. 8: *The idea that you must be quite dependent on others and need them and cannot mainly run your own life.*
- Irrational Idea No. 9: *The idea that one's past history is an all-important determiner of one's present behaviour and that because something once strongly affected one's life, it should indefinitely have a similar effect.*

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<sup>5</sup> Ellis uses mainly the word "belief", but for me "idea" describes it more clearly.

- Irrational Idea No. 10: *The idea that other people's disturbances are horrible and that one must feel very upset about them.*
- Irrational Idea No. 11: *The Belief that there is invariably a right, precise, and perfect solution to human problems and that it is awful if this perfect solution is not found.*

The origins of the irrational ideas got two sources: One correlates with biologicistic-evolutive factors (natural and innate tendency to irrationality located in precortical sectors in a humans brain that facilitates the appearing of irrational tendencies in its behaviour). The other source is generated by sociologic, educative, cultural factors (direct experiences of infantile socialisation or certain socio-familiar irrational ideas).

Let us take now a closer look at the way how Ellis uses the REBT for handle and change these irrational ideas.

### **1.2. The Basics of REBT**

The Rational Emotive Behaviour Therapy (REBT) is an action- and results-oriented psychotherapy which teaches individuals how to identify their own self-defeating ideas, thoughts, beliefs and actions and replace them with more effective, life-enhancing ones.

Essentially Ellis diagnoses, that emotions works like an imperative and the life in the occidental culture appears linear and not circular. Therefore his concept is an ambivalent and circular one. The sensations we have depend on the individual system of ideas respective our philosophy of live, if it is self-disturbing, self-healing or something between these extremes. That what affects us Now and Here depends on how we classificate, valuate, interpret, what we believe about the Now and Here. The more one individual<sup>6</sup> forces itself to phrases like *“must, should, need, ought to, have to, go to”* the stronger and more dogmatic is the emotional compulsion and the irrational idea. This is Ellis´

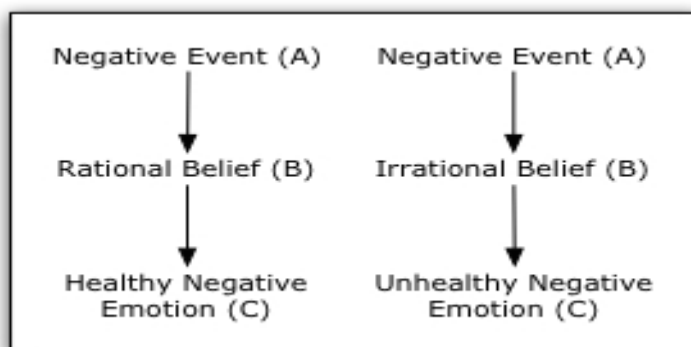
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<sup>6</sup> I prefer to use the word “individual” in the context of this work. . “Individual” is used analogue to the words “person”, “client”, “patient”. . “Individual” is used analogue to the words “person”, “client”, “patient”. Like this I can try separate moral connotations from standardized definitions and eventually create an objective discourse.

definition of self-distortion. Further this implies that our feelings are caused but not determined. So we are free to construct our (perception of) life.

The actual focus of REBT lays on the (re)structuralisation (ir)rational ideas. Short: “*Wrong*” premises leads to “*wrong*” conclusions<sup>7</sup>. What REBT does is detect irrational “*wrong*” ideas and motivate the individual to transform them into rational “*true*” ideas by the help of the ABC-model, which will be explained later. Ellis says, that the more apart, less equivalent one persons system of ideas is from the “*objective reality*”<sup>8</sup> the possibility of the appearance of unhappiness, depression or even of disturbed mental functions, grows correspondently. By the REBT a person learns to change his false premises into “*true*” ones, even when the event is negative. The individual learns to take the perspective of “*to make the best out of the situation*”.

The following scheme describes it simple and clearly:



(Illustration 1: “*Wrong*” premises leads to “*wrong*” conclusions.)

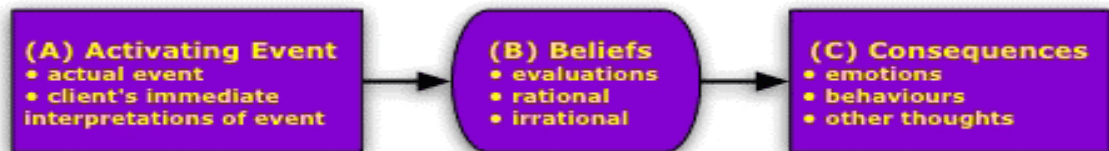
Excuse: Before we go further it seems important to say, that it would lead away from the topic of this work, when I would describe the whole REBT with all its details. Surely it would be interesting to pay attention to aspects like appropriated emotions versus impropriated ones; primary and secondary rational and irrational ideas<sup>9</sup>; or frequently appearing fears and other methods of intervention, like behavioural, emotive or other methods. De facto for our specific context of interlinks between REBT and MOVE there is no need to do this.

<sup>7</sup> These sentence was taken from the class of Isabel Paula

<sup>8</sup> That means the inter-subjective consensus of perception of the majority, the so called normality.

<sup>9</sup> According to the Irrational Occidental Ideas in part 1.1. of this work.

To understand the complex method of cognitive restructuring and the process of REBT we look now at the so called ABC-model. This model is the essence of the REBT and is used to detect the irrational beliefs and ideas, to debate, distinct and discuss them and to create new ideas, attitudes and beliefs. Let us get another visual impression:



(Illustration 2: the ABC-model by Ellis)

(A) Stands for the input or activating event. Before the individual experiences the consequences (C) it interpretes and judges by its´ system of ideas (B). (B) Are phrases of the types like “*must, should, need, ought to, have to, go to*”. (C) Are the phenomenological consequences. These three steps are told the individual.

The relation or role of the therapist is to reflect and debate (D) the individuals´ irrational ideas (B). After bringing the irrational ideas to the individuals´ consciousness the next step is to create new, rational, “*true*” ideas (E). The last and final step is the auto regulation (F) respective a new and happy philosophy of life, that, if possible, is hold up till the individuals´ last days.

### 1.3. Objectives

- Seek and uncover individual sets of ideas that frequently lead to emotional distress.
- Enhance personal growth by focusing the present and an individualized set of proven techniques for problem solution.
- Emphasize the individual’s capacity for create emotions and a fuller experience of life.
- Self-healing from individual disturbances by insights/ introspection and relative reflections by being aware of the REBT-process.
- Increase the individual’s effectiveness and happiness at work, let it live successfully with others, in parenting and educational settings, make our

community and environment healthier, and enhance health and personal welfare.

- Reformulation of dysfunctional ideas and develop a new philosophy of life.

Or in other words: A life in REBT means to live in Einstein's Theory of Relativity. You can look at the same glass of water and say about it "*it is half empty*" or "*it is half full*". The interpretation depends on the perspective.

#### **1.4 Evaluation**

There is no statistical analyse about the effect of REBT. But there are a lot empirical phenomena.

The Albert-Ellis-Institute (AEI) was the first cognitive behaviour therapy facility in the New York metropolitan area. Today, AEI provides over 20000 moderate-cost individual, family, and group therapy sessions a year. In addition to professional practice offered on-site, AEI has also conducted trainings at over 900 universities, corporate institutions and social-service agencies over the years. Its faculty members have provided trainings in cognitive behaviour therapy, addictions treatment, women's self-empowerment, anger management, and other topics. Since 1965, AEI has presented over 3000 self-help workshops to the community. Its 1970's pilot school for children, the Living School, spawned the development of emotional education programs now incorporated into school curricula throughout the U.S. AEI is a distributor of over 200 books, audio and videotapes, titles for professionals as well as the lay community. Many of these resources are in widespread use in social service agencies, schools and workplace settings around the world<sup>10</sup>. Besides the Usa there are Rational Emotive Behaviour Therapists in Argentina, Australia, Bermuda, Canada, Costa Rica, England, France, Germany, Greece, Israel, Italy, Mexico, Netherlands, Pakistan, Peru, Romania, Scotland, South Africa, Spain, Switzerland, Taiwan and Yugoslavia<sup>11</sup>. Last but not least the actual state of REBT discussion can be seen at the online-forum <http://www.albertellisinstitute.org/forums> .

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<sup>10</sup> Compare <http://www.rebt.org/missionstatement.htm>

<sup>11</sup> The complete addresses can be found under <http://www.rebt.org/referrallistinternational.htm>

## 2. MOVE

### 2.1. A Brief History

MOVE stands for „*Motivierende Kurzintervention für Jugendliche*“ („*Motivating Brief-Intervention for Youths*“) and was initiated by the state Nordrhein-Westfalen (NRW), Germany in 2000. The intention was on the one hand to close the supply-gap in the area of secondary prevention<sup>12</sup> and on the other hand to support the necessity of networking between the German Youth Welfare and the Drug Welfare. The program was developed by the coordinating authority for addiction-prevention GINKO with selected professional authorities in NRW and accompanied scientifically by the University of Bielefeld, faculty for addiction-prevention. After the testing-phase and adjustment there is now the actual version<sup>13</sup>.

First the University of Bielefeld made an expertise over the status of professional literary for the possibilities of brief-intervention for risky consuming youths. The results lead to hope reasonable, that this concept can be used also for experimental consuming youths. But the results showed, too, that there is still missing realization and practice. In spring 2000 GINKO, department for transfer, installed an interdisciplinary working group under involvement of a coach for Motivational Interviewing, prevention professionals, and contact persons to youths in the nonformal school-external youth-work. This group of experts elaborated the curriculum of MOVE with the objective to create a further education service for contact persons in the school-external youth-work. MOVE has been tested in five cities of NRW. In 2003 there were ca. 40 further educations with about 600 participants.

Addiction-prevention today aims a controlled and pleased use of legal substances, as also – respecting the BtmG<sup>14</sup> - the abstinence of illegal drugs. The consensus of the German Prevention Scientists is, that former strategies „*Abschreckung*“ (deterrence) and „*Repression*“ (repression) where substituted by „*Ansätze der Kompetenzförderung*“ (Set-Ups of Competence Forcing) and

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<sup>12</sup> Compare the VERSO-study, University of Bielefeld 1998

<sup>13</sup> Compare the GINKO-homepage respective Marzinzik 2003

<sup>14</sup> „Betäubungsmittelgesetz“, the law, that regulates (il)legal drugs in germany

“*Risikobegleitung*“ (Risk Counselling) at children and youths. Further they say the newer concepts are effective. These person-orientated main concepts are complemented by a demand for structuralized prevention, that forces the protective factors in systems like for example schools, instruction-schools or communities<sup>15</sup>.

This leads us to the three points of foundation of MOVE<sup>16</sup>:

1. The participants are able to build up motivation, construction and change of behaviour on youths.
2. The supply gap for risky consuming youths in a municipality is closed.
3. The cooperation between youth welfare and drug welfare is optimized.

## **2.2 The Basics of MOVE**

MOVE contains three days á eight units and is dedicated at employees of the Youth Welfare. One co-coach from the municipal youth welfare has to realize MOVE together with one prevention professional, if possible without modifying the concept. These two professionals build the so called “*Multiplikatorentandem*” (Multiplicator Tandem). The prevention professional has to introduce an already developed service offer, to win participants and to reflect, how far the prevention professional can use MOVE for further objectives of his institution. So MOVE has a pragmatic, specific and effective orientation.

The MOVE-curriculum contains:

- a) Introduction into the „*Transtheoretic Model*“ (TTM) by Prochaska and DiClemente<sup>17</sup>
- b) Introduction into the „*Motivational Interviewing*“ (MI) by Miller & Rollnick<sup>18</sup>
- c) Motivating brief intervention:
  - Handling ambivalences
  - Empathy
  - Detect and integrate discrepancies

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<sup>15</sup> compare Franzkowiak, Sabo, 1999, p. 90ff

<sup>16</sup> compare [http://www.ginko-ev.de/jugend\\_kurzintervention.html](http://www.ginko-ev.de/jugend_kurzintervention.html)

<sup>17</sup> Prochaska 1982, 1996

<sup>18</sup> Miller and Rollnick 1991, 2002

- Enter into dialogue
  - Handling of resistance
  - Set objectives
  - Make agreements
- d) Further reaching helps and cooperation
- e) Background knowledge about addiction and attitude of the counsellor
- f) Legal basics, laws

Let's take a closer view at points a), b), c) and e). I choose these points, because I am the opinion, that these are the crossing links between MOVE and REBT. Further the TTM and the MI are better seen as interlinked, because they are complementary to each other.

a) The TTM itself as “coaching and defines change as a, that passes different stadiums, containing the steps of:

1. **Precontemplation** (not planning to become drug-free)
2. **Contemplation** (planning to become drug-free within the next 6 months)
3. **Preparation** (ready to become drug-free)
4. **Action** (have recently become drug-free)
5. **Maintenance** (have been drug-free for over 6 months)<sup>19</sup>.

1. During the stadium of **Absichtslosigkeit (Precontemplation)** the change-readiness is very low or even non-existent. Phrases like “*never*” or “*I'm not going to change anything of my behaviour during the next six months*” point at a missing problem consciousness. At not (yet) motivated youths primary it is going about create problem consciousness, for example by giving information and reflecting discrepancies in the way of life and to avoid dealing with the youth.

2. But in the stadium of **Absichtsbildung (Contemplation)** an ambivalent perspective towards behavioural changes can already be realized. Pointing for a development of an ambivalent attitude towards the youths consume in this stadium, that means, that he/ she sees advantages and disadvantages of his/ hers consume, are phrases of the type “*one day*” or “*I will change something*”

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<sup>19</sup> Compare <http://www.clinicaltrials.gov/ct/gui/show/NCT00178776>

*during the next six months*". The Youth is already interested but not ready yet. The objectives here are to reflect and dealing with problematic behaviour, but no concrete plans and to develop and to force motivations of change.

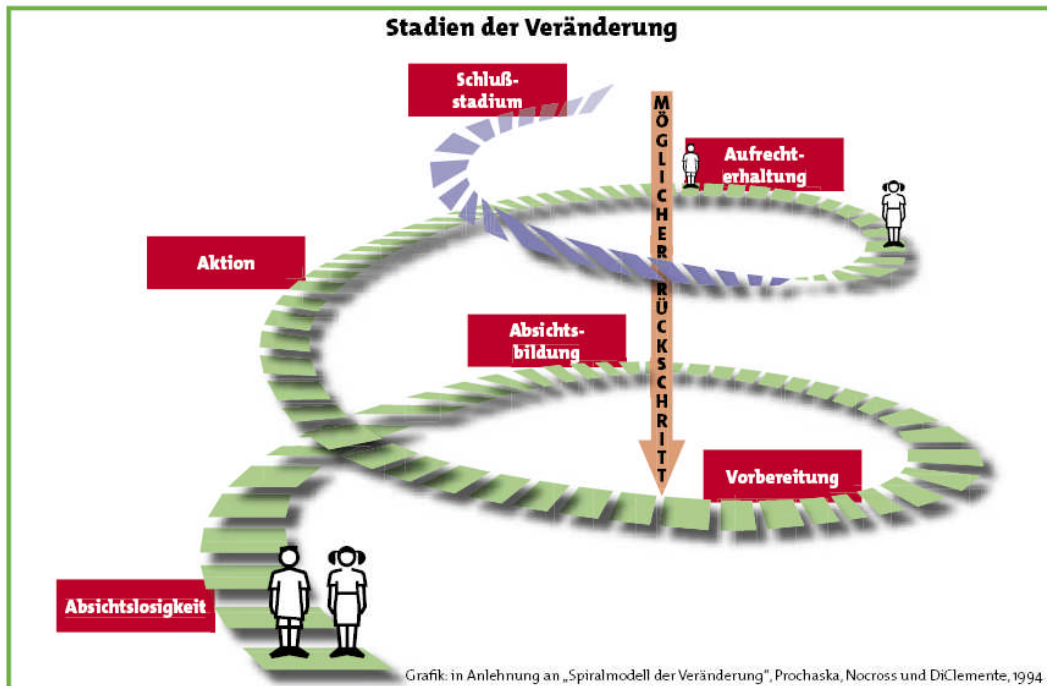
3. In the stadium of **Vorbereitung (Preparation)** are already planned concrete steps. Representative for this stadium are phrases like "*soon*" or "*I'm going to change something within the next 30 days*". The Youth is motivated highly for concrete steps of change, so it is important to take clear decision for a change of behaviour.

4. These steps are tested in the phase of **Aktion (Action)**. The corresponding phrase here is "*now*". There is a high grade of readiness and engagement. Concrete, evident steps of change are made and hold out during a longer space of time. But at this stadium is the risk of relapse very high.

5. At the end these steps are kept up in the stadium of **Aufrechterhaltung (Maintenance)**. Phrases like "*for ever*" or for example "*since six months I didn't consume Cannabis*" describe this stadium. Steps of change have been kept during a longer period.

Change is understood by MOVE as floating process, which can be accompanied at each stadium by a **Rückfall (Relapse)** in a former stadium.

The following scheme illustrates these steps, that where modified insignificantly for the new target group of MOVE:



(Illustration 3: The Transtheoretic Model (or Spiral Model) of Change)

b) The MI accepts any type of drug-use and defines motivation and change also as dynamic process. First has the motivation of each youth to be located via dialogue. Second the type of intervention has to be tuned to him/ her, depending in what stadium of TTM the youth is located. So the MI is complementally orientated on the youth. The youth has not to fit into an external concept or service, which maybe is far away and difficult to reach by him/ her<sup>20</sup>. There are various methods and instruments of the MI. The following ones are used by MOVE.

c) Basics of the motivated dialogue:

- accept the youths position
- be aware of the different levels of the dialogue (information, appeal, relation, self-revelation)<sup>21</sup>
- accepting company of the person (not of the consume) instead of confrontation
- respect of autonomy instead forcing respective compulsion

<sup>20</sup> For more details, the “moral basis” as blind spot of the classical intervention and other examples look “A Health-Oriented Substance-Use Interview” By Eugene T. Tinelli. [http://www.reconsider.org/issues/public\\_health/Interview.htm](http://www.reconsider.org/issues/public_health/Interview.htm)

<sup>21</sup> Based on the “Vier-Ohrenmodell” by Friedemann Schultz von Thun. <http://www.schulz-von-thun.de/mod-komquad.html>

- empathy instead dominating professional knowledge (active listening)
- clear response, instead of non-directive open commentaries (directive interventions)
- create an atmosphere of trust and open-mindedness
- handling of resistance during the counselling process

e) An important role is played by the knowledge and the attitude of the counsellor. To pay attention to the youths' situation empathic, respectful and objective positions towards the dialogue are important premises. It is also important to reflect one's proper emotions and mood of the actual day. By concrete dialogue situations the intervention strategies are presented and trained practically. The theoretical basics and background information (law aspects, development of addiction, etc.) are imparted by "*Referate*" (Reports) and by "*Begleitmaterialien*" (Attendant Materials). Every participant gets a dossier with deeper information and a lot of literary sources to each curriculum module.

All in all MOVE assumes from the perspective of the youth, which he/ she has from himself/ herself and his/ her situation and the actual change readiness. From this accepting basis the concept plans the next wise intervention, always interlinked with the context of change to consume and/ or its circumstances. The youth itself determines the tempo of the process and the contents of change. The classical TTM- and MI-Concepts adjust their types of intervention to each case. The type of intervention depends on the phase of (risky) behaviour and the stadium of change readiness and is orientated especially on the motivation of harm-reduction. MOVE is very suitable for people, which do not show manifest symptoms of addiction, but risky patterns of drug-use. A low existing change readiness is no reason of obstacle, but is used as starting-point of a dialogue.

### **2.3 Objectives**

- Support and force the Motivation to Change, define objectives together with the youth and agree (eventual) concrete objectives.
- Give inspiration and helps for the Target Groups. Optimize the communication between the Contact Persons and Youths and force a professional dialog and attitude.
- Critical reflection of own attitudes, behaviour and consume patterns.
- Support a conscientious way of life.
- Change dysfunctional behaviours and stabilize the functionality of society.

In short form: MOVE offers innovative, flexible and effective methods for harm-reducing interventions in the context of drug-use.

### **2.4 Evaluation**

The essence of the MOVE Evaluation:

There is a big necessity of MOVE. The response by the participants is very good. It has a big use for the work of the contact persons. MOVE forms an adequate and accepting connection to the youths<sup>22</sup>.

From my personal subjective experience I can say about MOVE that it is a program orientated on the reality of youth German drug-users, and not at the dogmatic ideal of abstinence. But for to see its` long-term effects at the target groups there are needed more empirical (quantitative and qualitative) investigations, for example via questionnaire that is given by participants to the youths.

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<sup>22</sup> The complete Evaluation by Marzinik can be downloaded in German under [http://www.ginko-ev.de/download/move\\_evaluation2.pdf](http://www.ginko-ev.de/download/move_evaluation2.pdf)

### **3. Similarities and Differences Between REBT And MOVE**

#### **3.1. Objectives, Target Groups<sup>23</sup> And (Psycho)Pedagogic Context**

One clear similarity between REBT and MOVE is the enforcement of auto motivation, which means to give help for self-help to handle compulsions. That can be summarized as the core of both concepts. Further both want to inspire the individual to critical self-reflection of own (unconscious) attitudes and to a higher consciousness of the proper thoughts and ideas. Both can be understood as professional healthy forcing accompanies and as advising support, that the individual feels (subjectively) happier and lives healthier.

Another similarity is the form of transmit the contents. REBT and MOVE do it by working at concrete examples and/ or cases, on what the processes can be seen evidently.

The main difference between both concepts lays founded in their definition. REBT is defined as a kind of therapy, while MOVE is defined as a type of brief intervention. Although both realize cognitive restructuring in a certain way, the aspect of behavioural change and problem solution is realized each on its own way.

Mainly, as I mentioned before, REBT serves for the treatment of mental and behavioural distortions, based on psychoanalytic and sexual aspects. So REBT is designed as therapy, which is primary realized in the therapist's office. Later, when the individual is involved actively into his proper therapy, it can be also realized at nearly all contexts and situations of everyday life. This holistic perspective allows integrating into this program the treatment of addiction by REBT as a type of non-specific intervention<sup>24</sup>. Further the REBT can be understood as a kind of unspecific prevention, which forces abilities to handle typical problems of the occidental society (drug-abuse, AIDS, anorexia, stress, depression, violence, fears, etc.). It is not only focused on harm-reduction, but can be used in this field by its techniques to construct a new perspective and

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<sup>23</sup> I define Target Groups as people, on whose these concepts are realized. I do not mean people that realize itself the proper concepts, like participants of a further training, instructors or professionals.

<sup>24</sup> Compare Timothy Learys' famous concept of substance-set-setting. The paradigmatic change from monocausal theories and treatments of addiction, that are mainly based in the substance, but ignore the personal (set) and social (setting) aspects, makes the REBT useful for this Target Group.

<http://www.drogenkult.net/text005.pdf>

philosophy of life. So REBT can be adjusted to each person, gender, age and of course to each distortion.

MOVE defines his aims very clearly as specific intervention in the field of drug-use. Mainly it is accomplished for German youths and adolescents that abuses Alcohol, Tobacco, illegal drugs and Cannabis. Their use is very popular under the 11 till 15 years old youths. For many teenagers and young people (age 14-21) the use of legal and illegal drugs has found its way into their everyday life<sup>25</sup>. Further MOVE makes a difference between experimental drug-use and risky drug-abuse<sup>26</sup>. It is less orientated at the paradigm of abstinence, but wants to reflect the drug-use and possible risks. The Youth has not to go to an institution, that is outside of his/ hers social context. It was designed to reach the youth, where he/ she is: free time, sport-clubs and schools. Further it is not easy to convince a youth to go directly to make a therapy, so this method allows giving brief impulses *“between the doors”*. It offers concrete help services and respects the individual’s autonomy.

The duration of each therapy respective the frequency of intervention can vary and depends on each individual/ youth.

### **3.2. Detection of Attitudes and Techniques For Emotive-Behavioural Changes**

The primary instrument or better the media used by both concepts is the individual-orientated dialogue. Independent, if the dialogue takes place between therapist and individual respective counsellor and youth or it is an introspective dialogue with oneself always the individual is in the focus. This technique allows permanent reflection and feedback of the situation, for therapist and individual. The idea is, that the position of each individual/youth is made conscientious on its own. The role of the therapist/counsellor is *“just”* to hold upward a mirror, that means to repeat the said ideas in other words, the clear and concrete essence, but without judge it. What the therapist/counsellor does mainly is asking reflective questions inductively, to inspire the individual/youth to get new perspectives. This technique has already been used 400 years before Christi by

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<sup>25</sup> Compare the comparing international study „Health Behaviour of school aged children“ (Hurrelmann et al. 2003).

<sup>26</sup> This is very progressive for drug-services developed by the German government. The German BtmG implicates an responsible use of legal drugs and the paradigma of abstinence of illegal drugs (like do the majority of the Germans addiction-therapies and drug-services).

Socrates<sup>27</sup> and was modified for nowadays. The individual and nobody else has all the responsibility and capacity to direct his life. The questions of guilty and causality do not import, like in the Psychoanalyse formulated by Freud. They are irrelevant, because the power of change one individuals life lays in the “*Now and Here*”, that means the actual attitude and behaviour of the individual.

This approach shows many similarities to the philosophic school of Existentialism at the beginning of the twentieth cycle<sup>28</sup>.

We can go even further and say REBT is a constructive philosophy of life. The impulse to life with REBT has to be voluntary. The configuration and contents of the ABC-model are depending on each individual. It is a dynamic and flexible therapy that means it configures itself and the range of action, orientated at each individual. MOVE on the other hand is “*only*” a static prevention program, that maybe is in the specific context of harm-reduction more efficient, but not holistic and not that complex. The individuals` situation is measured on the scale of the TTM. Of course it pays also attention to individual differences, but all these are standardized by (or better: into) the stadiums of TTM.

What REBT and MOVE have common in this context is that they claim to reach effects (change of attitude and behaviour) very rapidly and in different situations. What program effects longer or more efficient I cannot tell within these work, because for an analyse of that type more empirical (quantitative and qualitative) investigations are needed.

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<sup>27</sup> Elenctic Method; Socrates has been asking his dialogue partners so long, until the partner realizes, that he knows anything. From this basis both can look and create new knowledge, that is a practical one. During these process the direction goes from the special to the general.

Another aspect is the “*Mäeutik (Hebammenkunst)*”. Socrates understood himself only as helper for self-knowledge, because each individual has to find on (and inside) its own, but cannot be told from outside. Both methods would be called by the Psychologists “*Automotivation*” or “*Cognitive Restructuration*”.

<sup>28</sup> Related Philosophers are Karl Jaspers, Albert Camus, Jean Paul Sartre.

#### **4. Resume and Conclusions**

The actual situation of drug-(ab)use and mental-emotional distortions describes what kind of society we live. Our cultural context is defined mainly by economic and medial systems: The axiom of consume is found in all pores of the occidental society. Emotions, moods, ideas, state of minds (and drugs) get to demanded products in our world<sup>29</sup>. These facts and the perspective of responsibility of each human being for his/her life have born the programs of REBT and MOVE, with the objective to prevent self-damaging behaviour and to modulate it into a conscientious life.

Both programs can be described as interdisciplinary with many interlinked relations. Instead of look for the differences, that can create a certain ambient of concurrence, there should be looked at the similarities, the capacity of synergetic effects and the possibility of a common future. I mean concrete the connection of both concepts from brief intervention to long term therapy. This base shows a reciprocal supplementation: MOVE as additional brick of REBT in form of a primary diagnose or vice versa REBT as the holistic context of MOVE in form of a continuing therapy. The diagnose of a occidental problems could lead to interventional/ therapeutical resolutions, like the consumistic abuse of drugs. But, as mentioned before, more quantitative and qualitative investigations would be necessary.

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<sup>29</sup> An interesting investigation in this context made Horkheimer and Adorno (1957): „Die Dialektik der Aufklärung“. That drugs are getting more and more „pure“ products without socio-cultural-spiritual background was added by myself to Adorno`s and Horkheimer`s thesis about the “Kulturindustrie”.

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