THE COGNITIVE-BEHAVIORAL SUMMIT. A RATIONAL EMOTIVE BEHAVIOR THERAPY FRAMEWORK FOR UNDERSTANDING PSYCHOLOGICAL DYNAMICS IN MOUNTAIN WILDERNESS TREKKING

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Abstract

Mountain wilderness trekking exposes individuals to extreme somatic and environmental stressors, yet literature often neglects the cognitive mechanisms driving maladaptive behaviors like "summit fever" This theoretical synthesis bridges this gap by integrating Rational Emotive Behavior Therapy (REBT) and the ABC model with wilderness trekking. We conceptualize the mountain environment as an objective exposure setting where natural stressors serve as Activating Events (A). Rigid irrational beliefs (demandingness, catastrophizing, low frustration tolerance, self-downing) produce dysfunctional consequences (C), such as heuristic risk traps. We argue that nature's non-negotiable reality acts as an empirical Disputing (D) mechanism, promoting rational beliefs, Unconditional Self-Acceptance, and Unconditional Life-Acceptance (E). Finally, we outline experiential protocols, clinical safety parameters, and future research directions for using structured trekking as an in vivo cognitive restructuring intervention.

Keywords: Rational Emotive Behavior Therapy (REBT), wilderness trekking, ABC model, summit fever, cognitive restructuring.

INTRODUCTION

Specialized psychological literature on the interaction between humans and natural environments such as mountains has historically taken two main approaches: restorative ecopsychology and extreme sports.

Based mainly on ART – Attention Restoration Theory (Kaplan, 1995) and SRT – Stress Recovery Theory (Ulrich, 1983), classical models state that natural environments can help reduce fatigue in directed attention and lower levels of physiological stress markers. Nevertheless, these approaches focus mainly on passive exposure to low-intensity green environments, rather than the high-level, goal-oriented demands of wilderness mountain trekking.

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Research on mountain trekking and mountain climbing often looks at personality constructs such as resilience and sensation seeking. Although these studies show individual differences in risk tolerance, they rarely capture the cognitive mechanisms that trigger acute behavioral dysfunctions, such as overcoming physical failure thresholds or ignoring real, immediate dangers (McCammon, 2004).

While Adventure Therapy and Wilderness Therapy have long leveraged outdoor immersion for adolescent behavioral modification and trauma recovery (*e.g.*, Gass, Gillis, & Russell, 2012; Norton *et al*., 2014), their theoretical mechanisms often rely on psychodynamic, systemic, or non-specific experiential paradigms (*e.g.*, group cohesion, novelty, contact with nature). The present framework departs from general Adventure Therapy by introducing a targeted, mechanistic cognitive-behavioral architecture: it explicitly maps the physical landscape onto the rational-emotive ABCDE continuum, targeting discrete cognitive vulnerabilities (demandingness and performance-contingent self-worth) through structured behavioral exposure and empirical disputation.

Rational Emotive Behavior Therapy (REBT), developed by psychotherapist Albert Ellis, works on the premise that human emotion and behavior are not directly caused by external events, but by the cognitive evaluations and beliefs about those events (Ellis, 1962; Turner, 2016). Based on this idea, REBT differentiates between two core belief structures:

- Rational Beliefs (rBs) are flexible preferences, non-catastrophizing evaluations, flexible situational frustration tolerance, and unconditional self/life/others acceptance.
- Irrational Beliefs (iBs) are defined as core evaluations based on absolute demands (musts, shoulds, oughts), catastrophizing, low frustration tolerance, and global evaluations of self.

In competitive athletics, irrational beliefs – particularly demandingness ("I must succeed") and self-downing ("I am worthless if I fail") – have been consistently shown to impair emotional control, increase competitive anxiety, and degrade motor and tactical execution (Turner, 2016; Turner & Barker, 2014; Wood *et al*., 2017). In wilderness trekking and mountaineering, however, the consequences of cognitive inflexibility transcend performance decrements and become life-threatening, transforming athletic underperformance into severe heuristic failures (McCammon, 2004).

Integrating REBT into wilderness mountain trekking fills a critical gap in current health models for behavioral outdoor health. Mountains have an objective reality that cannot be changed, persuaded, or negotiated with (Brymer & Schweitzer, 2017; Frühauf *et al*., 2017). Therefore, when a trekker has an irrational belief such as "I must reach the summit, or I am a failure", the environment's physical limitations (severe weather, altitude fatigue) create acute cognitive dissonance. In social environments, people often use selfish prejudice or interpersonal explanations to

protect their irrational beliefs. The unyielding reality of mountain environments provides a unique ecological context where customary social rationalizations cannot alter physical outcomes. While structured trekking holds promise as an experiential adjunct for cognitive restructuring, these interventions must be treated as preliminary conceptual protocols requiring empirical verification before broad clinical adoption.

THEORETICAL FRAMEWORK AND METHODOLOGICAL APPROACH

This paper is structured as a conceptual analysis and integrative theoretical synthesis. Rather than conducting an exhaustive systematic review or meta-analysis of clinical trials, we utilized a narrative conceptual synthesis approach (*e.g.*, MacInnis, 2011; Baumeister & Leary, 1997) to bridge two traditionally disconnected literatures: (1) cognitive-behavioral and performance theory, specifically Rational Emotive Behavior Therapy (REBT; Ellis, 1962, 1994; Turner, 2016) and (2) outdoor, wilderness, and adventure psychology (*e.g.*, McCammon, 2004; Gass *et al*., 2012; Norton *et al*., 2014). Literature was identified across primary databases (PsycINFO, PubMed, Web of Science, and Google Scholar) using search terms crossing cognitive models ("REBT", "irrational beliefs", "cognitive restructuring", "in vivo exposure") with wilderness and extreme performance domains ("wilderness therapy", "adventure therapy", "mountaineering decision-making", "summit fever", "heuristic traps"). Sources were screened for their conceptual relevance in illustrating the ABCDE sequence under acute environmental and physical stress, focusing on peer-reviewed theoretical models, observational risk studies, and established clinical adventure paradigms.

THE MOUNTAIN WILDERNESS TREKKING ABCDE MODEL

To operationalize Rational Emotive Behavior Therapy (REBT) in mountain settings, the classical ABCDE model must be put in the context of the physical and psychological realities of mountain wilderness trekking, and not in isolation. This is because environmental conditions, cognitive evaluations, and somatic feedback loops operate continuously throughout a trek or expedition (Figure 1).

The trekking environment is a dynamic spectrum of activating events (A), including objective stressors such as sudden barometric decrease in pressure, sudden electrical storms, technical exposure in climbing situations, ambiguity in finding the right trail and gear malfunction. These can be combined with somatic tensions and interpersonal problems, including severe muscular exhaustion, altitude mountain sickness or discrepancies in trekking rhythm. According to REBT, the A part of the ABC model remains neutral, as the mountain environment works independently of human action, without any kindness or hostility. The mountain is not good or bad, it is simply an objective physical environment where knowledge and growth can occur (Naor & Mayseless, 2020).

The psychological route of a trekker is determined by their own evaluative belief system (Bs), which diverges into two cognitive structures, rational and irrational, when confronted with a stressful environment:

- Irrational Beliefs (iBs): When experiencing physical fatigue or time pressure, individuals often use a rigid, absolutistic thinking. This is expressed mainly as *demandingness* ("*I must reach the summit today, or this entire experience is a failure*"), *catastrophizing* ("*Experiencing dense fog is a complete catastrophe*"), *low frustration tolerance* ("*I cannot accept this burning incline, it is unbearable*"), and *global ego-downing* ("*Falling behind the group proves my fundamental inadequacy*").
- Rational Beliefs (rBs): In contrast, psychologically flexible trekkers process identical stress factors through adaptive evaluations. Absolute demands are changed into flexible preferences ("*I really want to reach summit, but staying alive and safety is my number one objective*"), catastrophic predictions are transformed into flexible evaluations ("*Aborting the ascent is very disappointing, but tolerable*"), stress intolerance is changed into a situational and flexible frustration tolerance ("*The ascent is intensely tiresome, but I am capable of tolerating the discomfort step by step*"), and performance is decupled from the value by an unconditional self-acceptance ("*A slower pace simply reflects current physiological conditioning, not my value as a human*").

The cognitive divergence from B determines distinct emotional and behavioral consequences (C):

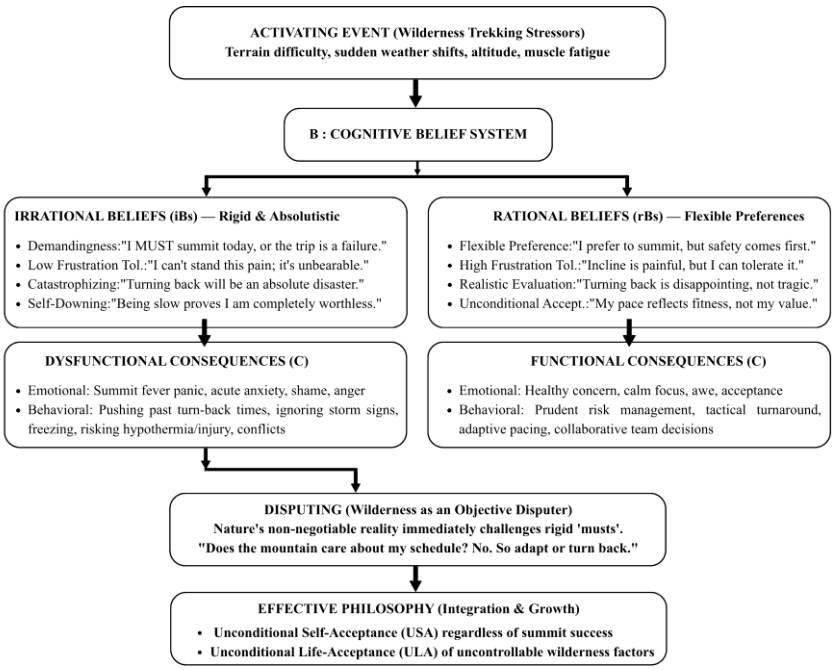
When iBs rule evaluations, the trekker experiences dysfunctional consequences: "summit fever" acute panic, shame, interpersonal hostility and reckless decisions. From a behavioral point of view, this often leads to heuristic failures, such as ignoring fixed response deadlines, ignoring obvious meteorological warnings or exhaustion and severe hypothermia or acute trauma.

On the other hand. rBs can facilitate functional negative emotions, such as healthy concerns, vigilance and proportionate disappointment alongside awe. All these support a careful management or risks, a disciplined adherence to rules, an adaptive rhythm and the preservation of collective group.

A particularity of the wilderness is its role as an objective and relentless environment for a rational disputation (D). In any conventional social or clinical medium, people can use complex explanations, rationalizations, or interpersonal defenses to hold on to their irrational beliefs. The mountain, however, rejects anything immediately – to ask for a storm that approaches to stop or an altitude headache to go away has zero physical efficacy. The absolute rigidity of nature blocks all the irrational demands of any trekker, in real time.

When properly managed, this confrontation with the surrounding environment can generate a whole new efficient philosophy (E). The trekker can go beyond transitory coping to internalize unconditional life acceptance (reconciling with environmental constraints beyond personal control) and unconditional

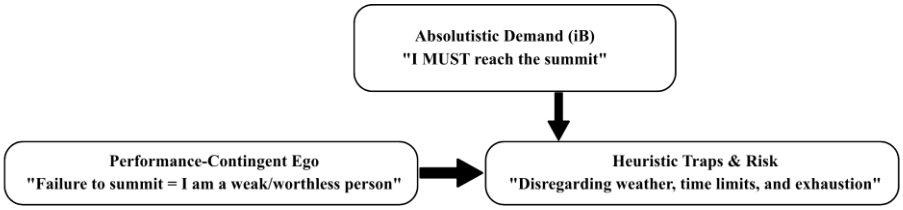
self-acceptance (anchoring self-esteem in long-lasting resilience rather than the arbitrary conquest of a summit).



Note. Conceptual model of Rational Emotive Behavior Therapy (REBT) applied to wilderness trekking, showing the path from Activating Events (A) to an Effective Philosophy (E). Adapted from Ellis (1962).

Figure 1. The Mountain Wilderness Trekking ABCDE Model

"Summit fever", the compulsive urge to reach a peak, regardless of objective danger, can be understood through REBT as a manifestation of rigid Demandingness coupled with Ego-Rating (Figure 2).



Note. Cognitive mechanisms driving summit fever, showing how absolutistic demands and performance-contingent self-worth lead to heuristic risk traps. Adapted from McCammon (2004).

Figure 2."Summit Fever": Demandingness and Ego-Rating

From a cognitive approach, summit fever is heightened by the sunk-cost fallacy and commitment escalation (Staw, 1976). When a trekker invests substantial finances, physical training and time in an expedition, the irrational demands appear ("I have sacrificed too much; therefore, I MUST reach the summit"), and this distorts the rational evaluation of reality and probability. When human worth is linked to external achievements, stopping an ascent before reaching the summit often triggers a catastrophic self-downing ("If I turn back, I am a failure"). To avoid this perceived threat to global self-worth, trekkers and mountaineers engage in cognitive distortions, systematically ignoring objective dangers (*e.g.* snow storms, avalanche risks or fixed return times) and thus yield to heuristic traps (McCammon, 2004; Tversky & Kahneman, 1974).

CLINICAL AND PRACTICAL IMPLICATIONS

PSYCHOTHERAPEUTIC APPLICATIONS & EXPERIENTIAL PROTOCOLS

Clinical psychologists can use such structured trekkings as an environment for in vivo cognitive restructuring (Table 1):

The experiential protocols proposed below are grounded in established cognitive-behavioral frameworks for behavioral experiments and in vivo exposure (Bennett-Levy et al., 2004; Ellis, 1994). Rather than serving as unstructured outdoor challenges, these protocols function as experiential hypothesis-testing mechanisms designed to empirically dispute irrational beliefs under ecologically valid conditions. In REBT, behavioral exposure is explicitly paired with cognitive disputation to test catastrophic predictions ("If I turn back, I cannot endure the shame") against objective empirical reality (Turner, 2016). In this context, the physical demands of the trail serve as a standardized, in vivo testing ground for evaluating distress tolerance and challenging performance-contingent self-worth.

- A trail marker exercise, which means designating a physical landmark on a route, where trekkers can stop and check for internal demands (musts/shoulds) and rephrase them as flexible preferences before moving on the trail.
- Voluntary discomfort exposure, which involves asking trekkers to maintain a safe physical strain (such as accepting a light rain or a steep incline as normal and manageable), without any verbal complaints for fixed periods of time, thus assessing the trekkers' real tolerance, compared to the predicted one.
- Forced turnaround experiment, which means stopping intentionally during an ascent, just before reaching the summit, to isolate and dispute feelings of shame and also encourage unconditional self-acceptance, independent of any external success.

Table 1

Trekking as an in vivo cognitive restructuring medium

Target Domain	REBT Construct Applied	Practical Intervention
Perfectionism & Anxiety	Unconditional Self-Acceptance	"Goal Abandonment" / Forced Turnaround Exposure
Distress Intolerance	High Frustration Tolerance	Voluntary Discomfort Protocol & Socratic Disputation
Mountaineering Safety	Flexible Preferences vs. Musts	Turn-back Time Decoupling & Summit-Fever Audits
Group Dynamics	Unconditional Other-Acceptance	Group Pacing Debriefs & Non-Judgmental Audits

Clinical Safety and Ethical Considerations

Implementing in vivo REBT protocols in wilderness requires strict ethical regulations and risk management procedures, such as:

- Medical screening. Before any therapeutical trek, participants should undertake a clinical and physical screening to identify any contradictions (*e.g.* cardiovascular vulnerability, severe asthma induced by physical strain or acute altitude sensitivity).
- The line between therapeutical discomfort and objective danger. Physicians and specialists must differentiate between therapeutical somatic discomfort (benign muscle ache, mild fatigue) and objective physical danger (incipient hypothermia, lightning storms, unstable snow). Exposure to physical stress must never compromise the trekkers safety.
- Informed consent and voluntary participation. The participants in any research must understand the nature of behavioral experiments and retain full autonomy in withdrawing and interrupting an exercise, without any clinical penalty.

Mountaineering Safety Education

Defining risk management through REBT can give safety educators an innovative cognitive-behavioral toolkit. Reframing a trekker's decision to turn back not as a “defeat” (which can be a self-downing) but as proof of situational frustration tolerance and rational preference can counter the sociocultural pressure that often fuels heuristic traps in wilderness mountain trekking.

Although this frame offers a new integration of cognitive theory and wilderness psychology, some theoretical limitations still occur:

- The purpose of wilderness context. This model is fit for mainly mountain trekking that is non-technical or semi-technical. Applying this to extreme mountaineering in high mountains (for example over 8000 meters high) involves

complex cognitive deficiencies induced by hypoxia, and that requires a different neuropsychological analysis.

- Cultural and individual differences. Baseline fitness, prior outdoor experience and expertise and cultural variations regarding achievements and self-worth can moderate the intensity of irrational evaluations during trekking.
- Absence of quantitative validation. As a theoretical synthesis, the proposed relations require a thorough testing and a psychometric validation.

CONCLUSIONS

Integrating REBT with wilderness mountain trekking shows the mountain as an excellent place for cognitive transformation. Physical fatigue, challenging weather and terrain do not cause directly psychological suffering. Rather, they activate core irrational beliefs. Because nature does not negotiate, wilderness mountain trekking forces the empirical disputation of absolute demands, cultivating a higher frustration tolerance, unconditional self-acceptance and psychological resilience.

To support this theoretical framework, future studies will have to connect psychometric assessments with physiological measurements and clinical studies in a coherent methodology. Prospective studies will have to prioritize psychometric quantitative validation of standardized instruments such as Shortened General Attitude and Belief Scale (SGABS; Lindner *et al*., 1999), in experimental designs, with pre and post measurements, to assess the discrete changes of core irrational subscales, particularly for achievements and low frustration tolerance. At the same time, integrating digital monitoring journal for the in vivo ABC model with objective physiology markers such as cardiac rhythm and salivary cortisol, will offer a profound empirical perspective on real time interaction between cognitive restructuring and biological stress recovery during trekking. Finally, these research lines should concur with strictly controlled clinical studies that evaluate REBT protocols in the wilderness, compared to traditional therapy for adventure. This will set the path for establishing experiential personalized interventions for people with maladaptive perfectionism, professional exhaustion and anxiety disorders.

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