

- 1 **David M. Pittle, Ph.D., M.Div.**
 - Primary orientation: REBT/CBT
 - Secondary tools:
 - Schema-Focused
 - Transactional Analysis
 - Gestalt
 - Hypnotherapy
 - Podcast: <http://www.turningspirit.com> or drdavidpittle.podbean.com
 - Pseudo-retired. Allows me the luxury to only accept patients who are otherwise unserved and "below the sliding scale"
 - Practice is primarily depression/anxiety, sex and sexuality (Especially seniors), marital issues, spiritual coaching
 - Primary Training: Kokusai Kirisutokyo Daigaku (Japan), SFTS, U. of Akron, AEI, Midwest Inst. for TA, San Quentin Prison (Internship)
- 2 **Who Invented Cognitive Behavior Therapy?**

And When?
- 3 **Epictetus, Invented Cognitive Behavior Therapy, ca. 100AD**
 - Men are disturbed not by things, but by the view which they take of them.
 - It is not what happens to you, but how you react to it that matters.
 - It is not he who reviles or strikes you who insults you, but your opinion that these things are insulting.
- 4 **CBT Umbrella Covers Several Different Styles/Modes**
 - REBT—Albert Ellis, developed early 1950s. Dissatisfaction with psychoanalysis
 - CT—Aaron Beck, middle 1960s. Also unhappy with psychoanalysis, inspired by Ellis.
 - Arnold Lazarus, 1960s
 - CBM—Donald Meichenbaum, 1980s
 - DBT—Marsha Linehan
 - Others: Hauck, Maultsby, Pelusi
- 5 **Original Sources for more information**
 - Turning Point
<http://www.turningspirit.com>
 - Rational Emotive Behavior Therapy
<http://www.nacbt.org/>
<http://www.rebt.org/>
 - Schema-Focused Therapy
<http://www.schematherapy.com/>
- 6 **Rational Emotive Behavior Therapy**

7 **Basic Concepts of REBT**

- Practical and symptom focus
- Philosophically based but techniques have empirical support
- Requires collaboration with client
- Clients change through identification of irrational thoughts
- Clients behavior and thought processes are evaluated

8 **Basic Concepts of REBT**

- Stresses thinking, judging, deciding, analyzing, and doing
- Assumes that cognitions, emotions, and behaviors interact and have a reciprocal cause-and-effect relationship
- Is highly didactic, very directive, and concerned as much with thinking as with feeling
- Teaches that our *emotions stem mainly from our beliefs*, evaluations, interpretations, and reactions to life situations
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9 **Basic Propositions of REBT**

- People have the potential to be rational, self preserving, creative, functional and to use metathought OR to be irrational, self-destructive, short-range hedonists
- Culture and family can perpetuate irrational thinking
- Humans perceive, think, emote and behave simultaneously
- All psychotherapies are not equally effective
- Highly cognitive, directive therapies requiring tasks and discipline are likely to be effective in a shorter time period with less sessions required

10 **Basic Propositions of REBT**

- A warm therapeutic relationship may be desirable but it is not necessary or sufficient condition for change
- REBT Therapists use a variety of techniques - the focus is not symptom removal but cognitive and behavioral change
- Neurotic thinking is the result of unrealistic, illogical thinking

11 **Basic Propositions of REBT**

- The causes of an individual's problems are not the events that have happened but how the individual perceives them
- There is an element between stimulus and response; it is thought
S thoughts R
- REBT holds that beliefs mediate events and emotions
- REBT provides clients with methods for changing irrational beliefs

12 **Comparing
Cognitive Therapy with REBT**

In CT thoughts are labeled dysfunctional
In REBT thoughts are labeled irrational

CT therapists are more collaborative
REBT therapists are more confrontational

CT less aggressive

REBT more aggressive

The most significant difference between REBT and Cognitive therapy (CT) therapist's forcefulness in disputing beliefs

Both CT and REBT use psychoeducation

13 **Comparing REBT and Behavior Therapy**

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- REBT focuses more on cognitive aspects
- REBT is more similar to CT and Multimodal Therapy than BT

14 **History**

- REBT – developed by Alfred Ellis
- After two decades of practicing psychoanalysis he became increasingly disillusioned by the limited progress clients were making
- First paper, *A Rational Therapy*, in 1953
- 1957 published *How to live with a Neurotic*
- 1975 published *A New Guide to Rational Living* which continues to be one of his most popular books
- 1977 published *Handbook of Rational-Emotive Therapy*

15 **Current Status**

- Albert Ellis Institute established in 1959 teaches principles of healthy living and trains therapists
- *Journal of Rational-Emotive Therapy* and *Cognitive Behavior Therapy* reports latest findings.
- (*Ellis died on July 24, 2007.*)

16 **Research Supports Several REBT Principles**

- Thoughts and feelings are not different processes – each affects the other
- Beliefs are more important than events
- Metathought occurs (often captured in images)
- Changing thoughts, behaviors, or emotions changes other modalities

17 **Personality**

- Basic tenet of REBT is that emotional upsets, as distinguished from feelings of sorrow, regret, annoyance, and frustration, largely stem from irrational beliefs
- Problematic beliefs center around words/concepts like ... should, ought, awful, must, I want, I need ...
- This is the basic personality theory of REBT ... Humans largely create their own distress

18 **Personality View of Human Nature**

- We are born with a potential for both rational and irrational thinking
- REBT suggests humans have an innate nature to want, need and condemn when needs aren't met
- If an individual's needs aren't met they display a tendency to childishly condemn themselves, others and the world
- REBT contends that we are self-talking, self-evaluating, and self-sustaining.
- We have an inborn tendency toward growth and actualization

- We learn and invent disturbing beliefs and keep ourselves disturbed through our self-talk
- We have the capacity to change our cognitive, emotive, and behavioral processes

19 **View of Emotional Disturbance**

- REBT views emotional disturbances as the result of irrational thinking and behaving.
- We learn irrational beliefs from significant other during childhood
- REBT therapist teach clients to feel "undepressed" even when they are unaccepted and unloved by significant others.

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20 **Personality**

View of Emotional Disturbance

- Blame is at the core of most emotional disturbances
- Irrational idea (e.g., I *must* be loved by everyone) → internalize → self-defeating
- We have a tendency to make ourselves emotionally disturbed by internalizing self-defeating beliefs
- REBT hypothesizes that we keep ourselves emotionally disturbed by the process of self-indoctrination
- REBT holds that neurotic problems directly stem from magical, "non-validated" thinking

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- The solution for dealing with an individual's demandingness most strongly supported by REBT is decreasing demandingness
- Compare with Buddhism. Ellis was an atheist, but many of his students were Jewish, Christian, and some Wiccan.

22 **The ABCs (and DE) of Emotion**

REBT refers to the ABCDE. ABCDE stands for, activating events, beliefs, consequences (or consequent emotion), dispute, and effect

In challenging an individual's thought processes, REBT uses persuasion and direct confrontation

23 **The A-B-C Theory of Emotional Change**

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A = C
or
A + B = C

26

27 **D = Dispute "B"**

- Is it true?
- Is it healthy?
- Is it helpful?
- Is it realistic?
- Is it logical?

- Is it rational?

28 **Irrational Ideas**

- Irrational ideas lead to self-defeating behavior
- Some examples:
 - "I must have love or approval from all the significant people in my life."
 - "I must perform important tasks competently and perfectly."
 - "If I don't get what I want, it's terrible, and I can't stand it."

29 **Twelve Common Irrational Ideas**

1. I need love and approval from those significant to me-and I must avoid disapproval from any source.
2. To be worthwhile as a person I must achieve, succeed at whatever I do, and make no mistakes.
3. People should always do the right thing. When they behave obnoxiously, unfairly or selfishly, they must be blamed and punished.
4. Things must be the way I want them to be-otherwise life will be intolerable.
5. My unhappiness is caused by things outside my control-so there's little I can do to feel any better.
6. I must worry about things that could be dangerous, unpleasant or frightening-otherwise they may happen.

30 **Twelve Common Irrational Ideas**

7. I can be happier by avoiding life's difficulties, unpleasantness, and responsibilities.
8. Everyone needs to depend on someone stronger than themselves
9. Events in my past are the cause of my problems-and they continue to influence my feelings and behaviors now.
10. I should become upset when other people have problems and feel unhappy when they are sad.
11. I shouldn't have to feel discomfort and pain-I can't stand them and must avoid them at all costs.
12. Every problem should have an ideal solution – and it's intolerable when one can't be found.

31 **Shorthand of iR Positions**

Rather than memorize the 12 iRs, a quick way to remember the basics is the three positions. .

- I stink!
- You stink!
- The world stinks!

32 **The Therapeutic Process**

- Therapy is seen as an educational process
- Clients learn
 - To identify and dispute irrational beliefs
 - To replace ineffective ways of thinking with effective and rational cognitions
 - To stop absolutistic thinking, blaming, and repeating false beliefs

33 **Therapeutic Goals**

- A basic goal is to teach clients how to change their dysfunctional emotions and behaviors via cognitive and behavioral methods - into healthy ones.
- Two main goals of REBT are to assist clients to achieving unconditional self-acceptance

(USA) and unconditional other acceptance (UOA).

- As clients become more able to accept themselves, they are more likely to unconditionally accept others.

34 **Therapist's Function and Role**

1. Encouraging clients to discover their irrational beliefs and ideas
2. Making connection of how these irrational beliefs lead to emotional disturbances
3. Challenging clients to modify or abandon their irrational beliefs.
4. Dispute the irrational beliefs and substitute rational beliefs and behaviors.
5. Displaying warmth toward clients may be desirable but it is not necessary.

35 **Client's Experience in Therapy**

- Client is a student and learner The client learns how to apply logical thoughts, experiential exercises, and behavioral homework to problem solving and emotional change
- Focus on here-and-now experiences
- Does not spend much time exploring clients' early history and connecting present and past
- Expect to actively work outside the therapy sessions.

36 **Relationship Between Therapist and Client**

- The role of the client in rational emotive behavior therapy is like that of a student and a learner

37 **Relationship Between Therapist and Client**

- Intensive therapeutic relationship is not required. But, REBT therapist unconditionally accepts all clients and teaches them to unconditionally accept others and themselves. (therapist accepts them as persons but confronts their faulty thinking and self-destructive behaviors)
- REBT believes that too much warmth and understanding can be counter-productive, fostering dependence for approval.
 - Minimum to achieve a therapeutic alliance.

38 **Relationship Between Therapist and Client**

- Therapists shows great faith in their clients' ability to change themselves.
- Open and direct in disclosing their own beliefs and values
- Transference is not encouraged, when it occurs, the therapist is likely to confront it (e.g., clients believe that they must be liked and loved by their therapists.)

39 **Therapeutic techniques and procedures**

- Cognitive methods
 - Disputing irrational beliefs
 - If I don't get what I want, it is not at the end of the world
 - Doing cognitive homework
 - Applying ABC theory in daily life's problems
 - Put themselves in risk-taking situations to challenge their self-limiting beliefs.
 - Replace negative self-statement to positive message
 - Changing one's language
 - It would be absolutely awful.. → It would be inconvenient
 - Using humor
 - Humorous songs

40 **Therapeutic techniques and procedures**

- Emotional Techniques

- Rational-emotional imagery
 - Imagine the worst things that could happen to them
- Role playing
- Shame-attacking exercises
 - Take a risk to do something that they are afraid to do because of what others might think...until they realize that their feelings of shame are self-created.
- Use of force and vigor
 - From intellectual to emotional insight
 - Reverse role playing
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41 **Main Goals of REBT**

- The primary goal of REBT is the alteration of basic values and beliefs
- REBT's goal is to achieve minimal demandingness and maximal tolerance
- Goal is minimization of musturbation, perfectionism, grandiosity, and low frustration tolerance
- In therapy, REBT teaches patients to differentiate between those items they want or desire and those they need
- REBT assist client in seeing how giving up perfectionism improves their lives
- REBT aims at changing habits as well as cognition through cognitive and behavior techniques
 - Increasing use of hypnotherapy for those REBT therapists who are trained

42 **Psychotherapy**

- REBT helps clients acquire a more realistic, tolerant philosophy of life
- REBT practitioners often employ a rapid-fire active-directive-persuasive-philosophical methodology
- The solution for dealing with an individual's demandingness most strongly supported by REBT is decreasing demandingness

43 **Application of REBT**

- Depression
- Anxiety
- Psychosis
- Bipolar
- Anger management
- Stress management
- Children
- Problems with love, sex, and relationships
- Couples and marriage and family counseling
- Prevention of dysfunction through learning REBT

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From:
Rational Emotive Behavior Therapy and Other CBT
To:
Schema Focused Therapy

- 45 **Why Schema Therapy?**
- REBT and most CBT has no good answer for personality disorders, particularly BPD. Nor do other therapy approaches. (except DBT)
 - DBT does work but is very resource intensive and requires an extraordinary commitment by both therapists and clients.
 - Personal search for alternatives for BPD family member.
 - Some CBT clients are resistive to cognitive approaches.
 - I have long integrated many TA concepts and Schema Therapy make use of some of them. Especially Parent-Child and Scripts.
 - Schema map fairly well to Irrational Beliefs. Handy for transitioning with clients.
- 46 **Schema Therapy**
- Created by Jeffery E. Young
 - Borrows extensively from Transactional Analysis (Eric Berne), Emotion-Focused Therapy (Sue Johnson and Leslie Greenberg), Attachment Theories (Bowlby, et al), as well as many other constructivist perspectives.
 - For more information, I recommend
Schema Therapy: A Practitioner's Guide, Jeffrey E. Young, Ph.D., Janet S. Klosko, Ph.d., Marjorie E. Weishaar, Ph.d. (ISBN 9781593853723)
- 47 **Schema Therapy:
Basic Treatment Approach**
- 48 **Two Phases of
Schema Therapy**
- ✓ Assessment & Education
 - ✓ Change
- 49 **Schema Assessment
& Education**
- 50 **Goals of Phase One:
Assessment and Education**
- Identify and educate patient about central life schemas
 - Link schemas to presenting problems & life history; explore origins of schemas
 - Bring patient in touch with emotions surrounding schemas
 - Identify dysfunctional coping styles
- 51 **Problem- and Pattern-Identification**
- Identify central presenting problems and symptoms; which core needs are not being met?
 - Is patient suitable for Schema Therapy?
 - Conduct Focused Life History Interview
 - Identify life patterns, then link to presenting problems
- 52 **Educating Patients
about the Schema Approach**
- Explain concepts of needs, schemas and coping styles
 - Assign introductory chapters in "Reinventing Your Life"
 - Relate individual schemas to patient's current life problems
- 53 **Assessing Schemas with the
Young Schema Questionnaire
YSQ-L3**

- 54 **Assessing Childhood & Adolescent Origins**
- Discuss patient's memories from childhood & adolescence
 - Assign Young Parenting Inventory
 - Link parenting behaviors with specific schemas
- 55 **Emotion-Focused Techniques for Schema Assessment**
- Elicit upsetting childhood images with mother, father & other significant people
 - Set up dialogues
 - Ask patients what they need from significant others in the image; link with schemas
 - Link emotions from childhood images with current life circumstances
- 56 **Therapy Relationship for Assessment**
- Be alert for cues that patient's schemas might be triggered in the session; point out cues to patient
 - Work together to identify trigger
 - Discuss which schemas were activated
 - Link in-session triggers to events outside therapy
- 57 **Schema Therapy:**
- Change Phase**
- 58 **Phase Two: Change**
- Cognitive: Restructure thinking related to schemas; develop healthy voice to create distance
 - Emotion-Focused: Practice emotive exercises to vent anger & grieve for early pain, to empower patient
 - Therapy Relationship: Focus on therapy relationship to provide limited reparenting, and to heal schemas & coping styles triggered in sessions
 - Behavioral Pattern-Breaking: Rehearse behavioral and interpersonal changes related to presenting problem; break dysfunctional life patterns
- 59 **Cognitive Techniques (1)**
- Column 1: List Evidence Supporting the Early Schema
 - A. From Childhood & Adolescence
 - B. From Adult Life
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 - Column 2: Reattribution
 - A. Was it my fault?
 - B. Are there other explanations? Special circumstances? Am I overgeneralizing?
 - C. Can I change?
- 60 **Cognitive Techniques (2)**
- Column 1: List Evidence Against the Early Schema
 - A. From Childhood & Adolescence
 - B. From Adult Life
 - Column 2: How I Discount the Evidence
 - Column 3: Reclaiming the Positive Evidence

- 61 **Cognitive Techniques (3)**
Dialogues between
the Schema Mode
and the Healthy Adult Mode
- 62 **Cognitive Techniques (4):
Self-Help Assignments**
- Therapist dictates flashcards, using template
 - Write separate flashcards for most recurring life situations or modes
 - Later in therapy, assign Schema Diary
- 63 **Schema-Driven Behavior in
the Therapy Relationship**
- Point out when patient's schemas seem to be triggered in a session
 - Ask patient for trigger event, emotions & cognitions; label schemas & coping styles
 - Are the therapist's schemas being triggered?
 - Distinguish the patient's accurate and adaptive reactions from schema-driven reactions
 - Link events in the session with situations outside therapy
- 64 **Limited Reparenting**
- Therapist's behavior serves as an antidote to patient's childhood experiences; tailor style to patient's schemas
 - Therapist fulfills needs that were never adequately met, within appropriate boundaries of therapy relationship ("corrective emotional experience")
 - Patient internalizes therapist's Healthy Adult mode
- 65 **Emotion-Focused
Techniques for Change**
- Imagery & dialogues for empowerment
 - Patient expresses anger and asserts rights appropriately in imagery and role-playing
 - Patient grieves for losses; faces & overcomes trauma
- 66 **Behavioral Pattern-Breaking**
- Clarify self-defeating behaviors that are part of the life pattern; review negative consequences & link to presenting problem
 - Patient keeps detailed, "verbatim" reports of current situations that are part of cycle
 - Therapist models, then patient practices new behaviors to break cycle in imagery and role-plays
 - Therapist assigns homework; uses schema imagery to overcome avoidance and obstacles to change
- 67 **Concept of
Empathic Confrontation**
- 68 **Forgiving Parents:
Moving Beyond the Past**
- Examine schemas of parents and other significant others who hurt the patient
 - Parenting is difficult; most do the best they can, given their life circumstances and psychological limitations
 - "Legacy of schemas"
 - Concepts of acceptance & forgiveness to achieve peace and closure, *if possible*

69 **Outcome Research**70 **Outpatient Psychotherapy
for Borderline Personality Disorder:*****Randomized Trial of
Schema-Focused Therapy
vs. Transference-Focused Psychotherapy***71 **Method**

- Treatments: Schema Therapy (ST), Transference-Focused Psychotherapy (TFP, Kernberg)
- Subjects: 86 Outpatients with BPD, Randomly Assigned to ST or TFP
- Sites: 4 Community Mental Health Centers
- Length of Treatment: 3 years, two sessions per week

72 **Results (1)**

- Significantly more dropouts in TFP than in ST: 50% for TFP, 27% for ST
- Dropouts in ST had significantly more sessions than in TFP (i.e., they dropped out much later in treatment): 98 sessions vs. 34 sessions
- ST was significantly more effective than TFP in reduction of BPD symptoms, general psychopathology, and personality pathology

73 **Results (2)**

- At completion, "full recovery" from BPD symptoms: 46% in ST, 24% in TFP
- At one year follow-up, "full recovery" from BPD symptoms: 52% in ST, 29% in TFP
- At completion, "reliable and significant change" in BPD symptoms: 66% in ST, 43% in TFP
- Schema therapy was more cost effective: net *gain* of 4,500 Euros per patient (5,700 USD)