Rational Living Therapy
Level-Two Certification

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Rational Living Therapy

An Effective, Shorter-Term Approach with Long-Term Results

Developed and Presented by:

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Rational Living Therapy®
Certification Procedure

Requirement for Certified Rational Living Therapist: Masters Degree or Above in Mental Health Field and completion of the five certification levels

Certification Levels

Level-One
Introduction to Rational Living Therapy
Dealing with Resistance
Intro. to the Treatment of Specific Problem Areas
Introduction to Group Therapy

Level-Two
Treatment of "Personality Disorders"
Advanced Underlying Assumption Therapy
Advanced Cognitive Modification Skills
Application to Mood / Anxiety Disorders
Group Therapy

Level-Three
Rational Motivational Interviewing
Marital Therapy
Substance Abuse Treatment
Treatment of Children

Level-Four
Advanced Case Application (In-Depth Work on Therapy Cases Presented by Attendees)

Level-Five
Practicum (Six-Month weekly feedback of cases conducted via audio tape / email, telephone)

Additional Available Training / Certifications

-- Certified RLT Supervisor
-- Certified RLT Instructor

-- Certified Rational Hypnotherapist (Some Rational Living Therapists elect to utilize this cognitive-behavioral approach to hypnotherapy to enhance the effectiveness of therapy. Rational Hypnotherapy is not a required aspect of Rational Living Therapy.)

Rational Living Therapy
Categorizes Thoughts into Six Types

1. Positive

2. Neutral

3. Negative

4. Optimistic

5. Pessimistic

6. Rational

The Rational Living Therapy Approach
Therapy Sequence

1. **Assessment** (Usually One Session)

What's the main reason for coming to see me today?

Make assessment of learned vs. not-learned behavioral problem.

Indirectly encourage success: Conversational Hypnosis Techniques

Toward end of session, ask:

What do you do well? What is right in your life?

Implication questions to ask:
- Who will be the first person to notice when you are feeling better?
- How will it feel to feel good?
- What will you do when you are feeling good?

Time bind suggestion:
- I don't know how long it will take before you feel the way you want to feel. It could take three, or as many as four session before you begin feeling better.

Emphasize the importance of self-counseling.

Homework: Introduction and Chapters 1 & 2 of "The Client's Guide to Cognitive-Behavioral Therapy"
Goals (Therapy, Life-Goals, Do and Avoid)
Feelings & Behavior Pattern Form

2. **Review Homework, ABC's of Emotions (One Session)**
- OR - Rational Hypnotherapy (Two Sessions)

If we elect to perform hypnotherapy, we will conduct two sessions of it, with the second recorded on audio tape for self-hypnosis purposes.

Homework: Chapter 3 (ABC Chapter) & Chapter 4 (Thoughts & Underlying Assumptions) & Chapter 5 (About Problems)
ABC Situations.

3. Review Homework, Rational Questions (Several Sessions)

Homework for First Session of this Phase
Homework: Chapter 6 (Rational Questions)
ABC Situations
Apply Rational Questions to Thoughts
Thoughts I Hope are Incorrect
Practice New Rational Replacement Thoughts

Homework for Second Session of this Phase
Homework: Chapter 7 (Mental Mistakes)
Apply Rational Questions / Mental Mistakes to Thoughts
Practice New Rational Replacement Thoughts

As we help the client apply the Rational Questions during this phase, we also are teaching them about any cognitive distortions they are making, and having them learn about the rest of them on their own by reading Chapter 7

4. Review Homework, Rational Action Planner (One Session)

Homework: Chapter 8 (Rational Action Planner)
Do at least one RAP

5. Review Homework, Importance of Practice, Practicing Techniques, Thought Growth (One Session)

Homework: Chapter 9 (Practice)

6. <u>Rational Hypnotherapy if Needed</u> (At Least Two Sessions)

At least two sessions, with the second being recorded for self-hypnosis purposes.

7. <u>Remainder of sessions spent reviewing RAP's</u> (Possibly Several Sessoins)

Homework: Behavioral Assignments

Chapters 11 (More Rational Techniques) & 12 (Conclusion)

Rational Living Therapy's
Theory of Personality Disorders

1. RLT rejects the common concept of personality disorder" and notion that a person "suffers from" or "has" one.

2. Well-learned patterns of thinking, feeling, acting, reacting. These well-learned patterns create unwanted emotions and goal- interfering behavior. These well-learned thoughts are underlying assumptions that affect ones perception of oneself and the world around us.

3. A variety of factors maintain these well-learned patterns, including the mental filter" mental mistake.

4. The person with these well-learned tendencies engages in a variety of compensatory strategies that result from the problematic underlying assumptions.

My reaction to people with:

(1) Dependent

(2) Histrionic

(3) Obsessive-Compulsive

(4) Avoidant

(5) Narcissistic

(6) Borderline

(7) Schizotypal

(8) Paranoid

(9) Passive-Aggressive

(10) Schizoid

(11) Antisocial

Basic Premises About Effective Treatment of "Personality Disorders"

Premise #1:Our Initial Interactions with the Client are Vitally Important

Premise #2: Utilizing a Variety of Techniques and Avenues by Which to Implement Them becomes Increasingly Necessary the Lower the Level of Likely Positive Response.

Premise #3: Helping the Client Develop a Personally Meaningful Reason to Change is Essential.

Typical Response to Current Treatment
(As Opposed to "Treatability)

<u>High Positive Response</u>

Dependent
Histrionic
Obsessive-Compulsive
Avoidant

<u>Intermediate Positive Response</u>

Narcissistic
Borderline
Schizotypal

<u>Low Positive Response</u>

Paranoid
Passive-Aggressive
Schizoid
Antisocial

Four Stages of Treatment

1. Engagement:

2. Thought / Underlying Assumption / Behavior Identification:

3. Thought / Underlying Assumption / Behavior Change:

4. Thought / Underlying Assumption / Behavior Change Maintenance:

Stages of Emotional / Behavioral Re-Education

1. Intellectual Insight

2. Practice

    Cognitive-Emotive Dissonance

3. Emotional Insight

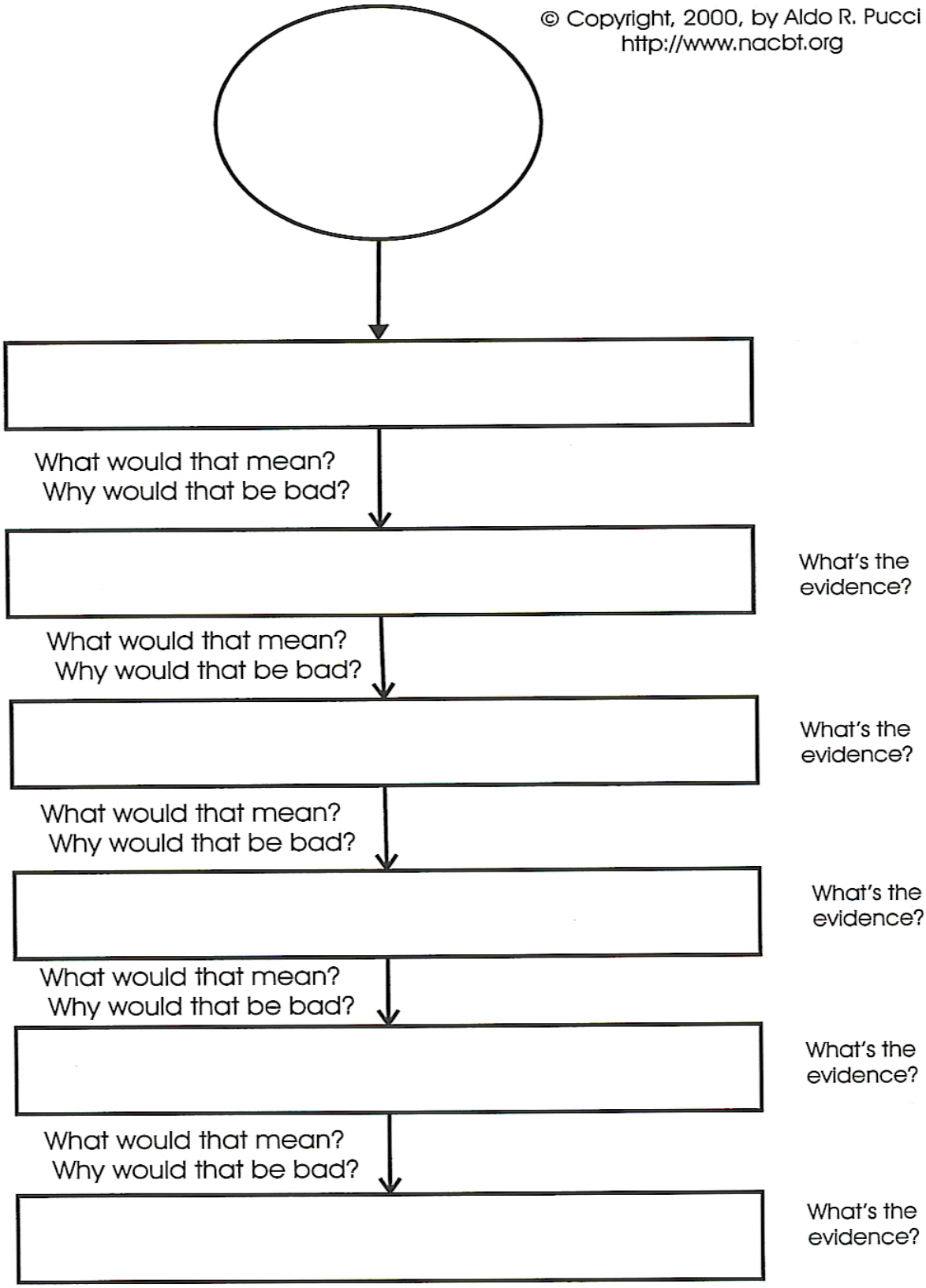
4. Personality / Trait Formation (Habit)

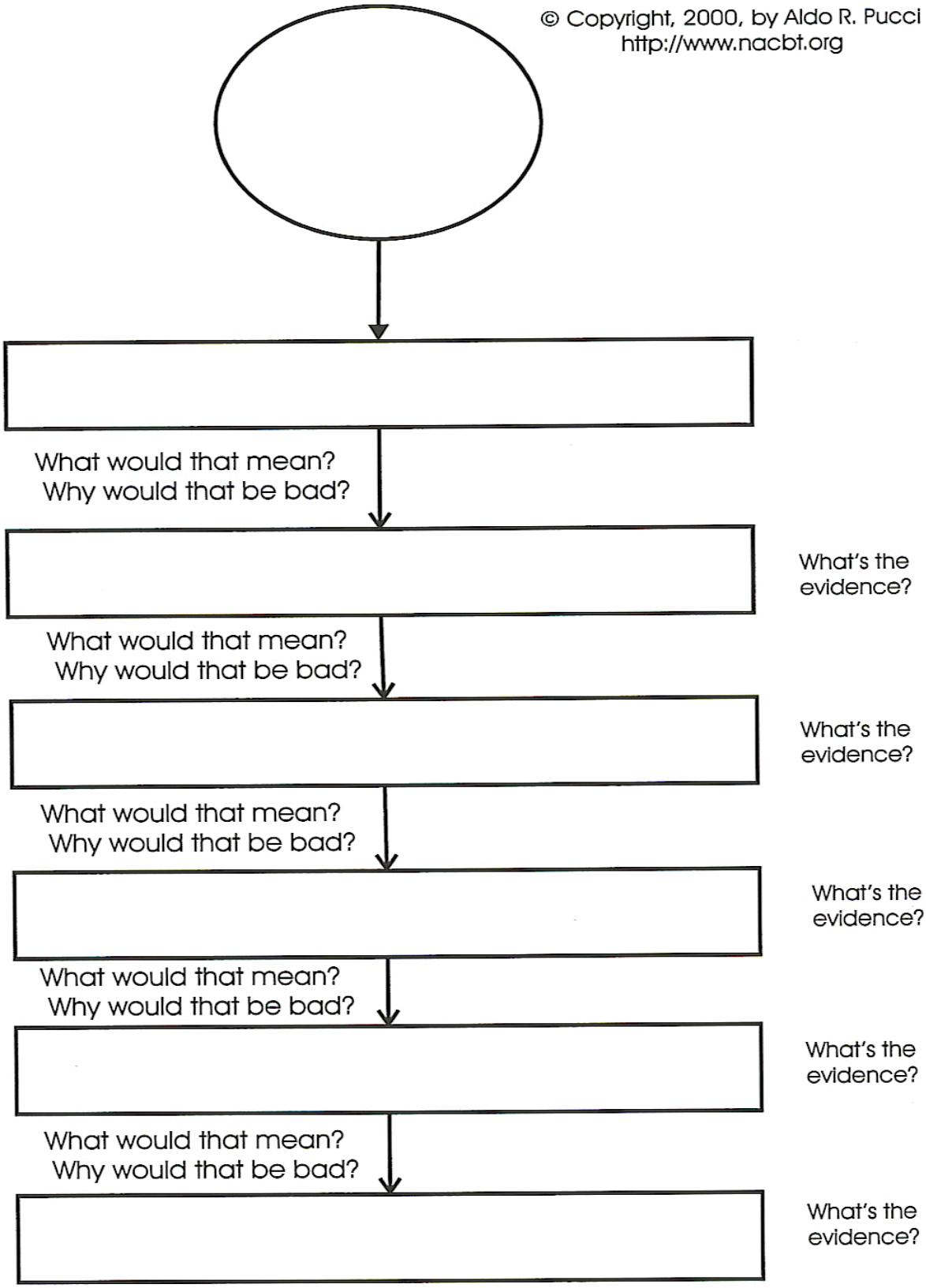
Methods for Assessing Underlying Assumptions

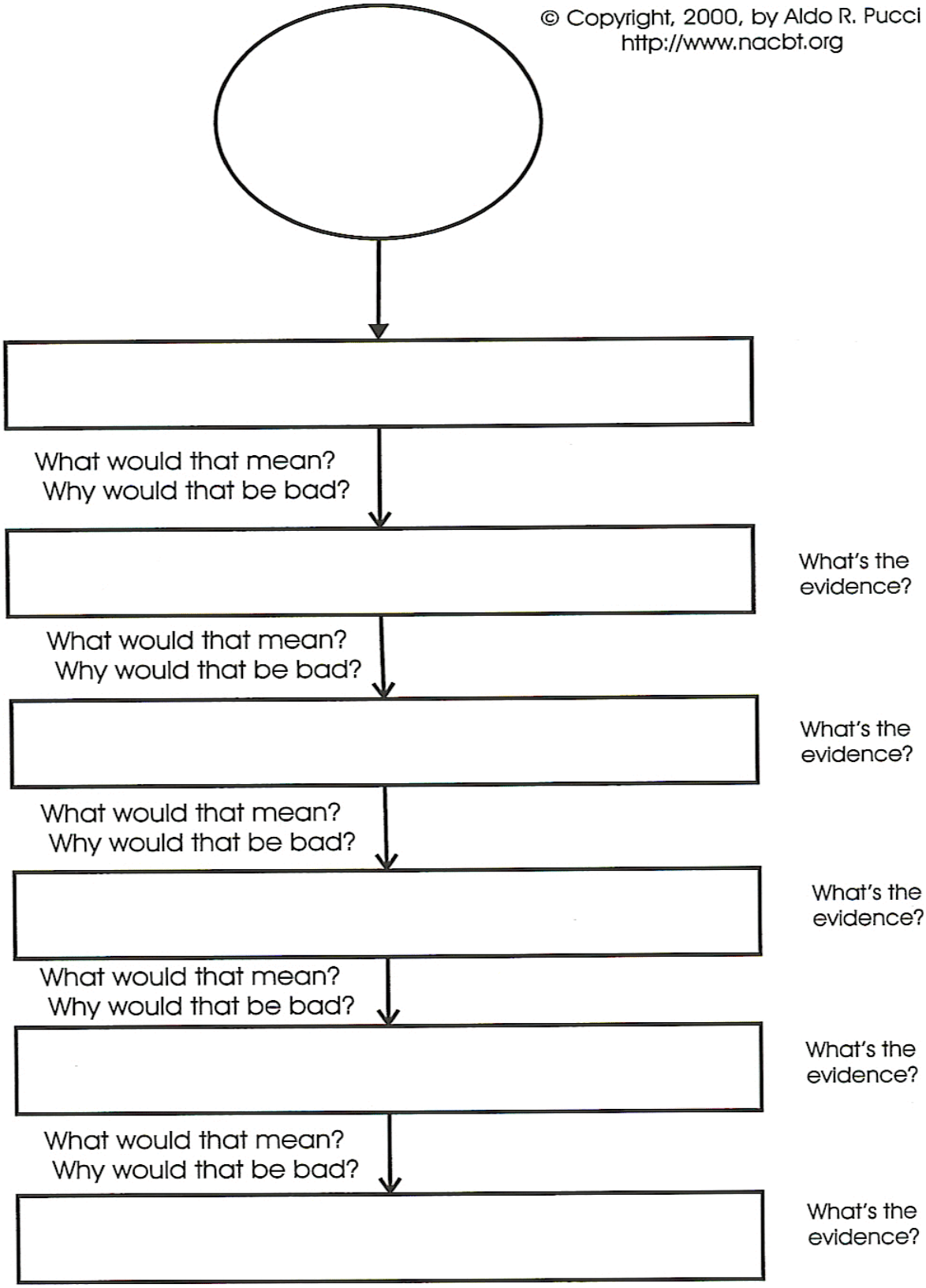
1. Adler's Earliest Recollection

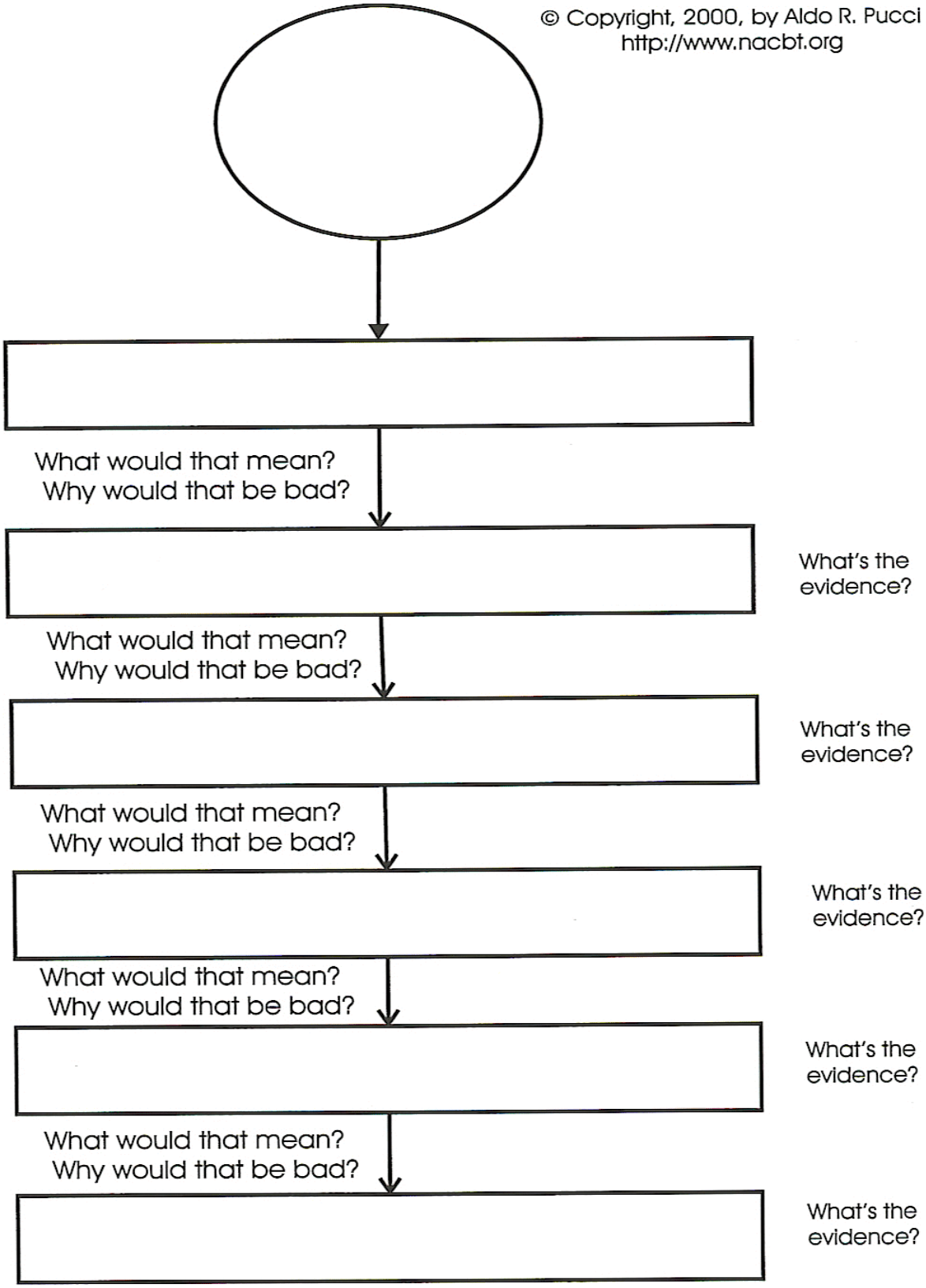
2. Downward Arrow Technique

3. Completing Thoughts









Underlying Assumption Structural Qualities

1. Breadth

2. Flexibility or Rigidity

3. Density

4. Valence

5. Comfort

Difference Between "Symptom Disorders" and "Personality Disorders"

Personality Disorder	Symptom Disorder
Underlying assumption is a part of everyday processing of information	Underlying assumption Only prominent when Experiencing problem (depressed, anxious, etc...)

Underlying Assumption Organization

Underlying Assumptions are organized according to a hierarchy that assigns progressive broader and more complex meanings at successive levels.

? If a loved one is angry, he will reject me.

? If people reject me, I will be alone.

? Being alone will be devastating.

Continuum of Thought / Underlying Assumption Change

1. Thought / Underlying Assumption Reconstruction (Ideal)

2. Thought / Underlying Assumption Modification

3. Socially Acceptable Adaptation

4. Thought / Underlying Assumption Camouflage

"Personality Disorder"	View of Others	View of Themselves	Core Assumptions	Resultant Behavior
Histrionic	Receptive, Awaiting Audience Admirers	Glamorous Impressive	People are there to serve or admire me. People should not deny me.	Dramatic behavior Charm Temper tantrums, crying Suicidal Gestures
Narcissistic	Inferior Admirers	Special Unique Superior Above the Rules	I'm special and deserve special treatment. I'm better than everyone and above the rules	Manipulate Transcend Rules
Avoidant	Critical Demeaning Superior	Vulnerable to rejection. Inferior Incompetent Socially inept	It's terrible to be rejected. I'm likely to be rejected, because there is something wrong with me.	Avoid evaluative situations.
Schizoid	Intrusive	Self-sufficient Loner	People are not interesting and rewarding. Relationships are a hassle.	Stay away from people.
Dependent	Competent Supportive Nurturant	Needy Incompetent Weak	I Need people to survive, be happy. I have to have support and encouragement. I can't make decisions on my own.	Seek and develop dependent relationships.
Passive-Aggressive	Demanding Controlling Dominating	Vulnerable to Control Inferior	Control by others is intolerable. I can't stand direct conflict.	Passive Resistance Apparent Submissiveness
Obsessive-Compulsive	Irresponsible Incompetent	Responsible Accountable	Details are crucial People should do better.	Perfectionism
Paranoid	Malicious Discriminatory	Innocent Vulnerable	Don't trust People are not on my side.	Look for hidden motives. Accuse Avoid People
Antisocial	Vulnerable	Autonomous Strong Loner	I'm entitled to break the rules. I'm smarter than they are. I can fool people.	Break rules / laws Deceive, Manipulate Present Charming Persona

Adapted from chart by Judith Beck, Ph.D., 1994.

Borderline Personality Disorder

Approach to Life	Problematic Thought
Guilty / To be Punished	"I'm bad. I should be punished."
Lacking in discipline	"I can't control myself."
Fear of losing emotional control	"Something bad will happen if I don't control my emotions." "I'm afraid that I can't."
Dependence	"I need someone on which to rely."
Concern with Abandonment	"No one will be there for me. I'll be alone, and that would be terrible."
Unlovability	"If people really knew me, they wouldn't like me." "I must have people like me."
Mistrust	"People will take advantage of me or hurt me in some way. I must protect myself." "People are either good or evil."
Over-emphasis on relationship and subjugating own desires.	"If I'm not exactly how others want me to be, they won't like me, and that would be terrible."

Underlying Assumption Assessment Form

Name_____ Date_____

Problem Thought	**Breadth** What areas of your life does this thought affect?	**Flexibility** How willing are you to at least consider changing this thought? (Circle One) I I I I I I I I I I I I I Very Unwilling ... Very Willing	**Density / Valence** How often do you think this thought or act on it? (Circle One) Every Minute Hourly Daily Weekly	**Strength** How strongly do you believe this thought is accurate? Rate between 0% and 100% _____% (0% = Not at all, 100% = Completely)	**Comfort** How comfortable is this thought to you? Rate between 0% and 100% _____% (0% = Not at all, 100% = Completely)

Opposite Thought	If I were to think this way, this is how I would benefit from it:	If I were to think this way, these would be the negative consequences from it:	**Strength** How strongly do you believe this thought is accurate? Rate between 0% and 100% _____% (0% = Not at all, 100% = Completely)	**Comfort** How comfortable is this thought to you? Rate between 0% and 100% _____% (0% = Not at all, 100% = Completely)

Underlying Assumption Assessment Form

Name_____ John Doe _____ Date____2/13/2003_____

Problem Thought	**Breadth** What areas of your life does this thought affect?	**Flexibility** How willing are you to at least consider changing this thought?	**Density / Valence** How often do you think this thought or act on it?	**Strength** How strongly do you believe this thought is accurate?	**Comfort** How comfortable is this thought to you?
I need a woman in my life because I'm nothing without a woman in my life.	Relationships (Strains them) Work (Can't concentrate) Health (Not sleeping well)	(Circle One) I I I I I I I (I) I I I I I I I Very Unwilling … Very Willing	(Circle One) Every Minute (Hourly) Daily Weekly	Rate between 0% and 100% ___95____% (0% = Not at all, 100% = Completely)	Rate between 0% and 100% ___95___% (0% = Not at all, 100% = Completely)

Opposite Thought	If I were to think this way, this is how I would benefit from it:	If I were to think this way, these would be the negative consequences from it:	**Strength** How strongly do you believe this thought is accurate?	**Comfort** How comfortable is this thought to you?
I am "someone" whether I have a woman in my life or not.	Wouldn't be so stressed about finding a girlfriend. Wouldn't be so nervous about women rejecting me. Work Better Sleep Better.	People might not like me if they think that I think that I'm someone. I might not get a girlfriend because I won't try as hard.	Rate between 0% and 100% ___25___% (0% = Not at all, 100% = Completely)	Rate between 0% and 100% ___10___% (0% = Not at all, 100% = Completely)

Continuum of Underlying Assumption Change

Identified Problematic Thought or Underlying Assumption:

_____

_____

_____

_____

_____

(1) Reconstructed Thought (At least _____% Strength by _____):

_____

_____

_____

_____

_____

(2) Modified Thought (At least _____% Strength by _____):

_____

_____

_____

_____

_____

(3) Socially Acceptable Alternative Behavior (Will being engaging in this by _____):

(4) Thought Camouflage Strategy (Will being engaging in this by _____):

How Underlying Assumptions are Maintained

? (1) Assumption Support

? A. Cognitive: highlighting or exaggerating supporting
? information and negating, minimizing, or
? denying information that contradicts.
? (Mental Filter)
? B. Behavioral: Adaptive behaviors that help the person
? cope with the irrational assumption.
? Self-sacrifice: very useful to try to please
? others.

? (2) Assumption Avoidance

? A. Cognitive: automatic or intentional attempts to block
? thoughts that might trigger the assumption.
? Suppression, repression, denial

How Underlying Assumptions are Maintained

? (2) Assumption Avoidance

? B. Emotional: automatic or intentional attempts to block
? feelings that are triggered by assumptions.
? Dissociative strategies are an extreme
? example of this.

? C. Cognitive-emotive dissonance: automatic or
? intentional attempts to avoid discomfort of
? "feeling wrong". Assumption that if
? something feels wrong, it must be wrong.

? D. Behavioral: Tendency to avoid real life situations that
? might trigger the painful assumption.

How Underlying Assumptions are Maintained

? (3) Assumption Compensation

? Person attempts to over-compensate for assumption by

? trying to disprove it by acting against it.

Problems in Collaboration with People "with Personality Disorders"

1. The client might lack the skill to be collaborative.

2. The therapist might lack the skill to develop collaboration.

3. Environmental stressors might preclude changing or reinforce dysfunctional behavior.

4. Clients' ideas and beliefs regarding their potential failure in therapy might contribute to non-collaboration.

5. Clients' ideas and beliefs regarding effects of the clients' changing on others might preclude compliance.

6. Clients' fears regarding changing and the "new" self might contribute to noncompliance.

7. The client's and therapist's dysfunctional beliefs might be harmoniously blended.

8. Poor socialization to the model might be a factor in non-compliance.

9. A client might experience secondary gain from maintaining the dysfunctional pattern.

10. Poor timing of interventions might be a factor in non-compliance.

11. Clients might lack motivation.

12. Clients' rigidity might negatively affect compliance.

13. The client might have poor impulse control.

14. The goals of therapy might be unrealistic.

15. The goals of therapy might be unstated.

16. The goals of therapy might be vague.

17. There might not be an agreement between therapist and client relative to the treatment goal.

18. The client might be frustrated due to a lack of progress.

19. Issues involving the client's perception of lowered status and self-esteem might be factors in noncompliance.

Engagement & Collaboration Issues (Page 11)

- (1) Dependent
  - Often wait for clinician to begin conversation
  - Establish rapport quickly
  - Proceeds smoothly as long as empathic about indecisiveness and failures
  - Strong desire to be accepted: Quite willing to meet expectations of clinician
  - Client's desire for clinician to take care of him/her.

Engagement & Collaboration Issues

NOTES:

Engagement & Collaboration Issues

- (1) Dependent
  - Counter-transference: Clinician succumbs to frustration over client's dependence OR desire to be idealized.
  - Be careful to avoid mistaking compliance for collaboration. Look for actions.

Engagement & Collaboration Issues

NOTES:

Engagement & Collaboration Issues

- (2) Avoidant
  - Initial sessions: guarded and disengaged
  - Will observe clinician closely for any indication of acceptance / rejection.
  - *** Empathy and Reassurance ***
  - Avoid confrontation initially as clients will interpret this as criticism.

Engagement & Collaboration Issues

NOTES:

Engagement & Collaboration Issues

- (2) Avoidant
  - More willing to trust and cooperate when clients believe that the clinician understands their hypersensitivity and will protect them.
  - Masters at testing their environment to see which individuals will be positive, neutral, or negative toward them.
  - Test clinicians by changing appointments, canceling at the last minute, etc...

Engagement & Collaboration Issues

NOTES:

Engagement & Collaboration Issues

- (2) Avoidant
  - Continue to test until they become convinced that the non-critical and non-critical behavior is genuine
  - If therapist fails: early termination

Engagement & Collaboration Issues

NOTES:

Engagement & Collaboration Issues

- (3) Borderline
  - Instability of emotions affects rapport
  - Focus Discussion, Curb Outbursts and Diversions
  - Calmly respond to anger directed toward therapist. Expect it.

Engagement & Collaboration Issues

NOTES:

Engagement & Collaboration Issues

- (3) Borderline
  - Typically enter treatment for the expressed purpose of feeling better rather than making changes in their lives.
  - Hope clinician will make everything better for them.
  - Limit setting extremely important.
    - Have a focus and agenda for every session!

Engagement & Collaboration Issues

NOTES:

"No Treatment Option" to help with pattern of failure

- (1) Offer to re-evaluate the client at another time when s/he is more prepared to begin treatment.
- (2) or Offer an extended evaluation period of 3-4 sessions during which the clinician evaluates the patient's readiness based upon response to homework assignments.

Engagement & Collaboration Issues

NOTES:

Engagement & Collaboration Issues

- (4) Paranoid
  - Direct attempts to convince the client of therapist's trustworthiness are likely to be perceived as deceptive.
  - Openly accept the client's distrust. "You have just met me..."
  - Gradually demonstrate trustworthiness through action.

2

Engagement & Collaboration Issues

NOTES:

Engagement & Collaboration Issues

- (4) Paranoid
  - Only ask the client to do what s/he is willing to do.
  - May be useful to select problems that can be addressed through behavioral interventions as the initial focus of therapy.
  - Paranoia is not presented as problem: work on other goals then gradually demonstrate how the paranoia is interfering with achieving those goals.

3

Engagement & Collaboration Issues

NOTES:

Engagement & Collaboration Issues

- (4) Paranoid
  - Transference / Counter-Transference:
    - "Another untrustworthy person"
    - Therapist's frustration of length of therapy and effort required

3

Engagement & Collaboration Issues

NOTES:

Engagement & Collaboration Issues

- (5) Passive-Aggressive
  - Often enter treatment because of complaints by other that they are not meeting expectations (household chores, for example)
  - Also often seek therapy due to depression due to chronic lack of rewards
  - Concern with therapist "controlling" him / her
  - However, drawn to strong figures because crave social approval

3

Engagement & Collaboration Issues

NOTES:

Engagement & Collaboration Issues

- (5) Passive-Aggressive
  - Apply same passive-aggressive approach to therapy by "forgetting" appointments / homework or "agreeing" with therapist but finding a way to prove him / her wrong (accidentally).
  - Professional distance, focus on CLIENT'S goals and ABC's of Emotions
  - Transference / Counter-transference:
    - "Another controlling person"
    - Frustration over "games"

3

Engagement & Collaboration Issues

NOTES:

Engagement & Collaboration Issues

- (6) Antisocial
  - Clarify role of being an assistant or cooperative partner, not a judge or arbiter
  - Avoid power struggles
    - Demonstrate that because they are good at fooling others, it is quite possible that the clinician could be fooled as well.
    - If therapist present him / herself as being tough, this could be seen as a challenge for the client

3

Engagement & Collaboration Issues

NOTES:

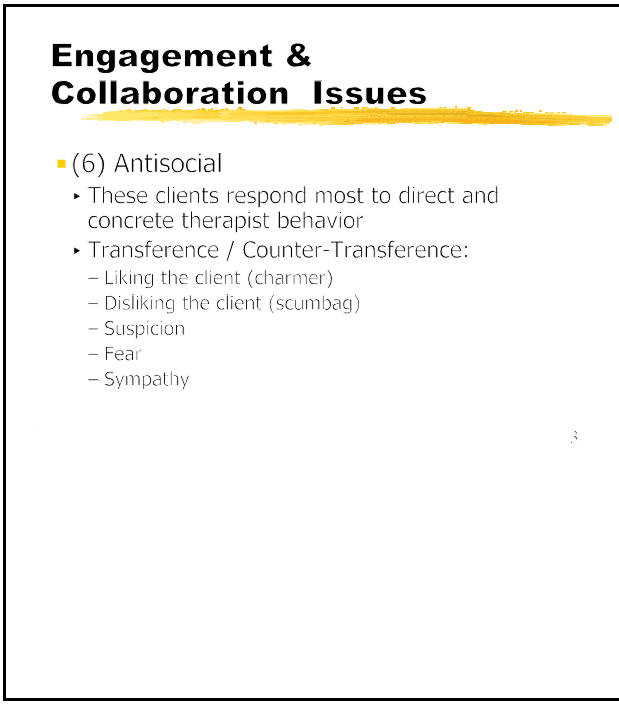
Antisocial Engagement

- Present yourself as having…
  - Self-assurance, but not arrogance
  - Relaxed and Non-defensive interpersonal style
  - Clear sense of personal limits
  - Strong sense of humor

3

Engagement & Collaboration Issues

NOTES:



Engagement & Collaboration Issues
NOTES:

Engagement Issues and Techniques for People with Personality Disorders

(2) Histrionic

(3) Obsessive-Compulsive

(5) Narcissistic

(7) Schizotypal

(9) Passive-Aggressive

(10) Schizoid

Thought / Underlying Assumption / Behavior Identification for People with Personality Disorders

(1) Dependent

(2) Histrionic

(3) Obsessive-Compulsive

(4) Avoidant

(5) Narcissistic

(6) Borderline

(7) Schizotypal

(8) Paranoid

(9) Passive-Aggressive

(10) Schizoid

(11) Antisocial

Thought / Underlying Assumption / Behavior Change for People "with Personality Disorders"

(1) Dependent

(2) Histrionic

(3) Obsessive-Compulsive

(4) Avoidant

(5) Narcissistic

(6) Borderline

(7) Schizotypal

(8) Paranoid

(9) Passive-Aggressive

(10) Schizoid

(11) Antisocial

Underlying Assumption Therapy Examples

Thought:_____

_____

_____

1. Thought / Underlying Assumption Reconstruction (Ideal)

2. Thought / Underlying Assumption Modification

3. Socially Acceptable Adaptation

4. Thought / Underlying Assumption Camouflage

Underlying Assumption Therapy Examples

Thought:_____

_____

_____

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Underlying Assumption Therapy Examples

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Underlying Assumption Therapy Examples

Thought:_____

_____

_____

1. Thought / Underlying Assumption Reconstruction (Ideal)

2. Thought / Underlying Assumption Modification

3. Socially Acceptable Adaptation

4. Thought / Underlying Assumption Camouflage

Termination and Relapse Prevention Issues and Techniques for People with Personality Disorders

(1) Dependent

(2) Histrionic

(3) Obsessive-Compulsive

(4) Avoidant

(5) Narcissistic

(6) Borderline

(7) Schizotypal

(8) Paranoid

(9) Passive-Aggressive

(10) Schizoid

(11) Antisocial

Countering / Disputing Techniques

(A) Soft Countering Techniques

Can defuse high emotional arousal and make it easier for clients to gently change their beliefs.

In a relaxed state, the irrational belief is challenged by both the counter thought and the counter emotion, providing two active treatment elements.

Progressive Relaxation

Think about (body part) and relax (body part).

For example, "Think about your eyelids and relax your eyelids. Allow your eyelids to grow nice an loose and limp and heavy and relaxed – nice and heavy with relaxation. So think about your eyelids, and allow the eyelids to relax now."

Suggested order:

Eyelids
Forehead
Cheeks
Lips
Chin
Jaw muscles
Back and front of neck
Shoulders to elbows to wrists to tips of fingers (then provide first suggestions: "Every breath you take doubles your relaxation, causing you to relax progressively more and more.")
Chest
Stomach Muscles
Hips to knees, knees to ankles, ankles to tips of toes (then provide second suggestion, "Every word that I speak doubles your relaxation, causing you to relax progressively more and more.")

Include embedded command, "relax now". For example, "So think about your eyelids, and allow your eyelids to *relax now*."

(1) Relaxed Countering

Based on Counter Conditioning

Traditional: pairing relaxation with anxiety inducing images

Cognitive-Restructuring: desensitizing beliefs instead of their images, thus reducing or eliminating any negative emotion connected to those beliefs.

(a) Thought Relaxation Conditioning

– Teach the client relaxation technique

– Develop a hierarchy of irrational beliefs that cause anxiety or distress. Order the hierarchy by degrees of fear the thoughts elicit or how strongly the thoughts are believed.

– Suggest that the client can also picture a scene that is associated with the thought if that would be helpful.

– Have the client imagine the least provocative thought on the hierarchy. When the thought is clearly in mind, have the client indicate such (raising right index finger) then immediately perform relaxation technique. When the client indicates that his or her tension level has returned to zero, repeat the procedure.

– Continue through the client's hierarchy of thoughts until the anxiety for all items is zero.

– Audio tape the procedure so the client can practice at home.

(b) Imaginary Assuring Figure

– Teach the client relaxation technique

– Develop a hierarchy of irrational beliefs that cause anxiety or distress. Order the hierarchy by degrees of fear the thoughts elicit or how strongly the thoughts are believed.

– Suggest or explore possible positive images that can be associated with the irrational beliefs. (Common ones are Superman, Power Rangers, favorite heros or heroines, peaceful images, religious figures, a wise guru, or visualizing oneself as a parent, adult, or child.)

– Have the client imagine the least provocative scene and listen to the irrational thoughts he or she says to himself or herself. When the thought is clearly in mind, have the client indicate such (raising right index finger) then immediately perform relaxation technique.

– While the client relaxes, use the positive images to help the client gently change the thought. For example, have the client imagine that he or she is a parent talking to a child, assuring her that the thought is incorrect. Gently persuade the child that her fears are not useful.

– Have the client continue to persuade the child until he or she feels a distinct weakening of the old, irrational thought and a distinct lessening of the unpleasant emotion.

– Have the client indicate when he or she is done, allowing all the time needed to achieve this.

– Repeat the technique twice more.

– When the client is able to imagine the scene and thought without anxiety, move on to the next scene and thought.

(2) Covert Extinction

In classical conditioning, extinction occurs when a conditioned stimulus and an unconditioned stimulus are no longer paired or associated. Therefore, the conditioned stimulus no longer produces the conditioned response.

(a) Consequence Removal

Have the client visualize doing the feared activity without the aversive consequences.

(b) Belief Extinction:

– Make a list of the thoughts associated with the clients anxiety

– Have the client imagine thinking the thoughts in various situations but with only a calm emotional response.

– Client can practice several hundred repetitions at home until extinction occurs.

(c) Neutral Images Conditioning

– Make a list of the thoughts associated with the clients anxiety

– Develop a list of neutral images to which the client reacts calmly, such as reading a newspaper, or eating a meal. Make certain that these activities produce only neutral emotions.

– Pair the irrational thoughts with the neutral scenes.

– At least 100 repetitions usually will be necessary.

(3) Covert Reinforcement

Cognitions can be used to reinforce rational thoughts.

Reinforcer: “I did a good job.”

Response: “I got a pay raise because I work hard.”

Discriminating Stimulus: “When I am confident, I do better work and my boss compliments me.”

(a) Best Possible Belief

– Create a hierarchy of problem situations and associated irrational thoughts.

– Develop a list of rational thoughts for each situation.

– Have client relax himself or herself, then imagine the ideal way of handling each situation. Ask them to picture themselves thinking the most rational belief possible while feeling and acting the way they want to in the situation.

– When this image is clear in their mind, ask them to imagine the best possible outcome from thinking this new way. Have them imagine what really good things would happen, and how their life would be better.

– Repeat this exercise a minimum of three times each practice session. Have client continue to engage in practice sessions until they report no negative emotional reaction when imagining the original scene.

– Continue through hierarchy until all situations and associated irrational thoughts are resolved.

(b) Standard Reinforcing Images

Modification fo Approach #1 in that therapist provides the client images to visualize and guides them through it, rather than leaving up to the client to create the positive images. Helpful if client has difficulty developing positive images.

(c) External Rewards

Reinforcing new, rational thoughts with external rewards.

Client is encouraged to reward himself or herself every time they think, and act as if they think, a new rational thought.

(4) Use of Relaxed (Possibly Hypnotic) States

Some research suggests that clients who are physically tense and have high levels of brain activity due to their processing several stimuli simultaneously, are less responsive to cognitive-behavioral type psychotherapy.

Relaxation, hypnosis, and mediation can diminish the tension and reduce the brain activity, thus helping the client to focus.

(B) Hard Countering Techniques

When a client argues against an irrational thought and does so repeatedly, the irrational thought becomes progressively weaker.

Hard counters are cognitions, usually emotive, that are contrary to the irrational thoughts.

Could be:

– One word: “Nonsense!”

– A Phrase: “Not True!”

– A Sentence: “Nobody at the party cares if I am not good a charades.”

– A Philosophy: “My goal is not to have everyone like me, but to have a few friends that like me and I like them.”

Short phrases can be helpful as they are quick reminders.

(a) Forceful Brief Statements

– Make a list of each irrational thought the client thinks.

– Help the client develop a rational hard counter for each irrational thought. Make certain they oppose the thought forcefully. "I cannot possibly know everything" is better than "I sometimes do not know things."

– Have the client develop as many counters possible.

– Make certain that the counters are based in fact, not just positive or "wishful" thinking.

– Instruct the client to use the hard counters repeatedly to dispute the irrational thoughts. Emphasize that it could take months of repetition, but the more that they practice, the sooner they will give up the old, irrational thought.

– Make certain that the counter is in the same mode as the irrational thought.

Irrational Visualization – Rational Visualization

Linguistic Errors – Linguistic Counters

Angry Thoughts – Calm, Compassionate Thoughts

Passive Thoughts – Assertive Thoughts

Example: Client fears tall building because she pictures them falling over.

(b) Counterattacking

The intensity of emotion the client puts forth in a counterattack is the key to its success.

Disputing is most effective when the client attacks the thought in a high state of arousal.

– Develop a list of hard counters.

– Help the client counter forcefully. Have the client practice in front of you, modeling your behavior until they match your level of intensity. Gradually move toward a dramatic attack with intensity and energy.

– Encourage a strengthening of the counterattack by having them use physical exertion and through voice modulation.

This technique is very helpful for passive and depressed clients. However, use with caution with those who are particularly anxious or seriously disturbed.

(c) Creating Dissonance

People tend to be motivated toward consistency, rather than accuracy.

For this technique to be effective, it is important that the therapist be persistent.

– Identify problematic underlying assumptions

– Ask a series of carefully prepared questions aimed at challenging the clients assumption. Instead of asking questions that lead to counterarguments, ask questions that create dissonance for the client.

– Client will usually defend the underlying assumption. Continue to ask questions that create doubt about them. It is important that you allow the client to answer the probes for themselves, rather than the therapist answering for them.

Examples:

Underlying Assumption: I must constantly guard against catching germs.

Question to Create Dissonance: How do you keep from breathing them?

Underlying Assumption: It is terrible when others reject me.

Question to Create Dissonance: When you reject others, is it terrible for them?

Underlying Assumption: If you are assertive, people will hate you.

Question to Create Dissonance: Do they love you now when you are passive?

Underlying Assumption: Women keep pressuring me for a deep commitment. They won't grant me my independence. They keep getting angry with me.

Question to Create Dissonance: If you were a woman, would you date yourself?

(d) Cognitive Flooding

Places clients in the presence of a very aversive conditioned stimulus and does not allow them to escape.

One of the last resort techniques because it can be quite painful.

(1) Images Flooding

– Have clients imagine the feared scene and accompanying irrational thoughts.

– Continue until the conditioned response subsides.

– When clients have irrational fears, instruct them to feel the emotion until they get tired of it.

(2) Verbal Flooding

– Have clients discuss, in great detail, their past trauma experiences. Go through every incident many times until your clients are tired of talking about them.

(3) Focused Flooding

– Client focuses only on the conditioned response during the practice sessions.

– Ask them to recreate all of the physical aspects of their anxiety response. Have them continue until symptoms naturally decline.

– Usually requires at least three ½ hour sessions.

(4) Negative Practice

– Have your clients say all of their irrational thoughts repeatedly until they are annoyed, bored, or tired.

(e) Viewing Irrational Thought as Being the Enemy

Cognitive Aversive Conditioning

1. Self-Punishment

– Record the major situations in which the client is likely to think irrationally. Make the scenes specific so that the client can visualize them.

– Have the client imagine a scene with the accompanying irrational thought. When it is clear in their mind, ask them to imagine the worst possible consequences of thinking the irrational thought. What bad things are occurring as a result? What pain is this thought causing you? Imagine them.

– Repeat the visualization at least three times with each irrational thought.

– You might have the client tell you what he or she is imagining so that you can help them make the visualization as aversive as possible.

2. Standard Aversive Images

– Provide images for the client to visualize.

Common images are of nausea / sickness

– Make certain to suggest during the visualization that it is the irrational thoughts that are causing the nausea.

3. Physical Aversion

– Have the client imagine the irrational thought.

– Associate an aversive stimulus with it, such as a snap of a rubber band on the wrist, tensing of the stomach muscles, holding one's breath, or strenuous exercise.

4. Red Taping

Allows the client to engage in the negative thinking, but only after they have performed some aversive activity.

Very good for obsessions.

– Permitted to think the obsessional thought only after having earned the right to do so.

– Have a ten-minute period where they are permitted to obsess.

– However, they can only take advantage of the ten-minute period if they do something aversive first, like exercise for 15 minutes, drink three glasses of water, etc...

5. Removing Positive Stimuli

Also referred to as "Covert Response Cost" or "Negative Punishment"

– Have client remove something positive if he or she succumbs to (acts on) the irrational belief.

6. Negative Labels

Framing irrational thoughts using emotive words.

Referring to thoughts as:

"irrational"	"ludicrous"	"laughable"
"foolish"	"monotonous"	"inane"

When using this technique, make certain that the client separates himself or herself from the label.

(C) Objective Countering Techniques

(a) Alternative Interpretation

Considers the rule of primacy: people tend to pay more attention to their first impressions of events than to later ones.

These first impressions tend to "stick".

This technique helps them suspend their initial judgement until they can obtain more information.

– As the client diagrams their emotional and behavioral responses with the "ABC Worksheet", have him or her write four equally plausible alternative explanations or interpretations.

– During the following therapy session, help the client determine which explanation has the most evidence to support it.

Example: Young man walking though the mall notices that women are not looking at him.

First Interpretation

I must be ugly if they do not look at me.

Alternative Interpretations

1. Maybe some women noticed me without me knowing it.

2. Maybe women do not "check out" guys like guys "check out" women.

3. Maybe all of the women there had boyfriends or are married.

4. Maybe women are not as obvious as men are when they notice someone attractive.

(b) Utility Assessment

Helps clients examine the pragmatism of beliefs, rather than simply the validity of them.

– Make a list of problem thoughts and associated situations.

– Make a list of the goals associated with those thoughts.

– Ask, "Do my thoughts help me achieve my goal or not?"

– Ignoring whether or not the thought is accurate, help the client develop a more useful thought that would increase chances of success.

– Have client practice new belief.

(c) Public Meanings

Basically, if someone were observing you and your situation, what might they think?

Helps to develop a more objective perception.

Example:

Event: I was criticized by someone.

Private Meaning: I must have done something wrong. There is something wrong with me.

Public Meaning: Someone disagrees with something I might have done. The cause for the disagreement is unknown.

(d) Successive Approximations of Thought Acquisition (Pucci)

Developing approximations of the most "elegant" thought and helping the client to pursue it.

Successive Approximations of Thought Acquisition
(SATA)

This will never work for me.

This *might* work for some people, but not for me.

This *does* work for some people, but not for me.

This does work for some people, and it
might work for me, too.

This does work for some people, and it
probably will work for me, too.

This does work for some people,
and it does work for me, too.

Successive Approximations of Thought Acquisition

Goal:_____

_____

Strength of Thought (0% = I do not believe it at all / 100% = I believe it completely)
How Good Does It Make You Feel (0% = Not at all / 100% = Fantastic!)

Least Helpful Thought

Strength of Thought _____% How Good It Makes You Feel _____ %

Strength of Thought _____% How Good It Makes You Feel _____ %

Strength of Thought _____% How Good It Makes You Feel _____ %

Strength of Thought _____% How Good It Makes You Feel _____ %

Strength of Thought _____% How Good It Make You Feel _____ %

Strength of Thought _____% How Good It Makes You Feel _____ %

(e) Correcting Logical Fallacies

Problems in Scientific Thinking

1. **Theory Influences Observations**

Our theory influences how we observe reality.

2. **The Observer Changes the Observed**

By observing something or someone, we change it or them, thus possibly not obtaining an accurate perception or assessment. Hawthorne Effect.

3. **Equipment Constructs Results**

The methods we have for collecting information can determine the conclusion we to which we come.

Problems in Pseudoscientific Thinking

4. **Anecdotes Do Not Make a Science**

Ten anecdotes are no better than one. One hundred are no better than ten.

5. **Scientific Language Does Not Make a Science**

Because science has such a powerful mystique in our society, those who wish to gain respectability but do not have evidence try to do an end run around the missing evidence by looking and sounding "scientific."

6. **Bold Statements Do Not Make Claims Factual**

Something is probably pseudoscientific if enormous claims are made for its power and veracity but supportive evidence is scarce.

7. **Heresy Does Not Equal Correctness**

Just because ideas are ridiculed does not mean they are correct.

8. **Burden of Proof**

The burden of proof tends to be on the "outsider" making the claim.

9. **Rumors Do Not Equal Reality**

"I read somewhere that..." or "I heard from someone that..." Eventually becomes, "I know that..."

10. **Unexplained is not Inexplicable**

Many people are overconfident enough to believe that if *they* cannot explain something, it must be inexplicable and therefore a true mystery of the paranormal.

11. **Failures Are Rationalized**

Rather than viewing a failure as a learning experience that provides us valuable information, failures are ignored, not reported, or explained away.

12. **After-the-Fact Reasoning**

Also known as “Post hoc, ergo propter hoc” which means “after this, therefore because of this.”

Same as “Correlation equals Causation” mental mistake

13. **Coincidence**

When the probability of something occurring appears either very low or very high, and it actually occurs, people often explain the occurrence by assuming a paranormal phenomenon.

14. **Representativeness**

People sometimes view coincidences as representative of situations or conditions. They remember the meaningful coincidences and forget most of the insignificant ones.

Logical Problems in Thinking

15. **Emotive Words and False Analogies**

Emotionally charged words, whether positive (motherhood, America, integrity, honesty) or negative (rape, cancer, evil, communist) can cloud our thinking and steer us on a side path.

Metaphors and analogies can be irrational, such as calling inflation, "the cancer of society" or referring to industry as "raping the environment".

16. **Ad Ignorantiam**

An appeal to ignorance that is related to the "burden of proof" and the "unexplained is inexplicable" mistakes.

Scientific thinking seeks positive evidence in support of a claim, not lack of evidence for or against a claim.

17. **Ad Hominem and "You're Another"**

Literally means "to the man" and "you also"

Redirects the focus from thinking about the idea to thinking about the person holding the idea. The goal of an ad hominem attack is to discredit the claimant in hopes that it will discredit the claim.

18. **Over-reliance on Authorities**

The greater the IQ, level of success, or education a person has, the more likely we are to view him or her as an authority figure.

Problem: (1) accept a wrong idea just because it was supported by someone we respect (false positive) or (2) reject a correct idea just because it was supported by someone we disrespect (false negative).

19. **Either-Or**

Also known as the "fallacy of negation" or the "false dilemma".

Either life was divinely created or evolved. If one argues that the theory of evolution is incorrect, then the conclusion is that divine creation must be correct.

20. **Circular Reasoning**

Also known as the fallacy of redundancy, begging the question, or tautology.

The conclusion or claim is simply a restatement of one of the premises.

21. **Reductio ad Absurdum and the Slippery Slope**

Refutation of an argument by carrying the argument to its logical end and so reducing it to an absurd conclusion.

Psychological Problems in Thinking

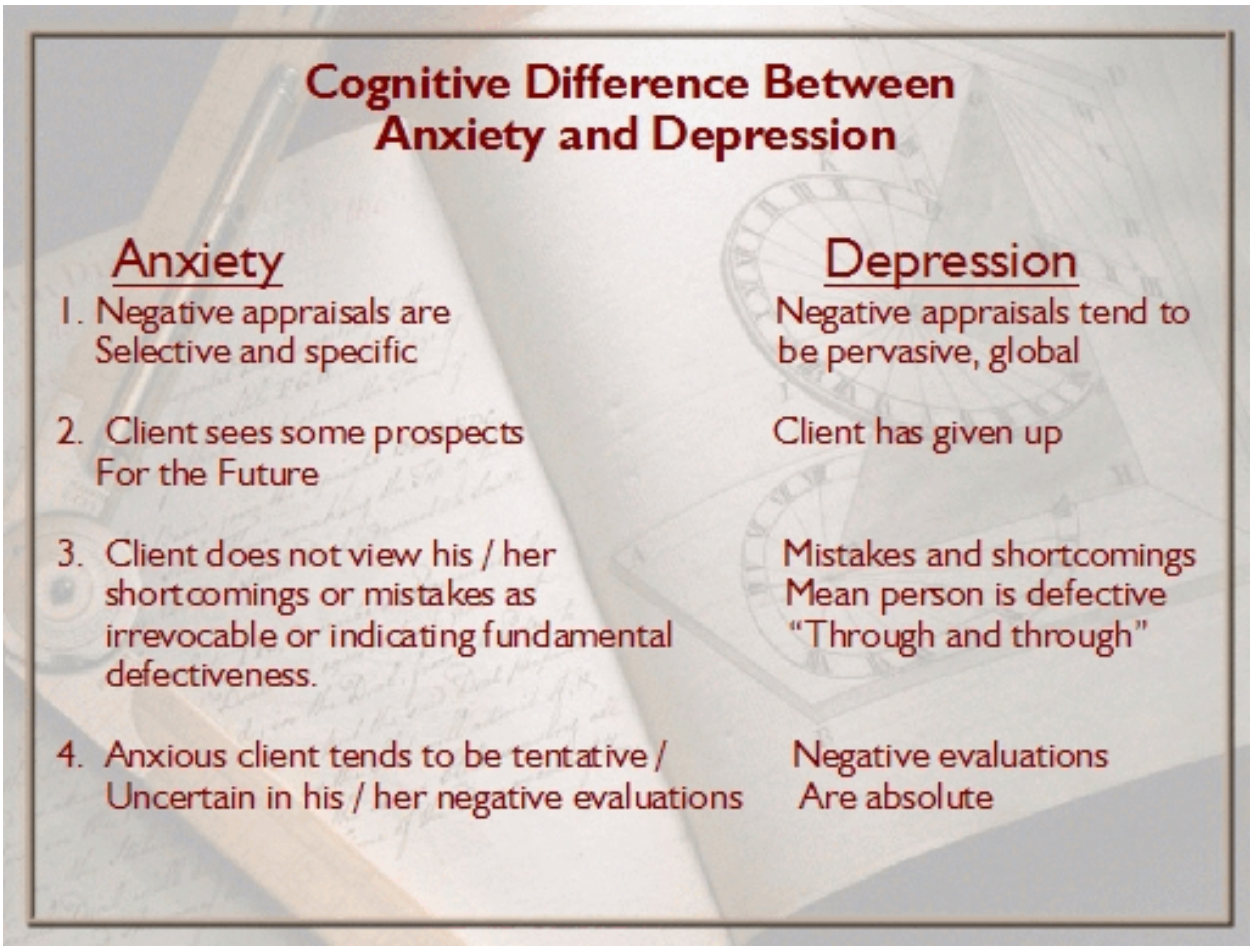
22. **Effort Inadequacies and the Need for Certainty, Control, and Simplicity**

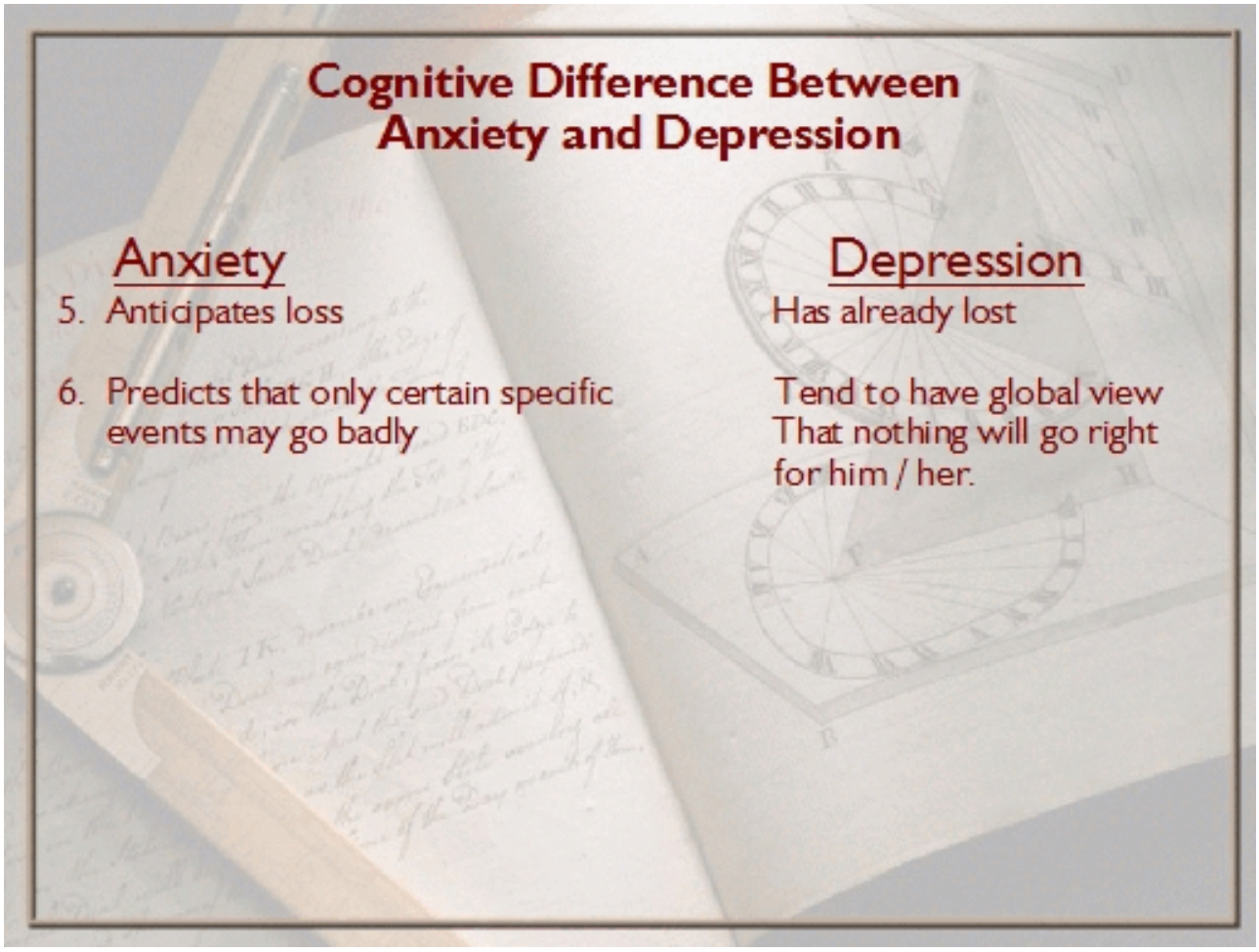
Humans tend to want certainty, as sense of control, and tend to prefer a simple explanation. They tend to want explanations as quickly as possible.

Important to be willing to tolerate uncertainty and consider all of the facts to increase probability that our thinking will be based on fact.

Mood / Anxiety Disorders

(1) "Mood Disorders"




Cognitive Difference Between
Anxiety and Depression
Anxiety
5. Anticipates loss
6. Predicts that only certain specific events may go badly
Depression
Has already lost
Tend to have global view
That nothing will go right
for him / her.

Depressive Problems

- Look for beliefs that encourage depressive feelings:
  - There is only one way to be happy
  - All-or-none thinking (overlooking possibilities for happiness)
  - Jumping to Conclusions
  - Too Much / Too Little
  - Being upset about "idea" rather than reality of situation
- Help client develop stoic philosophy – "No amout of misery will change this situation."

Depressive Problems

- Some perceived loss (lost something already had, lost potential for obtaining something in the future).
- Hopelessness or "Giving Up"
  - Perceived "Objective" Insurmountable Obstacle"
  - Perceived lack of ability to overcome obstacle, to recover from loss, or to obtain what was lost.

Depressive Problems

- Confusing of "Needs" and "Wants"
  - Required to Live
  - Required for happiness / sanity
    "I couldn't take being miserable"
- Symptom Stress
  - Depressed / Angry / Anxious about being Depressed
- Inactivity exacerbates depressive symptoms

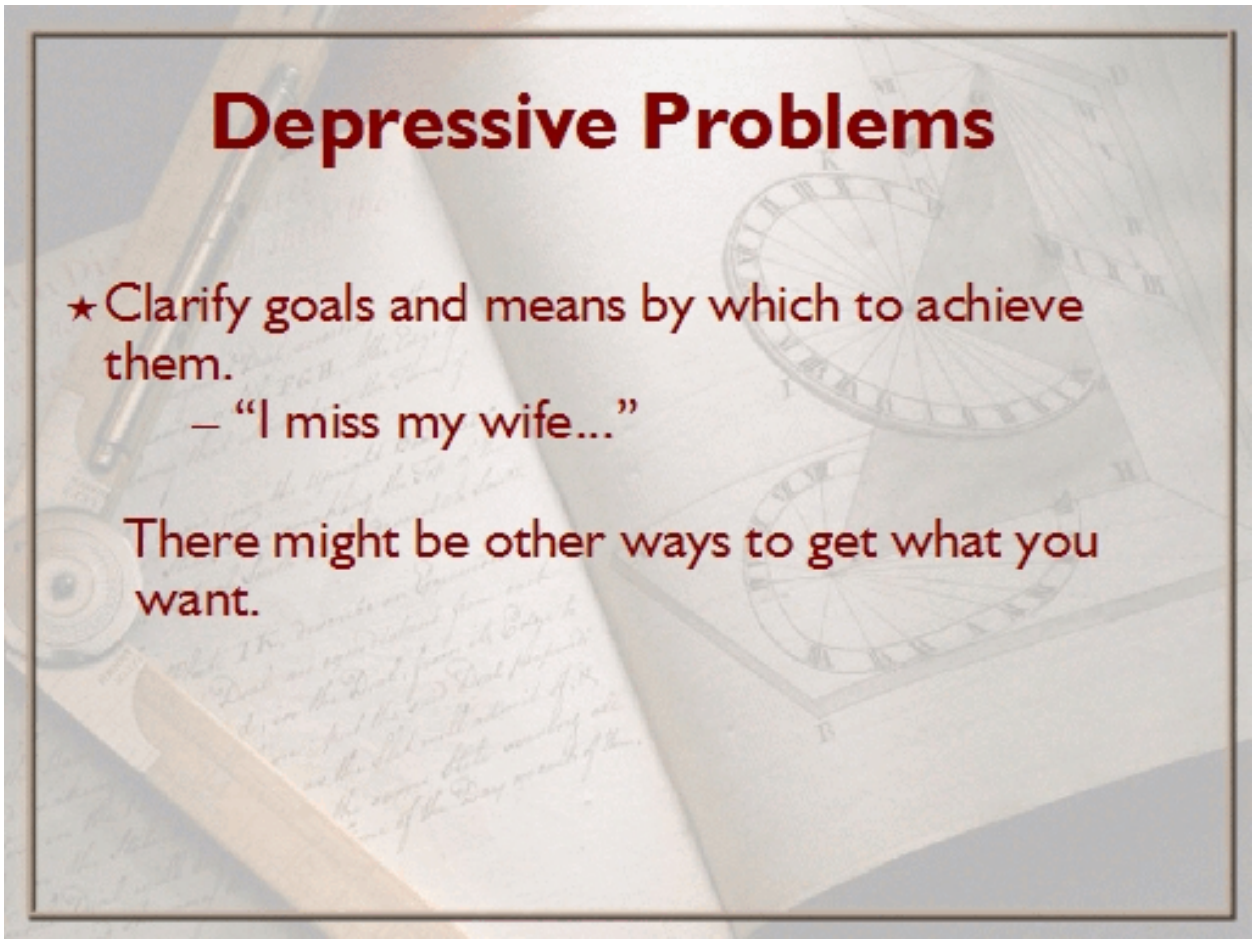
Depressive Problems

Main Therapeutic Approach

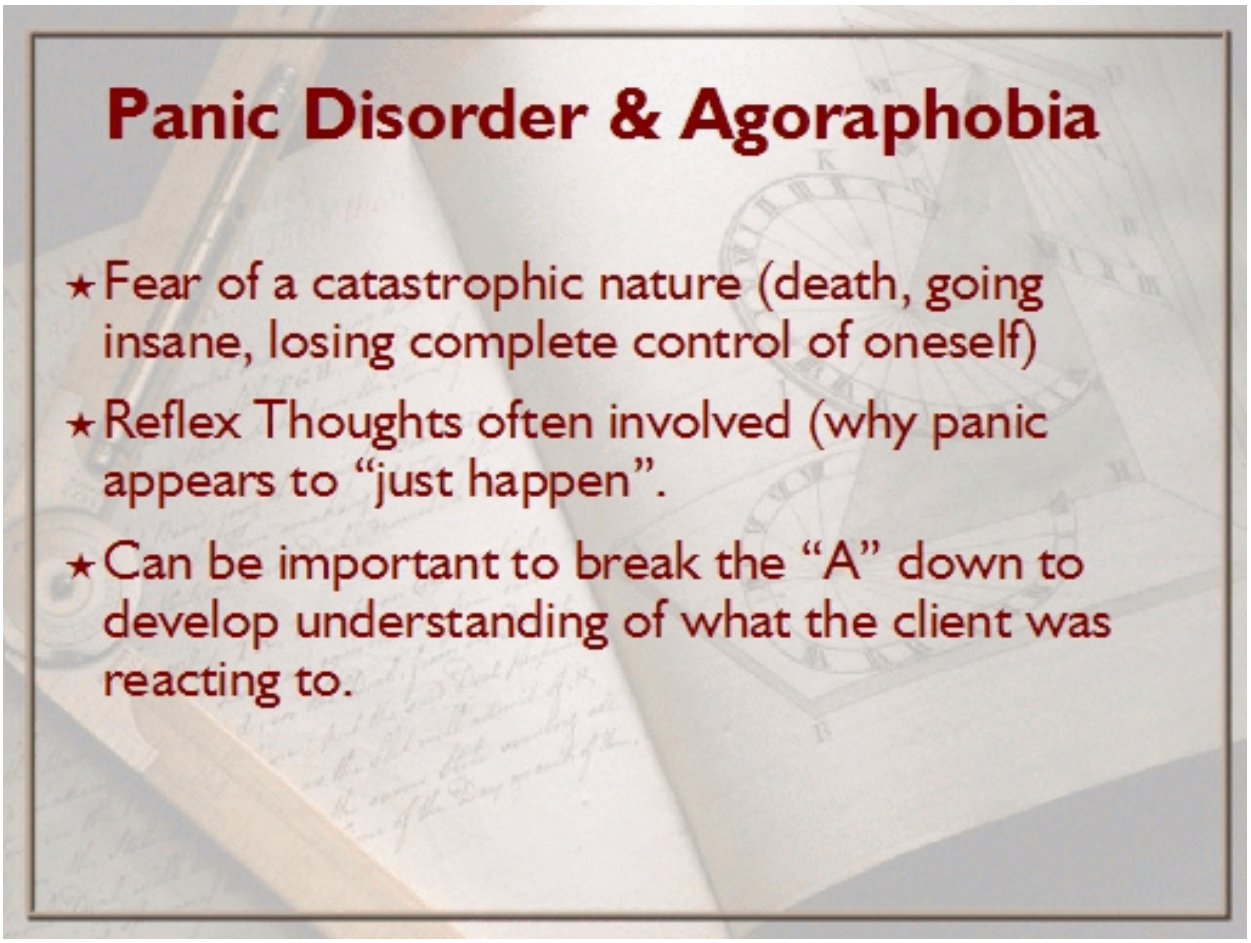
- ★ Overcome symptom stress
- ★ Get client moving and acting "as if"
- ★ Accurately assess loss (jumping to conclusions)
  - Husband said he is going to divorce me.
- ★ Reduce / Eliminate attitudes leading to hopelessness / helplessness
  - Accurate perception of objective potential for situation to change
  - "Four A's"

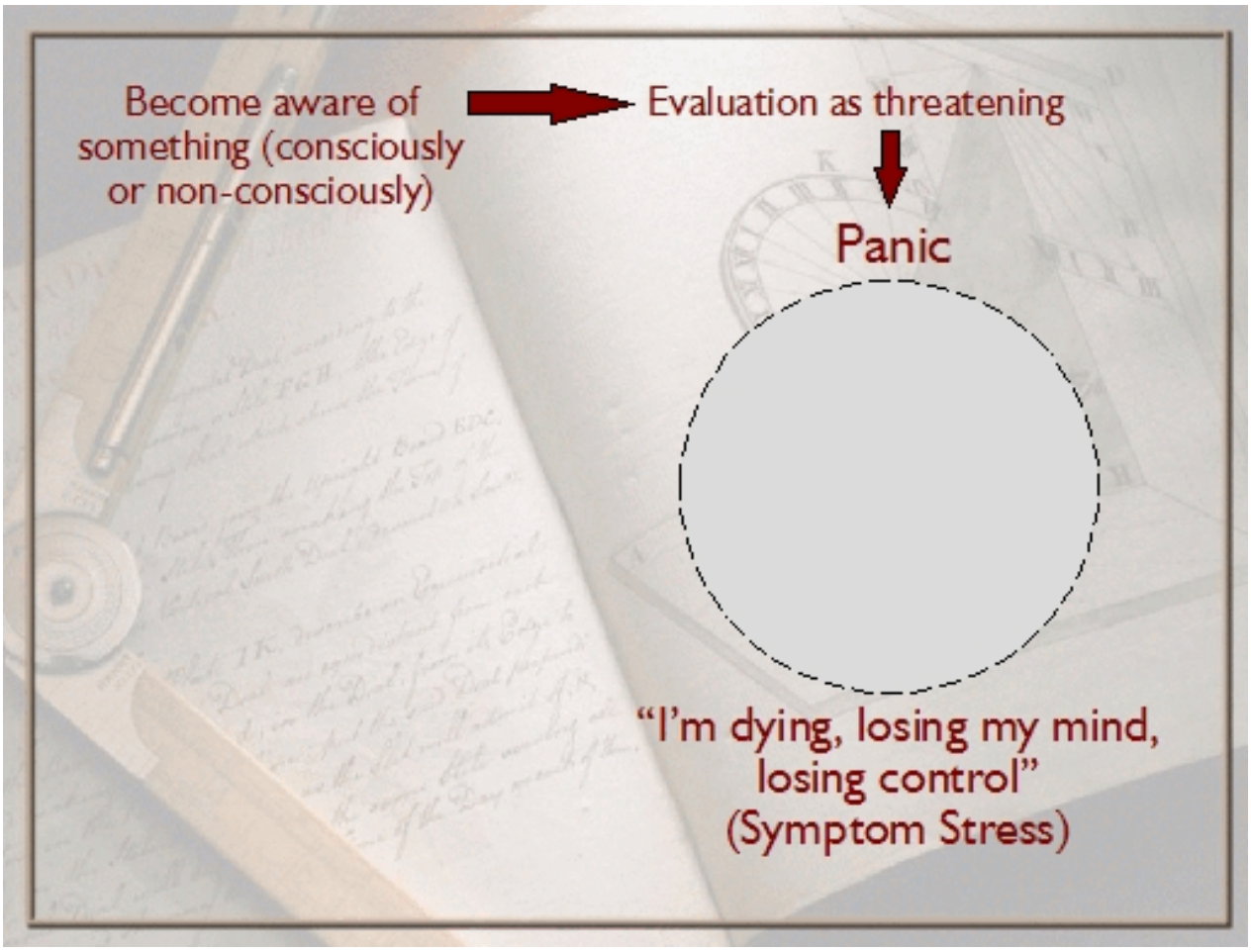
Depressive Problems

- Work on accurate understanding of needs and wants to provide "deeper, more elegant solution."
- Utilize variety of techniques discussed in Levels I and II, including the persuasive techniques (Changing parameters of behavior).
- Utilize variety of behavioral techniques discussed, including breaking response chains and activity scheduling)
- What do you have to lose?


Depressive Problems
★Clarify goals and means by which to achieve them.
– "I miss my wife..."
There might be other ways to get what you want.

(2) "Anxiety Disorders"




Become aware of something (consciously or non-consciously)
Evaluation as threatening
Panic
"I'm dying, losing my mind, losing control"
(Symptom Stress)

Panic Disorder & Agoraphobia

★Agoraphobic Thinking:

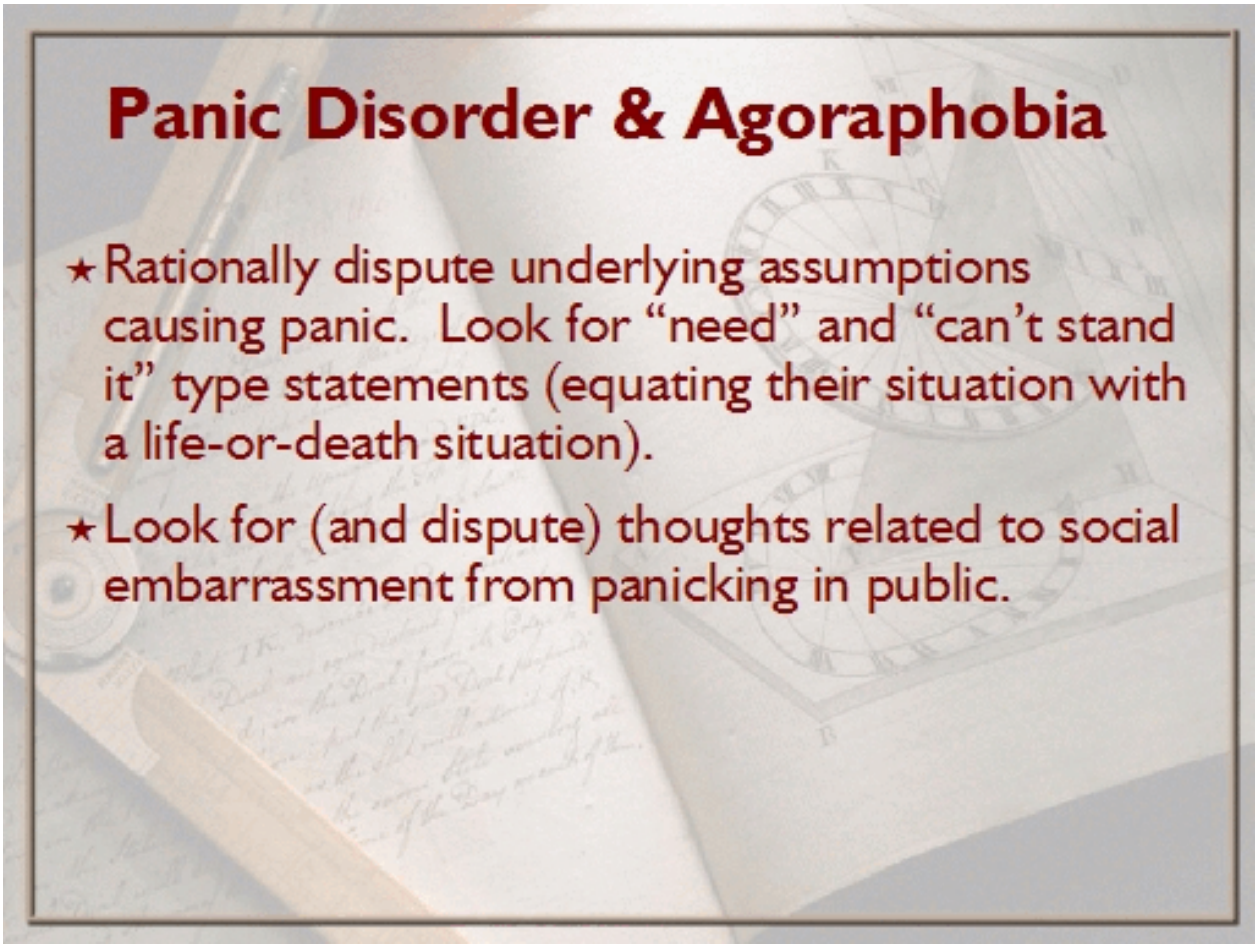
- Fearful of being alone at home or away from home without a trusted companion.
- "An overwhelming disturbance (panic attack) can occur at any time."
- "There is nothing I can do to ward a panic atttack off."
- "If someone is around, they can help prevent it or reduce the consequences."
- "If the process isn't disrupted, it can cause me to die or be severely embarrassed."

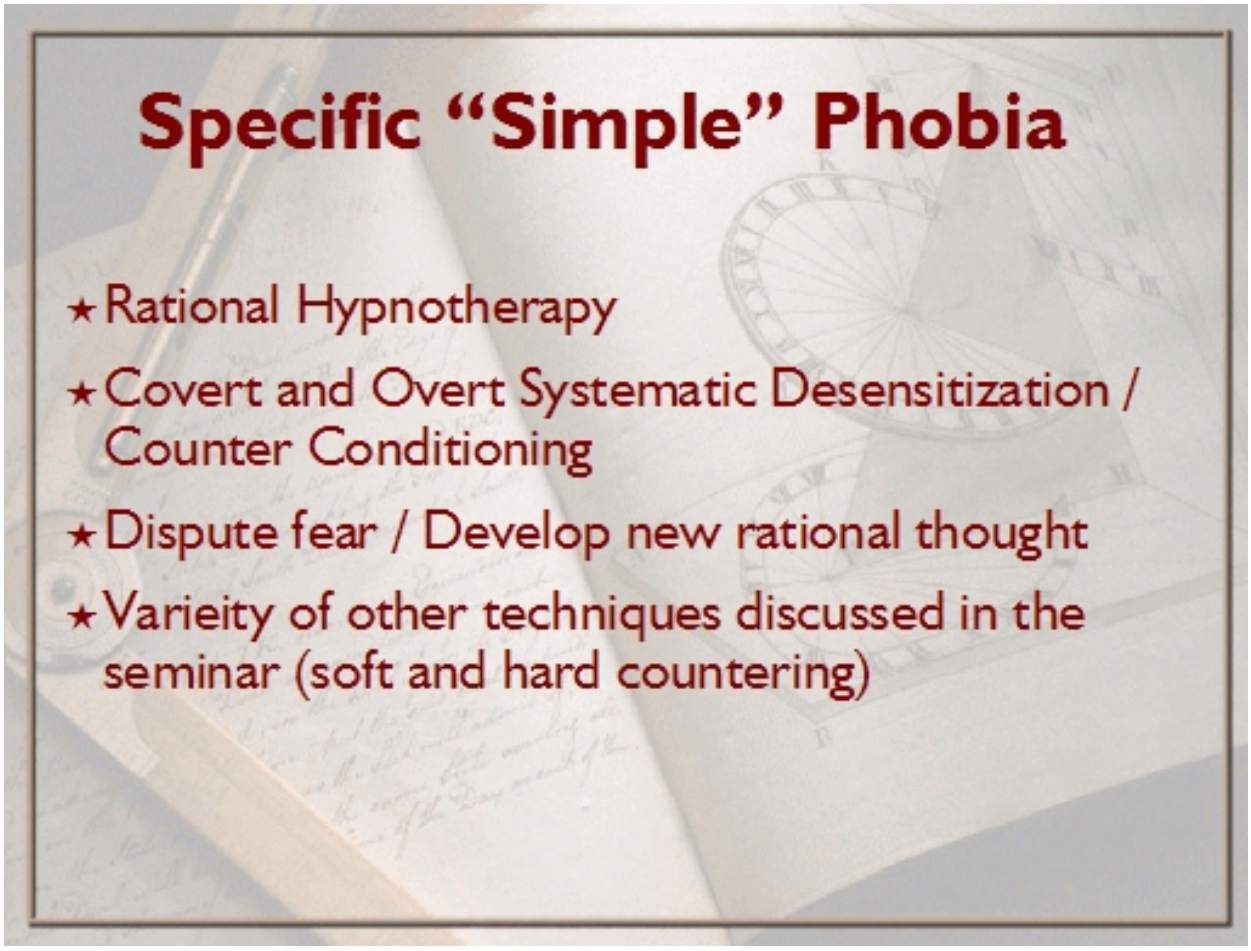
Panic Disorder & Agoraphobia

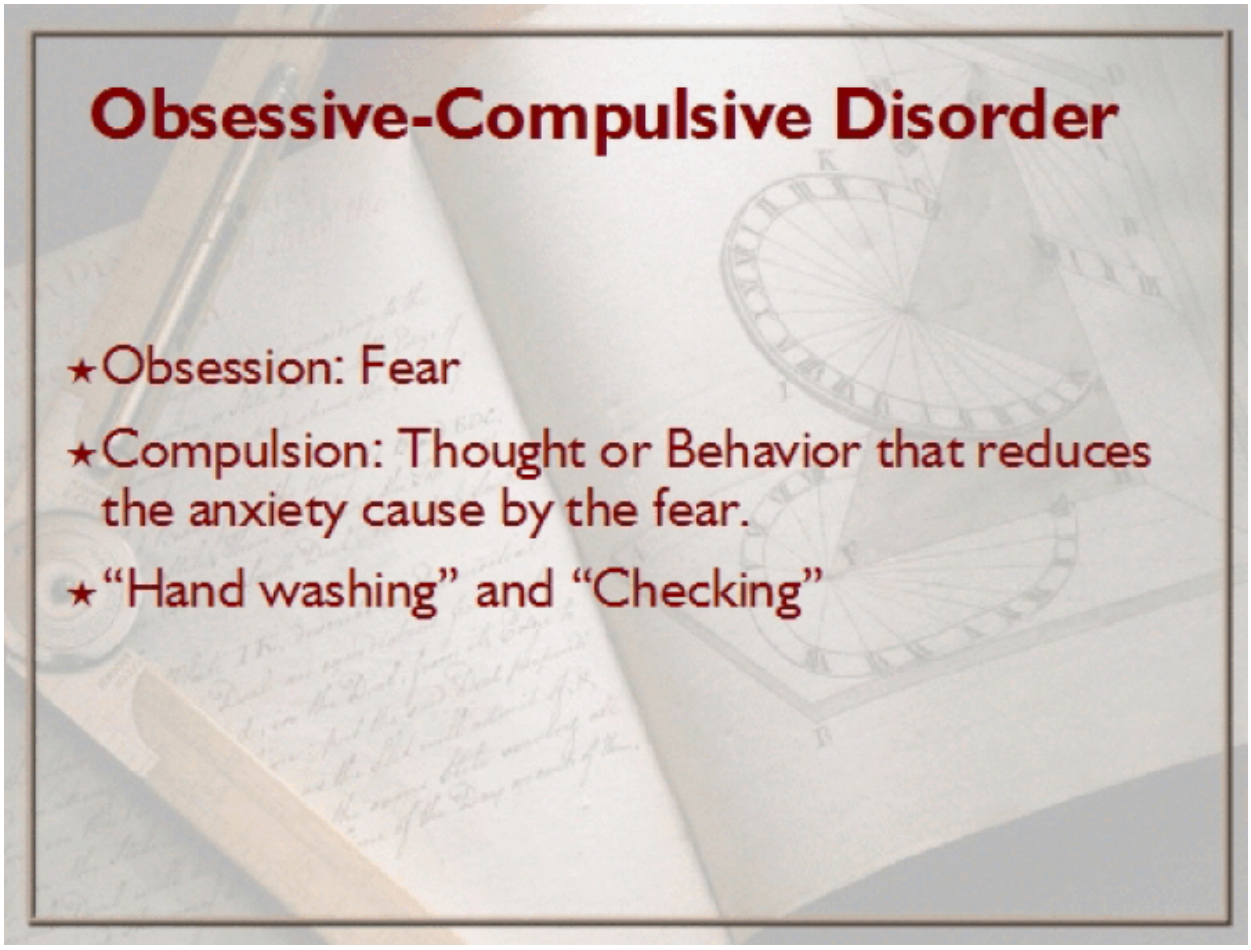
- ★Consider Rational Hypnotherapy as a technique to more quickly help client remove symptoms.
- ★At very least, teach client progressive relaxation at beginning therapy process to provide relief.
- ★Teach client about the cognitive explanation of panic and agoraphobia. Help remove the "it" as in "it just happens."
- ★Help the client overcome symptom stress related to panic, including fear of passing out, dying, losing control of car, etc...(become "unafraid" of it).

Panic Disorder & Agoraphobia

- As client practices traveling away from home, an "Out" very important.
- Systematic Desensitization by gradually traveling farther away from home, and staying away for longer periods. Might also involve gradually less reliance on someone accompanying them.
- Use variety of techniques discussed in this seminar to desensitize the client's fearful thoughts and images.


Panic Disorder & Agoraphobia
★Rationally dispute underlying assumptions causing panic. Look for "need" and "can't stand it" type statements (equating their situation with a life-or-death situation).
★Look for (and dispute) thoughts related to social embarrassment from panicking in public.


Specific "Simple" Phobia
★Rational Hypnotherapy
★Covert and Overt Systematic Desensitization / Counter Conditioning
★Dispute fear / Develop new rational thought
★Varieity of other techniques discussed in the seminar (soft and hard countering)


Obsessive-Compulsive Disorder
★Obsession: Fear
★Compulsion: Thought or Behavior that reduces the anxiety cause by the fear.
★"Hand washing" and "Checking"

Obsessive-Compulsive Disorder

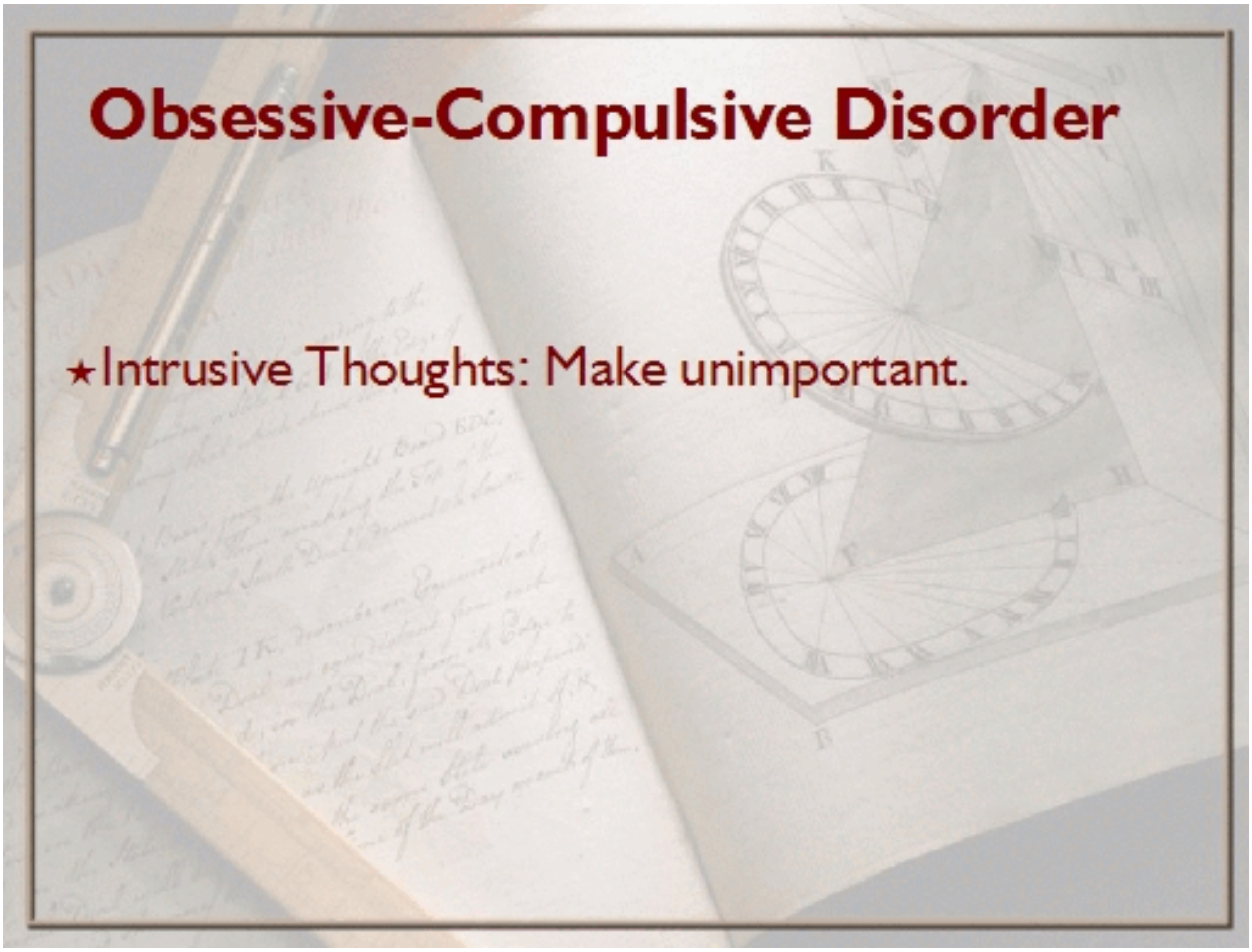
Exposure and Response Prevention

- ★Develop hierarchy of fear (least contaminated to most)
- ★Expose client to least feared aspect (door knobs) for specified time period or until anxiety subsides. Have client report to you subjective units of distress.
- ★Prevent the client from engaging in compulsive behavior during the exposure period and for a specified time afterwards.

Obsessive-Compulsive Disorder

Exposure and Response Prevention

- When client reports experiencing a pre-determined SUD's level (often "zero"), we proceed to the next most feared aspect (bar of soap).
- Work at cognitively disputing fear that causes anxiety and subsequent compulsive behavior.
- Understanding origin of fear can place us in a better position to dispute the fear. (Look for unspoken fear if particularly resistent. – AIDS example.)


Obsessive-Compulsive Disorder
★Intrusive Thoughts: Make unimportant.

RLT Group Therapy

(1) Therapist's Role

A. Instruct the group in the theory and techniques of rational self-counseling

B. Monitor group members as they apply the rational self-counseling skills to their personal problems

C. Facilitate continuous therapeutic group interactions

Effective RLT Group Therapists:

1. Encourage all group members to talk by helping the members see how the topic at hand relates to them.

   Ask group members to describe the similarities and differences they see between their problems and the one being discussed.

2. Stay in control of the group maintaining its focus (without obviously controlling it)

3. Open and give closure to all group sessions.

(2) Selecting Group Members

Have three characteristics

1. Want to improve their emotional health

2. Capable of learning healthy behaviors

3. Are willing to do what's necessary to learn health behaviors

Group Size: 5-10 Ideal. 20 Maximum

Group Composition: Usually no need to have diagnostically homogeneous groups unless the clients have an emotionally-charged behavioral problem, like urge to rape, sexual deviance, child abuse, etc...

(3) Ground Rules

A. Confidentiality a must.

B. Socializing among group members outside of the group is not encouraged.

C. Members are expected to attend regularly and willing to present a Rational Action Planner (or similar technique).

(4) Process

Volunteers present their personal problems by way of a Rational Action Planner (or similar technique). Group members are asked to give comment in terms of the rationality of the thoughts expressed by applying those thoughts to the Rational Questions. If thoughts are found to be irrational, the group helps develop a new, rational alternative thought for the presenter to practice.

Rational Action Planner™

Old ABC's

A	B	C
(What you are aware of)	(Thoughts or Beliefs about it)	(Emotional & Physical Reaction)

What were (are) your goals in this situation (Conscious or Implied)?

Achieved?

Camera Check of "A" Section
(What Would a Camera Show)

Rational Questions

Apply the Rational Questions To Each of the Thoughts in the "B" Column and Write Down Whether or Not They Passed Them.

1. Is my thinking based on Fact?
2. Does my thinking help me achieve my goals?
3. Does my thinking help me feel the way I want to feel?

Keep any thoughts that pass the Rational Questions and replace any that do not.

Rational Action Planner™
Side 2

New ABC's

A (Camera Checked)	**B** (New Thoughts to Practice)	**C**
Whenever I'm in this Situation:	***I'll think this:***	***As a result of my new thinking, I'll feel and do this:***

Do these new thoughts pass the Rational Questions?

Practice imagining yourself in the "A" Section, Thinking the "B" Section, and Reacting like the "C" Section. Act "As If" you believe the new thoughts until they feel comfortable to you.

Additional Training in Rational Living Therapy

If you would like additional training in Rational Living Therapy, please contact Aldo Pucci at the Rational Living Therapy Institute at:

Rational Living Therapy Institute
203 Three Springs Drive, Suite 4
Weirton, WV 26062
1-304-723-3980

Certification in Cognitive-Behavioral Therapy

If you would like to become certified in cognitive-behavioral psychotherapy, please contact the National Association of Cognitive-Behavioral Therapists at:

NACBT
P.O. Box 2195
Weirton, WV 26062
1-800-853-1135

Web Site: http://www.nacbt.org

Email: nacbt@nacbt.org

The NACBT offers a host of certifications in cognitive-behavioral therapy, including the Certified Cognitive-Behavioral Therapist (CCBT) and the Diplomate in Cognitive-Behavioral Therapy (DCBT) credentials.