

## Applying counseling theory by comparing and contrasting Rational Emotive Behavioral Therapy (REBT) and Person-Centered Therapy (PCT)

Robert Douglas Neve  
Bellevue University

### Main Concepts

This paper compares and contrasts Rational Emotive Behavioral Therapy (REBT) as established by Albert Ellis and Person-Centered Therapy (PCT) as established by Carl Rogers. Both theories found their origins in humanistic philosophy, though Ellis has clarified the fact that REBT “includes profound religious and spiritual elements” (Ellis, 2004, p. 439).

PCT springs from the concept that all we humans know for sure is that we humans exist and that we may well be the center of existence. Therefore the client should be the center of the therapeutic relationship, and the work of the PCT therapist is to see the world from the client’s perspective, because the therapist does not necessarily know what is best for the client. Roger’s assumption is that the client is essentially good, trustworthy, maturing, growing, and able to solve their own problems. Therefore in PCT, the focus is more on the client than the method. The PCT therapist is to understand the client as a whole being, not as a diagnosis or a person with specific psychodynamic complexes, as Freud would say. Therefore the main responsibility of the therapist is to create an environment in which the client feels free and sees clearly enough to solve her own problems, to realize her full potential (actualizing tendency), and the movement towards a higher evolution or social complexity (formative tendency). PCT is a phenomenological approach as it is based on the client’s perception of reality, not on a basis of purely objective rational thought as Ellis emphasizes.

REBT springs from the concept that similar stimuli produced different responses in different people. This reinforced the concept that a person’s reaction or consequence to a stimulus is based on his beliefs, his view or his experience of the stimulus. Problems come not from what happens to us, but from how we react to what happens to us and the meaning we place on the events. Ellis believes that we have an innate potential for self-construction and self-destruction (Corsini & Wedding, 2005). He concedes that environment can exacerbate self-defeating behaviors. Ellis posits that only hard work and practice can correct irrational beliefs, and until the client takes responsibility for his own beliefs and their consequences, the client will continue to re-victimize himself with the dysfunctional beliefs that result in undesirable consequences. REBT works on one problem at a time, and is therefore problem or issue centered, as opposed to PCT which works on the whole person all at once. The main dysfunctional and irrational thoughts that Ellis finds people have tend to closely relate to the myths that “others must treat me well” and “I must do well”. Furthermore REBT discourages the client from making global generalizations (“I am bad.”), but rather to evaluate each action individually (“That act was bad, but it does not mean I am bad.”). REBT also challenges the client to dispute his need for approval, his obsession with perfectionism or fear of failure, his blaming others, his exaggerating consequences (maximizing or catastrophizing), his belief that he is helpless or hopeless. REBT will challenge the utility of his preoccupations, avoidance, and revictimizations, along with “chasing nirvana” (using should, must, and have to).

Roger’s core concepts for PCT include congruence, empathy, and unconditional positive regard for the client (Corey, 2001). The goal of PCT is for the client to arrive at a more positive self-regard, to shift the locus of evaluation and to experience life in a new way. Self-regard speaks to increasing the client’s self-esteem. Shifting the locus of evaluation is the phrase used to recognize that the client has made progress when he shifts the source of his expectations, beliefs,

and values from others to himself (i.e. no longer seeking to meet someone else's expectations, but rather formulating his own and meeting them). With this, the hope is that the client becomes less rigid, more flexible and more open to experiencing himself and the world.

Ellis' core concept includes congruence, empathy and unconditional positive regard, but does not emphasize it as highly as Rogers. Ellis does not see the warm relationship of PCT as a necessary element of REBT. The goal of REBT is for the client to dispute his irrational thinking, thus the therapist will at times initiate a dispute. Similar to PCT, REBT will often seek to dispute the expectations of other people that the client has allowed to be imposed upon him, and by disputing to change the locus of evaluation. The result being the minimization of neurotic problems like rigidity, inflexibility and a closed mind, which in this way is similar to PCT.

### Helping Process

In PCT, the therapist develops a permissive and non-directed climate. Empathy and unconditional positive regard create a nurturing environment that encourages greater independence and integration of self. Since the client is able to solve his own problems, the therapist does not offer advice, suggestions, or direction. The therapist does not have any answers or secrets that he is to share with the client, as the client knows best for himself and has the solution within himself. The therapist is only there to draw that out.

In REBT the therapist is to help the client identify irrational, untrue, or self-defeating beliefs. The therapist does have advice, suggestion and occasionally a clear direction as to correcting the client's non sequitor logical statements. The therapist is to suggest other ways to view the world and the events that happen to the client.

### Methods or Technique

In PCT, self-disclosure by the therapist is discouraged, so as to avoid contaminating the client's perspective with the therapist's perspective. The therapist listens, accepts, respects and responds positively to anything the client says. The therapist must be entirely honest and genuine. If there is an initial assessment, it may be in the form of an autobiography so the therapist can see the whole person. The client chooses the direction in which the session goes.

The essential process of REBT is disputing irrational, self-defeating, and untrue beliefs. The work is to identify the undesirable consequences, behaviors, or feelings that the client wants to change. From these, the dyad tries to determine the underlying irrational beliefs that cause the client to arrive at the undesirable state or action. These beliefs will be disputed to recognize their true and actual impact on the client's life. Often the therapist will suggest "Suppose the worst case happens?", and typically the client will see that even the worst case is not the end of the world, and even then there are always options and choices to make, especially with regards to how the client views the stimulus. REBT is a multimodal therapy using homework, teaching, role playing, behavior modification, assertion training, desensitization, operant conditioning, reading and movies.

### Hypothetical Clinical Case

Suppose we have a 30 year old white male, college educated, employed at an engineering firm, single, never married, owns his own home, is financially stable, has a number of close friends, and has never been in military service. He comes to the therapist complaining of a constantly sad mood, not enjoying the things in life that he used to, sleep problems, concentration

problems and occasional bouts of crying for no clear reason. Upon probing in the initial interview, the therapist finds that he has a history of drug use, claims no use other than alcohol and cannabis for the past 10 years, though he admits the alcohol and cannabis use is excessive, daily, and followed by weekend binges. He admits that recently he has had suicidal thoughts.

The PCT therapist would start the session by welcoming the client warmly, with open arms. He would find nice things to say about the client to start to look for ways to mirror the client to start to establish rapport. The client would decide what he is going to talk about and where the direction of the conversation would go. Often in this kind of therapy, the client will ask the therapist what he is supposed to talk about, or ask the therapist for direct advice to solve the problem. The PCT therapist will respectfully decline and ask the client what he thinks the solution to his problem is. The therapist will agree with the client to reinforce in the client's mind that his own judgment can be trusted. This reassurance may boost the client's mood and self-confidence. This form of therapy may take a long time for the client to get around to addressing his deeper problems. In any case, the therapist will be entirely flexible, and each session will be open-ended. Whatever the client says, the therapist will show acceptance and approval of the client's thinking, feeling and resultant condition. The PCT therapist will create a positive, trusting, comforting, happy environment being very sensitive to the client's feelings and far less cerebral than the REBT therapist.

The REBT therapist will recognize that the client is likely substance dependent and is suffering from a depressive episode. Given the therapist's high level of training, typically higher than the PCT therapist, he will start in on identifying the typical depressive thought patterns, addressing helplessness and hopelessness. This method will take less time to address the client's problems because it is so direct.

REBT has been proven effective for depression and substance abuse. There is less supporting research to show the effectiveness of PCT. Though there is some research that suggests the therapy method is less important than harmony in the personality of the client and therapist, which might favor the PCT approach (Glauser & Bozarth, 2001). Nonetheless, REBT may be the best fit for this client as (1) managed care will be more likely to pay for REBT than PCT due mostly to time constraints and cost, (2) the therapist that empathizes with the depressed person will spend more time commiseration and little or no time presenting solutions, (3) often a depressed person cannot think clearly enough or confidently enough to be able to discover a solution or voice a solution if he thinks of one, (4) because the client has had suicidal thoughts lately, time is of the essence for the safety of the client.

The REBT therapist will define a problem statement, a goal, possibly some strengths or resources that he client has that will help him solve this problem, and several objectives, or steps that will take the client to the goal. The problem statement might be (from the client's perspective) "My pot smoking and drinking demotivates me and saps my energy preventing me from accomplishing my dreams." The goal might be, "Abstain from drugs and alcohol long enough to think clearly about its long term effects on me, to restore my energy level, and to start enjoying life again." The therapist might point out that the man is obviously industrious, hard working, and intelligent, which will help him to solve these problems. The therapist might propose the following objectives: (1) Read the *Feeling Good Handbook* by Dr. David Burns, identify my dysfunctional thinking patterns from the "Ten Forms of Twisting Thinking" table, and write out my experiences that preceded this thinking and beliefs formation, followed by (2) attend daily AA or NA meetings until established in sobriety, (3) journal throughout the day, writing down every time you use the words "should, must, have to, always, never", summarize the circumstances, and discuss them in the next session with therapist. The *Feeling Good Handbook* is possibly the best psycho-educational text that addresses depression. I have used this book with

great success and often use the Ten Forms of Twisting Thinking with clients to identify their dysfunctional beliefs. Attending AA and NA meetings and becoming involved in that program significantly increases the client's chances of recovery from drugs and alcohol. This client will not likely be able to make progress on his depression until he stops taking depressants (alcohol and cannabis) and possibly starts taking antidepressant medication. As a therapist I cannot prescribe medication, but I would refer him to a psychiatrist to consider medication. The journal concerning the "musterbating" and the "shoulding on myself" are typical elements of REBT that identify a person's external locus of expectations, i.e. expectations that others place on the client which prevent him from becoming self-actualized and autonomous.

### Insights about Experiential Learning

Experiential learning is a necessity for being a good therapist. There are some things you cannot learn from a book. The subjective impressions of therapists in ascertaining the subtleties, the intricacies, the combinations and the dynamics of a treatment mode would be difficult, lengthy and maybe impossible to delineate in a book, though they can be easily obtained by a perceptive therapist, as Bluestone (1999) points out.

One thing I have found in practice is that depending on the needs of the client, the therapist may change from one theory and technique to another within a short time, or even move back and forth between approaches and theories. I have found myself giving a client positive regard for an act that I felt was wrong, giving him understanding of how he arrived at that place, and acknowledging that his bad act was trying to meet some need. Being also REBT oriented, I will at some point discuss the dysfunctional thinking and belief. However I know the benefit to the client comes after establishing rapport, after I have gained substantial understanding of the client on the whole, after he comes to trust me, so that he will be open to listening to me when I do discuss his dysfunctional thinking. By establishing a rapport, I disarm him from his natural or practiced defenses, so when I do compassionately address his irrational thinking, he is able to save his dignity and self-confidence and simply address the problem without defending himself and without feeling badly about himself.

Most importantly, in my practice, I have discovered the benefits of Motivational Interviewing which seem to combine the best of my two favorite modes of therapy, PCT and REBT. In Motivational Interviewing (MI), the target behavior (the behavior or state of being that the client wants to change but cannot seem to do it on their own) is always defined by the client, not the therapist. For example, if a client wishes to stop smoking crack and marijuana but continue smoking cigarettes, then crack and marijuana will be the focus of treatment. No matter how much I want to point out that cigarettes kill half a million people a year in our country, I will hold the discussion of cigarettes in reserve until a time when the client is ready to discuss it. MI is the best technique known to create a client-counselor therapeutic alliance, build rapport, resolve inner conflicts, to strengthen healthy inner dialogue, to empower personal freedom, to strengthen a person's determination, and to effect positive change.

Finally, another insight is that in practice, each separate theory and its set of techniques do not necessarily contradict each other. Thus it is best to not interfere with another therapist's recommendation for a certain client. Even though I may think I have a better method for that client, and I may suggest such to the other therapist, but in the end, that therapist has responsibility for that client and that therapist's approach may be just what that client needs. This allows me to be accepting of my fellow therapists and allows me to stay out of the client's attempts at manipulating therapists using one against the other (triangulations). This insight has brought me great peace and acceptance in the jobs in which I have worked.

## References

- Bluestone, H., Clemens, N. A., & Meyerson, A. T. (1999). Should clinical training in long-term psychodynamic psychotherapy be mandatory in residency training? A debate. *The Journal of Psychotherapy Practice and Research*, 8(2), 162-169.
- Corey, G. (2001). *Theory and practice of counseling and psychotherapy*. Belmont, CA: Brooks/Cole.
- Corsini, R. J., & Wedding, D. (2005). *Current psychotherapies*. Belmont, CA: Brooks/Cole.
- Ellis, A. (2004). Post September 11<sup>th</sup> perspective on religion, spirituality, and philosophy in the personal and professional lives of selected REBT cognoscenti: A response to my colleagues. *Journal of counseling and Development*, 82(4), 439-443.
- Glauser, A. S., & Bozarth, J. D. (2001). Person-centered counseling: The culture within. *Journal of Counseling and Development* 79(2), 142-147.