

## CONCEPTUAL ANALYSIS AND APPLICATION REALITY THERAPY AND COGNITIVE BEHAVIOR THERAPY

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### *Abstract*

*In this study a comparative analysis of the basic concepts of William Glasser's Reality Therapy and Cognitive Behavioral Therapy is proposed with an extensive focus on the initiation and mechanism of change. In our view adapting the conceptualization of the problem by contextual elements specific to each therapeutic approach through the application of specific strategies will lead to significant early effects, which in turn will contribute to the internalization of the new cognitive behavioural skills. The compatibility of the two therapeutic approaches allows for an increase in the efficiency of several therapeutic factors such as the therapeutic relationship, client self efficacy, and the development and maintenance of functional coping mechanisms. The paper proposes a critical analysis of Reality Therapy and Cognitive Behavioural Therapy, without favouring one approach over the other.*

Keywords: therapy, reality, cognitive-behavioral, compatibility, efficiency

### **Introduction**

William Glasser's Reality Therapy (RT) and Cognitive Behavioral Therapy (CBT), appeared in the sixth decade of the last century. These two therapies have the same purpose and similar methods but based on different concepts. Considering that CBT comprises the concepts of cognitive-behavioral approaches formulated by Albert Ellis (*Rational Emotive Behavior Therapy*), Aaron Beck (*Cognitive Therapy*) and Donald Meichenbaum (*Cognitive*

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*Behavior Modification*), throughout the paper we refer to CBT as an approach that incorporates basic assumptions of the therapies mentioned above.

The present work analyzes RT and CBT by comparison, reviewing, in a compact manner, the most important elements that outline a therapeutic approach. For start, we will present the main concepts of the therapies in discussion. Afterwards will focus on practical models acknowledged in published literature, the WDEP program in RT and the ABC model in CBT, along with other therapeutic strategies.

The compatibility between RT and CBT is evidenced through a comparative analysis of these two therapeutic approaches, both at an conceptually and an applicative level. The main aim of this analyze is to bring in attention of the scientific community the importance of a flexible conceptualization and insight in the therapeutic process depending on peculiarities of the individual receiving therapy.

### **Specific concepts of RT and CBT**

Choice Theory (CT), called in original form Control Theory, represents the base of RT with the following specific concepts (Glasser, 1981):

- *Basic Needs* genetically encoded and present from birth: survival, love and belonging, power/performance, freedom and fun. Failure to satisfy these needs leads to perceptual error.
- *Perceptual Error* is explained as the root cause of mental problems. Glasser denies the existence of mental disorders and claims the power of personal choice in all aspects of the internal and external world.
- *Total Behavior* includes the following dimensions: action, thinking, feeling, physiological. This behavior appears in the form of a sequence including each dimension. If we don't have an available behavioral sequence immediately, or one that was efficient in the past, we generate new behaviors over reorganization process.
- *Reorganization Process*. Depending on the situations created by the environment and by us, mental representations and informations are restructured by the reorganization process.
- *Quality world (QW)* is described as a photo album, an ideal world, the image of how our life should be. The perception that each of us has on reality includes people, activities, beliefs and has positive valence

because we represent our world according to our expectations. Objective reality and these mental images may be in conflict generating perceptual errors. Managing and elimination of these errors depends on selecting the appropriate behavioral sequence.

Individuals can eliminate perceptual errors through optimizing actions and choices. Remission of mental disorders is possible largely through behavioral strategies, centering on purpose and solutions, mobilizing resources and engaging in action. The action plan is advisable to not harm the value panel and the real goals of the individual (Corey, 2001).

CBT is based on the assumption that the individual's emotional and behavioral problems are due to irrational interpretations of negative events. *Irrational belief, disfunctional emotions* and related *maladaptive behaviors*, represent in RT simple uninspired choices (Roth, Eng, & Heimberg, 2002). Perceptual error (Glasser, 1981) represents in CBT the misinterpretation of an event which generates disfunctional emotions along with associated behavioral manifestations. The therapeutic goal is to eliminate the conflict and distress by disputing irrational beliefs and changing them into rational ones; a strategy which lowers the intensity of disfunctional emotions and encourages the adoption of appropriate behaviors (Roth, Eng, & Heimberg, 2002).

Irrational beliefs named by Beck (1979) *maladaptive cognitions*, were classified and ranked as follows (Beck, 1995):

- *Central Beliefs* – deep cognitive structures that represent the ideas characterized by stability, rigidity and generality about oneself and others;
- *Intermediate Beliefs* – cognitive structures represented by rules, assumptions and attitudes that are more accessible and malleable compared to central beliefs and more profound compared to automatic thoughts;
- *Automatic thoughts* – specific cognitive structures that pass through the mind of the individual in a particular situation and generates distress; are easily verbalized and tested.

People who exhibit emotional difficulties tend to make logical errors called *cognitive distortions* which are in RT perceptual errors. The main

cognitive distortions that occur most often in the form of automatic thoughts are (Dattilio & Freeman, 1992):

- *Arbitrary inference* refers to concluding without supporting and relevant evidence;
- *Selective Abstraction* is the process by which some informations are ignored and the context loses its significance leading to the formation of erroneous conclusions;
- *Overgeneralization* is the process whereby beliefs are formulated based only on an isolated event or detail and used improperly in dissimilar situations;
- *Maximizing* and *Minimizing* consist of erroneous perception of the relevance of a situation or event;
- *Personalization* is the tendency of individuals to connect external aspects with themselves even if they don't have a real basis for this connection;
- *Global Labeling* consists in the global defining of a person based on manifested behaviors and mistakes made in the past;
- *Polarized thinking* involves interpretation of events in terms of "all or nothing" and evaluation of situations in terms of "black and white".

As we can see the character and the relationships between the key concepts of the two theories, RT is a solution-centered approach with many behavioral elements and CBT is an problem focused approach which is based on both behavioral aspects and cognitive aspects. Conceptual differences between RT and CBT fade in practical contexts.

### **Practical perspective of RT and CBT**

RT approach methods in a therapeutic context are also used in CBT for integrating cognitive changes in the form of rational cognitions, achieved by behavioral tasks prescribed after the cognitive restructuring. In RT cognitive restructuring is done implicitly, over the changes made in behavioral sequences at each scale of the Total Behavior. Individuals are capable of making choices and generate more effective behaviors to eliminate or reduce perceptual error (Yaniger, 2003).

According to the underpinning, interconnected elements of CT: desires, behavior and perceptions, Robert E. Wubbolding created a therapeutic model

(or program) under the acronym WDEP which is schematically illustrated in Figure 1. This model includes:

- *W* refers to exploring individual desires and perceptions (what he wants from the world around him and how willing he is to act towards meeting his desires and basic needs), how he perceives himself in the world and what is under his control;
- *D* component of the model which aims at awareness of personal choice, internal language and feelings (people choose cognitive content and emotional states that they experience);
- *E* component is considered the cornerstone of this program, represented by the self-evaluation of behavior and choices made to determine their effectiveness in meeting the desires and goals set;
- *P* element in this model is the main objective of practical and emotional troubleshooting achieved by constructing a well-defined action plan (Wubbolding, 2002).

Developing an effective action plan in order to achieve positive changes in the client's life includes a number of essential ingredients summarized under the acronym SAMIC<sup>3</sup> and used by Wubbolding since 1988 (Wubbolding, 2000):

(*S*) Effective plans are *simple*. If a plan is drawn too complex, the individual may become confused and overwhelmed which can lead to failure when implementing it.

(*A*) *Accessibility* and realism are defining characteristics for effective plans. In other circumstances the client may be discouraged.

(*M*) The action plan should be *measurable*. Clients need to know if the plan is working and to have the opportunity to make and see progress at every step of the plan.

(*I*) Effective plans can be *implemented immediately*, or as soon as possible. If individuals can not immediately implement the plan, immediate motivation and memory of what they have to do may be compromised.

(*C*) Whoever makes the plan *controls* the plan. It is advisable to ensure that the plan is contingent with the client's behavior.

(*C*) Clients have to make a *commitment* to proper implementation of the plan. Of course, the less committed individuals are to the plan, the chances of success decreases.

(C) Effective plans are implemented *continuously*. This is similar to the mindfulness approaches. When things go well, clients are most of the time aware of their desires and what they have to do to fulfill them.

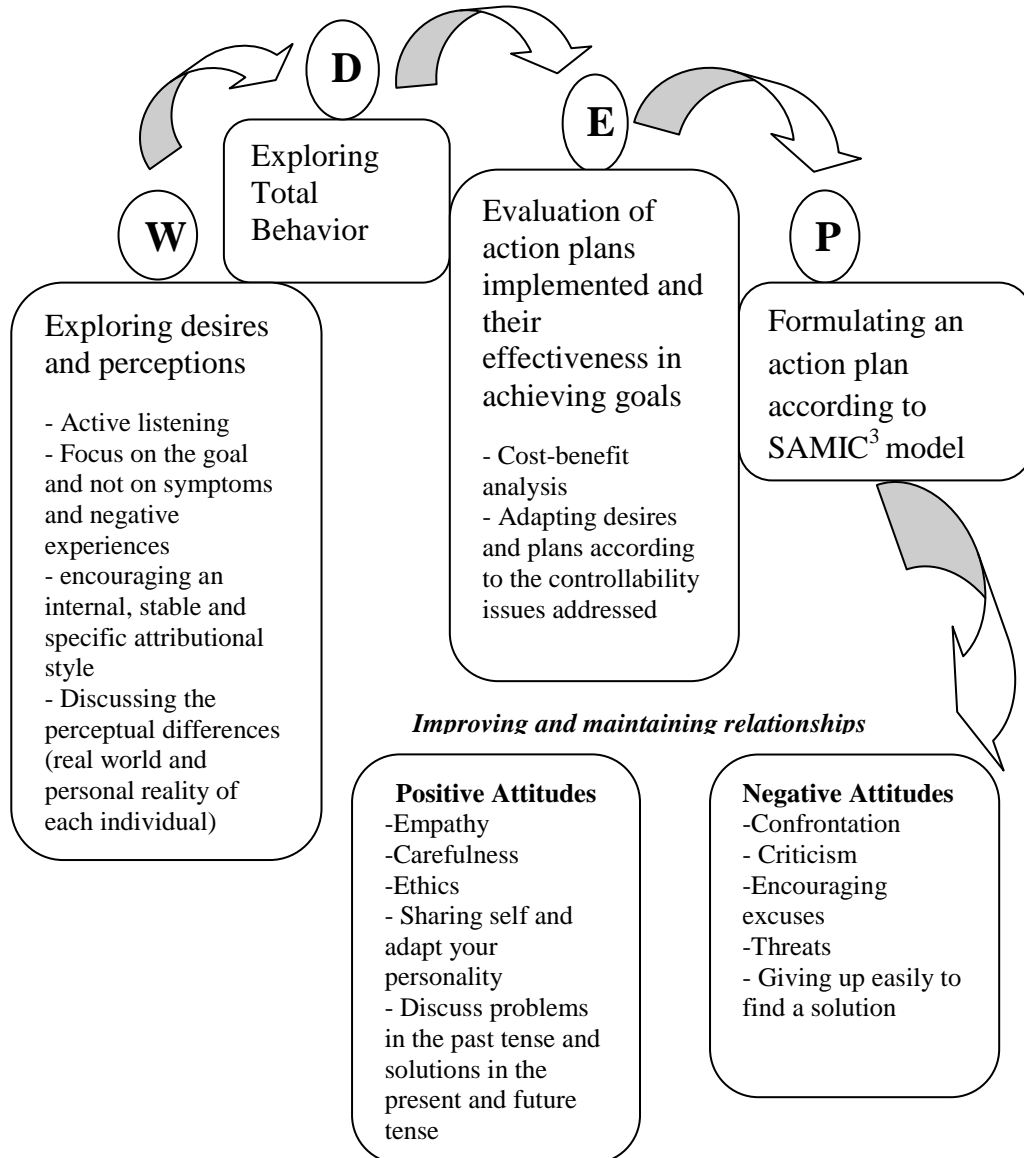
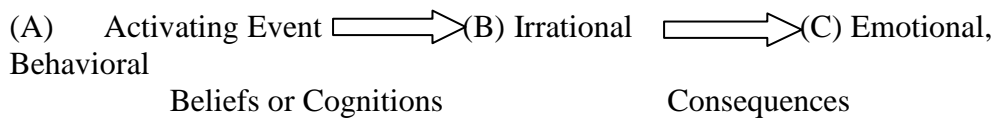


Figure 1. RT intervention program (WDEP, *apud* Wubbolding, 2002).

RT specific intervention program, schematically illustrated in Figure 1, reinforces the client's sense of autonomy and competence by triggering the mechanism of change starting from the first meetings and by building a strong therapeutic relationship as a positive role model in improving and maintaining interpersonal relationships.

Cognitive-behavioral intervention is based on the theoretical ABC model illustrated in the diagram below, where A is an activating event, B represents the interpretation and meaning assigned by the individual to the event in the form of irrational cognitions, and C includes emotional, behavioral and physiological consequences generated by the interpretations of the event (B).



Emotional distress can be alleviated or eliminated through cognitive restructuring of irrational or evaluative cognitions. The next step consists of replacing these misinterpretations with more realistic and rational interpretations, yielding after the internalization of rational alternatives, appropriate emotional reactions and functional behavioral manifestations (David, 2006).

The main evaluative cognitions are:

- *Should statements* with rational alternatives expressed preferentially (ex. I must pass the exam vs. I wish/ I prefer to pass the exam);
- *Awfulizing* each negative event and his interpretation as the worst thing that can happen with the rational alternative of representing adverse events on a continuum;
- *Low frustration tolerance* as an irrational cognitive process by which the individual evaluates a situation or negative event as intorelable;
- *Global evaluation* of others, self and reality is an error because we can not draw general conclusions based on inductive reasoning (the rational alternative is the contextual, specific evaluation).

These thoughts and irrational beliefs appear along with cognitive distortions. Awareness of and modifying these cognitive distortions together

with evaluative irrational beliefs remedy the individual's emotional problems and adjust the related behaviors (David, 2006).

Both therapeutic approaches have been shown to be effective in clinical practice but considering the interindividual differences, future studies would be necessary to stress the importance of adapting therapeutic intervention to the peculiarities of the individual. This can be done by using in conceptualization and implementation of change specific features of one of the two therapies. This statement is supported by the compatibility between RT and CBT which is evident as we suggest in the following section.

### **Compatibility between RT and CBT**

Described broadly over the previous sequences, we analyzed the common and specific underlying RT and CBT interventions. CT formulated by Glasser supports the view that the human brain works like a thermostat whose purpose is to regulate their own behavior to change the world around him. All behaviors are intended to efficiently fulfilling basic needs thus resulting in a sense of control (Glasser, 1981). In CBT terms all this represents full functionality of the individual.

Both client's emotional and practical problems, according to RT, occur due to perceptual errors as a result of the inadequate fulfillment of basic needs and the discrepancies between personal perception of reality (different for each individual) and the universal reality. In CBT's vision, mental problems occur due to an irrational cognitive style that is based on cognitive schemas formed during the life history of the individual. Cognitive-behavioral conceptualization of the problem is formulated in cognitive terms to understand how beliefs generate automatic thoughts in specific situations and how they affect reactions (Beck, 2002). RT's conceptualization is formulated in behavioral terms, so the focus is not on how individuals interpret events in their lives but on the effectiveness of the behaviors taken to achieve the assumed values and set goals.

In both therapeutic approaches eliminating distress is the main purpose. In RT this is done by enriching the range of behaviors or improving those that already exists in the actional repertoire of the individual (Glasser, 1985). On the other hand, in CBT the main strategy includes awareness and changing irrational thoughts and evaluative patterns adopted by the individual.



In order to achieve these objectives, the most important techniques used in CBT after identifying irrational beliefs are cognitive restructuring procedures, behavioral procedures (changing antecedents/consequences) and biological procedures. Intervention at the cognitive level includes cognitive restructuring techniques, stress inoculation procedures (SIT), problem solving and assertiveness training (Beck, 2002; David, 2006). Problem solving significantly fits WDEP system (Wubbolding, 2002), as previously presented, with the following stages (David, 2006):

- a. *Identify the problem* that in RT is exploring perceptions (W);
- b. *Setting goals*, wishes and needs exploration stage of RT (W);
- c. *Generating alternatives* or formulating an action plan that in RT meets SAMIC criteria (P);
- d. *Analyze the consequences* or RT self-evaluation (E).

The basic strategy in RT can be regarded as behavioral activation in CBT used especially in the case of people with depression. The WDEP program includes all elements of behavioral activation but in a different structure. For example BATD (Brief Behavioral activation treatment for depression) behavioral activation program has the following steps (Lejuez, Hopko, Acierno, Daughters, & Pagoto, 2011):

- Awareness of the most important areas of life;
- Identifying values and goals related to those areas;
- Identify activities that correspond to these values;
- Using the identified activities in planning daily activities.

Although the number of CBT intervention techniques is large, the change is expected to occur in the cognitive dimension first and then in the behavioral one, by practicing cognitive restructuring between therapy sessions. On the other hand cognitive changes in RT are generated implicitly by exploring desires, needs, perceptions and after the implementation of action plans developed since early sessions. Depending on individual particularities, explicit cognitive restructuring may be insidious even if the individual accepts the cognitive-behavioral conceptualization.

In recent decades, Glasser wrote in detail about building a therapeutic relationship, what behaviors and habits should be promoted and avoided. These behaviors / habits provide an excellent guide for proper interaction between therapist and client and for any interpersonal relationship. This guide promotes a supportive, encouraging therapeutic relationship, active listening, acceptance,

trust and respect. Also through the therapeutic relationship the client can develop the ability to compromise, to negotiate differences (a basic assumption of CT argues that although all individuals have the same five basic needs, how to achieve them varies from individual to individual) and to extrapolate effective means of communication used in the relationship with the therapist in other interpersonal relationships.

Functionality criteria for interpersonal relations, leaves no place for critical attitude, guilt, attitude of helplessness, denial, threat, punishment and reward control. Adoption of these attitudes will lead to damage and ultimately irreversible destruction of any relationship (Wubbolding, 2004). In CBT the importance of the therapeutic relationship is given by the fact that it facilitates the therapeutic process and change. The therapist assumes the role of an adult, with an encouraging attitude in acquiring new coping mechanisms and the client has the role of the learner in the therapeutic process (Dryden, 1993).

### **RT efficiency versus CBT efficiency**

In terms of effectiveness of the two approaches on which we focus, the differences are significant. CBT is one of the most empirically fundamental therapies and to rigorously illustrate the positive results achieved by CBT we call upon the synthesis made by Andrew C. Butler and collaborators (2005). This includes 16 meta-analyses with a total of 9995 subjects from 332 studies. A classification according to psychiatric disorders showed a high efficiency in treating depression in adults and adolescents, generalized anxiety disorder, panic disorder with or without agoraphobia, social phobia, post-traumatic stress disorder, and also in the treatment of depressive disorders and anxiety in children. Moderate effect sizes were obtained after comparing CBT with control groups in case of marital problems, anger management, somatic disorders in childhood and in the case of variables related to chronic pain (for example: expression of pain, activity level, social role functioning and cognitive coping mechanisms) (Butler, Chapman, Forman, & Beck, 2005).

Unlike CBT, in case of RT there are no extensive studies showing the effectiveness of this form of therapy in severe mental disorders, but positive effects were observed by implementing in therapy the conceptualization and the principles of RT with young people and children. The results showed an appropriate and functional behavior, setting realistic and objectives goals and

how to adopt a coherent and effective plan to achieve them, and improving interpersonal relationships by increasing empathy and altruism (Watson & Arzamarski, 2011). Other positive results were highlighted at the development and improvement of cognitive, social and self-management skills (Villares, Brigman, & Maier, 2010), in improving academic performance (Hinton, Warnke, & Wubbolding, 2011), responsibility in social context and attributional style adjustment (Kim, 2002).

RT efficiency was tested not only in terms of optimizing human performance but also in improvement of more severe symptoms and psychopathology. For example, RT was implemented at group level for chronic pain management, and the results highlighted an increase in coping skills, satisfaction in life and treatment (Sherman, 2000), but like most empirical studies on RT, the sample was small and the study did not include a control group. Another example is the implementation of a program that promotes health and wellbeing, after which those with mental disorders recorded improvements in the clinical spectrum (Casstevens, 2013).

### **Comparative analysis**

RT was analyzed in parallel with other therapeutic approaches. In a study by Yvonne Malone from 2002, commonalities and key differences between CT of William Glasser and Cognitive Social Learning Theory (SCL) of Albert Bandura were analyzed. Common basal elements underpinning the two theories were the premise of individual responsibility, but at a terminology level there are major differences. For example, Glasser avoids the concept of reinforcement because this term refers to the external control psychology and its purpose is to focus the client on internal control. While SCL emphasizes the fundamental reward, CT argues that self-rewarding for maintaining "straight path", does not fit with the CT principle of getting what you want and feel good about getting what you want (Malone, 2002).

RT was compared with Rational Emotive and Behavioral Therapy (REBT) by Albert Ellis. Besides the existence of significant differences, the two approaches share the principle that external forces are not causing distress, depression, anxiety or any other difficulties. The theory's founders' vision, claims that examining past experiences for understanding the life of clients is pointless. However realistic therapists stresses the idea that behavior is a

choice. Destructive behaviors, although they are ineffective can be chosen to meet a specific desire linked with a basic need therefore effective alternative behaviors can be chosen in the future. RT conceptualizes choice as a way of living more efficiently, without the need for cognitive changes as prerequisite (thinking is seen only as a component of Total Behavior). A significant difference between the two systems reveals human needs as sources of human behavior. REBT is based on the idea that we are human beings because we think and when we experience distress we don't think rationally. RT on the other hand claims that thinking is an internal behavior accompanied by action, emotions and physiological changes. Total Behavior, in which thinking is only a part of, has a clear goal - fulfilling the five basic needs (Glasser & Wubbolding, 1995).

### **Discussion and perspectives**

In this paper we conducted a comparative analysis between two therapeutic approaches that can be seen as a synthesis form of therapy. RT is based on existential, behavioral, cognitive elements, and person-centered elements and CBT includes all elements of cognitive and behavioral approaches.

Putting RT in parallel with CBT reveals more shape differences and less content differences, so RT's conceptualization is formulated predominantly in behavioral terms while CBT's conceptualization is formulated predominantly in cognitive terms. At first glance this difference is easily considered essential, but a close look emphasizes that RT's therapeutic process and strategies are included in CBT under other labels. Thus the WDEP model is found in cognitive techniques at problem solving procedures and in BATD. Assertive training is implemented in RT in the therapy session with chances of generalization in various contexts considering that the first therapeutic target in RT is to create a therapeutic relationship that serves as a model for interpersonal relationships outside the therapeutic context.

The therapeutic relationship promoted by both therapeutic approaches has a collaborative supportive, encouragement and guidance character. In CBT the power ratio is evident, the therapist assuming the role of adult that educates, and the client assuming the role of the student.

This paper questions the modeling and flexibilization of the therapeutic process depending on the individual features and the prerequisites that client has when he comes into therapy. For example, if the client has a low educational status a more inspired approach would be from a behavioral to cognitive dimension than seeking for linguistic expressions that have an impact on the cognitive level. It is also much easier and effective to combat distorted beliefs when in the minds of clients the behavioral evidence of their irrationality already exists.

A widespread feature among individuals, both with and without psychiatric problems is the need for control. This raises the question of to what extent does RT's conceptualization would be more easily assimilated by these clients through responsibility and internal control with which they are invested; thus facilitating the initiation and the mechanisms of change. Similarly CBT's conceptualization may be better assimilated by individuals with technical thinking for which verbal disputes outweigh evidence obtained through behavioral exercises.

In order to further validate the ideas mentioned in this paper it is necessary to perform further studies that highlight the effectiveness of different forms of therapy depending on a number of individual features for maximum impact of the therapeutic intervention in a clinical context.

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