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REBT Assessment and Treatment with Children

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Psychology has gone cognitive, and cognitive-behavior therapy has become the Zeitgeist in psychotherapy. Since the early 1980s, the cognitive orientation so popular with adults has filtered down to interventions with children (see Kendall, 2000). Today, many practitioners working with children use not only behavioral or family-systems conceptualizations to plan treatment but incorporate cognitive change as well. Cognitions have become viewed by many as the mediational variables by which these external factors (family systems and behavioral contingencies) have their effect. One can change children's behavior by restructuring systems or by rearranging contingencies or, more directly and, perhaps more efficiently, by attempting to change the child's cognitions directly.

As with adults, rational-emotive behavior therapy (REBT) hypothesizes that children's disturbed emotions are largely generated by their beliefs (Ellis, 1994). Irrational beliefs and distortions of reality are likely to create anger, anxiety, and depression in children just as they do with adults. In fact, because children are children—immature, less sophisticated, and less educated—one might expect them to make more cognitive errors than adults and to become upset more easily. There has been considerable research on the role of cognitions and irrational beliefs in particular in contributing to emotions not only in adults but in children (e.g., Bernard and Cronan, 1999).

Over the past 30 years, a variety of REBT-oriented publications have enabled cognitive behavior therapists and other child-oriented practitioners (school counselors, school psychologists, social workers) to integrate child-friendly REBT methods in their work with children. Chief amongst these publications has been Bill Knaus' (1974) book *Rational Emotive Education: A Manual for Elementary School Teachers* who for the first time, "translated" rational and irrational beliefs and disputing techniques into language and practices that could be understand and utilized by children as young as six. Child practitioners who discovered this resource found that their young

clients readily understood relationships among Happenings→Thoughts→Feelings→Behaviors taught via "Mr. Head" and other child-friendly activities. Virginia Water's (1982) chapter on REBT with children appearing in the *School Psychology Handbook* outlined and discussed common irrational beliefs of children as well as outlined her common practice of always seeing the child with his/her parent(s) together in therapy in order for the parent(s) to learn how to support maintenance of the child's rational beliefs after therapy ceased. Ray DiGiuseppe (1981) pioneered the use of *rational self-statements* with young children (as distinct from positive self-statements). He also wrote about the use of *empirical disputation* as an easier form of disputing than logical disputing for children in the concrete stage of operational thought. Since the 1980s, REBT resources designed for children in the 6 to 12 year old age range have provided cognitively-oriented child practitioners with engaging activities that could be used in one-to-one child therapy to teach the basics of REBT instead of or having to rely on "talk therapy." Ann Vernon published "Thinking, Feeling, Behaving" (1989) and the "Passport Program" (1998) which have been extensively utilized at the elementary school level in individual and small group work. Michael Bernard's "Program Achieve" (2001a, b, c) a three volume curricula of personal development activities based on REBT is being used extensively throughout the world including many thousands of primary schools in Australia. Jerry Wilde published the popular board game for use with children "Let's Get Rational" in 1987. Finally, the publication in 1983 of the first edition of this book, in 1984 of Bernard and Joyce's "Rational Emotive Therapy with Children and Adolescents" and Bernard's 2004 book "The REBT Therapist's Pocket Companion for Working with Children and Adolescents", has provided cognitive behavior therapists with the theory and practice of REBT that applied to children and their parents.

This chapter outlines some of the ways in which REBT has been used over the past four decades to bring about cognitive changes and associated improvements in children's emotions and behaviors. This chapter addresses special aspects that need to be considered when using REBT with children ages six through twelve. Issues surrounding the use of REBT when working with the parents of children who present with depression, anger and anxiety are covered in the chapter by Marie Joyce that appears in the final section of this book.

Developmental Perspectives

Child-oriented REBT practice has always taken into account the child's cognitive-developmental status in selecting appropriate cognitive assessment and intervention procedures (e.g., Vernon and Clemente, 2006) and involving parents in child treatment (e.g., Waters, 1982). Armed with the knowledge that basic learning processes and abilities (e.g., attention,

memory, verbal mediation, and cognitive strategies) appear to develop progressively over the childhood period, child-oriented practitioners have in the past few years begun to question the role of different developmental characteristics in determining the efficacy of cognitive-behavioral intervention (e.g., Cohen and Myers, 1983). Early work in this area focused in determining whether children's level of cognitive development influences their capacity to profit from self-instructional training (Meichenbaum, 1977), which is introduced at different levels of complexity employing different teaching formats. Schleser, Meyers, and Cohen (1981) suggested that pre-concrete-operational children may not have achieved a sufficient level of metacognitive development to profit from verbal self-instruction that employs directed discovery rather than direct expository methods. The related research of Cohen and Meyers (1983) indicated that preoperational children are unable to spontaneously generate cognitive self-guiding strategies.

REBT child-oriented practitioners employ several principles and guidelines when taking into account the child's cognitive status. We know from our review of Piaget that it is only when children are in the formal operational period (approximately 12 years and older) that they are generally capable of the type of hypothetico-deductive reasoning we believe is a necessary prerequisite for the disputational examination of irrational beliefs when they are presented in therapy as abstract propositions (e.g., "Does it make sense to demand that your fallible parent act fairly all the time?"). Bernard and Joyce (1984) have written:

> Many children do not have the cognitive capacity to (a) recognize *their general* irrational beliefs (e.g.,"The world should be fair and bad people should be punished") *when they are presented as a hypothetical proposition,* (b) rationally restate irrational as rational beliefs (e.g., "The world is not a fair place to live and people who act unfairly can be helped to correct their ways"), and (c) utilize and generalize their rationally restated belief as rational self-statements in all situations (where they are treated unfairly).

We know from Piaget and others (e.g., Flavell, 1977) that children between the approximate ages of 7 and 11 structure their world in an empirical and inductive manner. As a consequence, basic RET attitudes, insights, concepts, and beliefs are taught to children *through intensive analyses of specific situations*. Concrete examples and teaching illustrations are the rule. Bernard and Joyce (1984) illustrated this developmental orientation as follows:

> For example, in working with aggressive and conduct disordered young boys (7–11 years of age), we find they frequently believe that people whom they perceive "doing them in" deserve to be "done in" themselves. We have achieved good success in getting this population to change their beliefs by (a) discussing a specific situation (e.g., being unfairly treated in a math class by a teacher), (b) defining the concept of "fairness" and having them empirically analyze whether the current situation is unfair or not; this step frequently involves using puppets so that the child can view

the situation from another's perspective, (c) discussing the concept of "mistake making" and explaining the different reasons why a math teacher may act unfairly and make mistakes, (d) providing a set of rational self-instructions (e.g., "It's okay to make mistakes; no one's perfect; I can handle this situation; I don't have to get upset") which are modeled and role-played, (e) discussing the concepts of "fairness" and "mistake making" in the context of other problematic situations (e.g., other teachers, parents, siblings, in-class, at play, at home), (f) giving practice in applying the rational self-statements to novel situations, and (g) reinforcing the child (and getting him to self-reinforce) for using rational self-talk with the practitioner and in "real life situations."

In a section of this chapter, we illustrate how disputational strategies can be modified for use with younger populations taking into account their developmental characteristics. When we work with very young children (under 7 years old) we are especially cognizant of their difficulty in readily taking into account the perspective of others (egocentrism) as well as considering more than one relevant dimension at a time. As children during this period rely heavily on perceptual analysis rather than conceptual inference (Morris and Cohen, 1982), we deemphasize extensive discussion and analysis of irrational beliefs and, instead, rely on the child's more advanced capacity for dealing with iconic representation, and employ a great many concrete and simple materials (pictures, diagrams, stories) that young children can readily learn from. Developmental work in verbal mediation (e.g., Flavell *et al.,* 1966) indicates that children between the ages of 6 and 9 who fail to spontaneously produce functional self-guiding verbal mediators may learn to do so from instruction. Therefore, we spend a great deal of time with younger children teaching them through a variety of different techniques what to think and how to spontaneously use rational self-talk in problem situations.

REBT practitioners are also aware that children, especially at the earlier developmental levels, are active learners and that knowledge acquisition is facilitated by "doing" and "seeing" as much as by "hearing." We again recommend the use of pictures and stories, which may serve as imaginal mnemonic aids and may also to enhance the experiential aspect of the learning episode.

Relationship Building

While REBT practice with children views a positive working relationship as an essential condition for progress to be made, REBT practitioners assume that the relationship will develop as therapy progresses. That is, REBTers do not wait for the relationship to develop before commencing therapy; rather starting in the first session with children, REBT practice combines relationship building practices (e.g., warmth, unconditional acceptance, empathy) with data-gathering that initiates the change process including the identifica-

tion of negative events and the assessment of rational and irrational thoughts, appropriate and inappropriate negative emotions, and adaptive and dysfunctional behaviors (see Table 1 for suggestions for beginning the first session with children). The exception to this rule is when children arrive at therapy with limited understanding of why they are there or have limited self-awareness of the need to change.

TABLE 1. Suggestions for REBT child session number one.

1 Define role of therapist/counselor (problem solver: "I am good at helping you if you have hassles with others, worries about the future, hurt feelings.") Reassure young clients that they are not crazy and that having a problem is not "bad"—everyone has problems—especially when growing up. Explain that just as they go to a medical doctor when they have a cold, break a leg, etc., they go to someone when they have a social, behavioral or emotional problem. Explain that counseling is a safe place to explore feelings and thoughts.
2 Establish confidentiality limits with parents, teachers and young client. Ask whether there is anything they have shared with you that they do not want someone else to know.
3 Share reason for referral.
4 If you sense a young client's reluctance/resistance to being referred, normalize feelings ("It seems that you don't want to be here and that's all right. However, someone who cares about you thinks there is something wrong, maybe I can help.")
5 Share information about the counseling/therapy process you are using. Explain that the two of you will be working together helping the young person deal with particular problems. Indicate that for most sessions, you will be asking them to talk about their thoughts, feelings, behaviors and you will be showing them different ways to manage their feelings so that when something bad happens, they do not feel so upset and will know how to feel better. Indicate you will be asking them to perform various "experiments" during the week that can provide them with additional ways to solve problems. Stress that it is very important that the young client carry through with the practice involved in conducting the experiments. Indicate the number of sessions.
6 Normalize problem and communicate hope ("Lots of kids lose their temper a lot, have big worries, get very down." And lots of kids learn how to feel better and not be so upset. We can come up with some ideas to deal with this.") (With adolescents, share information about typical adolescent development).
7 Start off by finding out about interests/hobbies/skills/talents of young client including pets/family members ("teach me about you"). Ways to do this: write a story; draw a picture of family, an acrostic poem. Consider using a "get acquainted" structured activity (share something personal).
8 Ask one question about the presenting problem ("I heard you are being treated badly by a classmate?") and then paraphrase/summarize the answer. Gain agreement. Do not minimize the problem nor dramatize.
9 Indicate that you would like to be able to talk with the young client about ways to make things better.
10 Review what young clients can to say to their classmates in response to the question: "Where were you?" during time client was with you (possible answer: "I was getting extra help with my homework"). Have clients select what they feel comfortable saying.
11 Inform the child how you will be communicating with parents.
12 Work on developing their self-awareness and readiness to change as a prerequisite to REBT.

Expectations

Few children understand what psychotherapy is about. They have some notion that a psychologist is a person who "helps" people, but outside of this, most of their notions are negative. Many children believe that our profession treats "crazy people" and therefore that being at our office is a stigma. The other model that children have for us is the school psychologist. Often, they perceive this role as a disciplinary one.

Young clients present with different degrees of willingness to change. Some may be so caught up in their personal issues (e.g., abuse) they may be unaware of the need for therapy and the need for them to work on changing themselves. Said another way, you may be ready to do REBT, but they might not. In these cases, be patient.

Besides not knowing about the process of psychotherapy, many children arrive at our offices with no awareness of why they have come. Their parents have not discussed it with them. Children are unlikely to become collaborators in a process they do not understand. Therefore, a first job is to explain to them what a psychologist is, who we help, how we help people, and what we help people with. After such an explanation, the child should have a problem-solving set and hopefully a positive schema for the profession, as well as no negative stereotypes. The following transcript shows how this topic can be introduced to children (from DiGiuseppe, 1981, p. 54):

THERAPIST: Johnny, I'm a psychologist. Do you know what that is?

JOHNNY: Oh! No. Well a kind of doctor for crazy people?

THERAPIST: Well, that's not totally true. Psychologists are doctors who study how people learn things. And psychologists help people learn things they have been unable to learn. For example, some children have trouble learning to read. And psychologists help them learn to read better. Other children are sad or scared. They haven't learned not to be unhappy or afraid. Psychologists help them learn not to feel that way. We help children with other problems, too, like anger, bed-wetting, making friends, and lots of things they don't know how to do. Do you understand that?

JOHNNY: Yes.

THERAPIST: Well, what problem do you think I can help you with?

Self-Disclosure and Rapport

Self-disclosure is a prerequisite for any verbal psychotherapy. Children are less likely than adults to self-disclose to therapists because they desire help. For most children a warm, accepting relationship is probably a necessity before they will honestly tell how they feel or think. We do not mean to imply that rapport is curative in and of itself with children, but that it is more desirable to attain self-disclosure and to convince them to listen so that the therapist's interventions can have an effect. Although reflection has been the primary

strategy by which therapists develop rapport, reflection is not the only way to accomplish this end. Another strategy is honest, direct questions that communicate a commitment to help. Children are quite sensitive to dishonesty, and they generally respond well to people who are open and who trust them. Many therapists ask children questions when they already know the answer (e.g., after the mother has called to inform the therapist that $20 is missing from her pocketbook, the therapist's first inquiry is "Were there any problems at home this week?" or "Did you do anything wrong?"). Children are not stupid and are not likely to bring about rejection willingly. Therefore, they may be reluctant to disclose their misdemeanors. So they usually respond to inquiries about their misdeeds with "No, I didn't do anything," or "No there are no problems." Here the therapist has set up a situation in which the child is most likely to lie. Once the child has lied, the therapist is placed in the difficult situation of revealing a lie before it can be discussed. Exposing the child's lie impacts negatively on rapport. To avoid such situations, we think it better to confront children honestly with the facts as you know them, and then to ask for their opinion or interpretation of the events.

Another strategy to help foster rapport is to discuss with the child how therapy can achieve ends that the *child* desires, rather than focusing on the goals of the parents and teachers. Because children are not self-referred and they may not always have the goals of the significant others in their lives, it may be particularly important to show children how they can benefit from therapy before they will be willing to participate. Some goals of therapy that children desire may be (1) to lessen the degree of their parents' anger at them; (2) to develop more predictable rules within the family so that life does not seem as arbitrary; or (3) to attain some major rewards they are seeking, such as a larger allowance, staying out later, or a home video game. The therapist may then act as the child's agent in negotiating for these items when contracting for appropriate behaviors.

An additional strategy is to help shift some of the responsibility for the problem and referral away from the child. A child may feel outnumbered if there is a group of adults trying to induce change. By focusing on how the parents' behavior may contribute to the child's problems or how the parents' upset exaggerates the problem, one diffuses responsibility away from the child and may form an alliance with the child.

We have already alluded to the necessity of building a relationship with a young client to maximize the likelihood that the child will be open about thoughts and actions. To facilitate self-disclosure, three strategies have been recommended:

1. *Do not be all business*. If your initial expectations are too high, the child may find the sessions aversive and then just not talk to you. Allow the child some time to get acquainted with you through play and off-task conversation. Shaping can be used to develop the self-disclosure and on-task conversation required in therapy.

2. *Always be honest with the child.* Children are more cautious than adults, probably because they are more vulnerable. They appear to be sensitive to deception, which they use as a measure of a person's trustworthiness.
3. Go *easily and carefully on the questions*. Children do not trust those who try to give them "the third degree." (DiGiuseppe, 1981, p. 56)

Waters (1982) indicated that self-disclosure can be learned quite effectively if the practitioner: (1) is a good model for self-disclosure; (2) accepts whatever the child says without putting her or him down; and (3) reinforces the child for disclosing.

Consequences and Alternatives

Disputing is the process whereby a client's irrational beliefs are challenged and attempts are made to substitute more rational alternative ways of thinking. Disputing makes sense to rational therapists because they have some prerequisite assumptions about the client and about the nature or emotional disturbance. The first assumption seems somewhat obvious. It is the idea that the client's affect or behavior is negative, disturbed, self-destructive, and better changed. The second assumption is that negative, disturbed emotions can be replaced with alternative non-disturbing, non-self-destructive, albeit unpleasant, affective states. A third is that irrational beliefs create the disturbed affect in the first place. Given these prerequisite assumptions, it logically follows that disputing one's irrational cognitions would be helpful. If these assumptions are not made, however, a client might find disputing a critical, unpleasant process and either drop out of therapy or become extremely uncooperative.

Many children do not recognize that their behaviors or emotional states have a negative impact on their lives. Nor are they necessarily aware that there are alternative ways to act or feel. Most adult clients have a head start on children in this way. Because adults are usually self-referred, they usually recognize that their actions and emotions are self-defeating and that the therapist is there to help them develop alternative ways of responding. If they did not believe this, they probably would not have come in the first place. Children are almost never self-referred. The initial stages of treatment may be exclusively devoted to an evaluation of children's affect and action potential and to convincing them that these bring about negative consequences that are avoidable. Focusing on the consequences of the child's present modus operandi is the first treatment step. Children may have limited schemata for emotional reactions. They may conceptualize feelings as bipolar dichotomous constructs (i.e., happy-mad or glad-sad). It would be quite unlikely for a child to work with a therapist to change being extremely mad to only annoyed when her brother pulls her hair if she has no schema to incorporate the latter emotion.

In many cases, children say that they have no options and that their disturbed emotions are the way they should or must feel. Children may have

developed these beliefs concerning their emotional responses by either modeling or direct reinforcement from their parents or families. In many families, the parents respond in the same exaggerated ways as their children do, so that the child has never seen an alternative response. The parents may show a wider range of emotional reactions, but they may never expect this range of their children and fail to directly teach them alternatives.

In summary, before one can proceed to identifying and disputing irrational beliefs, one must first agree on a goal. Before one can agree on a goal, it might be necessary to expand the child's schema concerning emotional reactions so that the goal is within his or her frame of reference. This expansion can be accomplished through modeling, imagery, stories, parables, and discussions of TV characters that play out different emotional reactions. Evaluating the consequences of the child's emotional reactions, and developing a wider range of perceived, possible emotional reactions is likely to be an important and lengthy step in therapy. Once children perceive that their affect and action tendencies are self-defeating and conceptualize alternative ways of responding both emotionally and behaviorally, they will be more willing to enter into a discussion of how their thinking causes their emotions, and they will be more likely to participate in the disputing and not to see it as an attempt to be critical of them.

The therapist is advised not to assume that these two initial steps in therapy will be achieved instantaneously. It may take a number of sessions to explore these issues before the child becomes convinced of them.

Language

A common error among novice rational-emotive behavior therapists who work with children is to use the jargon of REBT (e.g., awfulizing, terrible, should, shithood, self-acceptance). Children are likely to express their irrational ideas in vocabularies different from adults' or rational-emotive behavior therapists'. Pay close attention to the child's words that represent the irrational concept. Many children express the concept of demandingness by referring to "unfairness." The concept of self-downing or self-worth may be expressed by phrases such as "He is a jerk" or a "jerk-off," or whatever word is currently in vogue in the child's subculture. It is best to avoid translating the child's vocabulary to REBT jargon and, rather, to attempt to use the child's own lexicon. Children may also lack a vocabulary for expressing emotions. Even if they do possess a schema for a wide degree of emotional reactions to problems, they might not have the words to express these differences. If they do not have the wide range of alternative emotional reactions mentioned in the above sections, along with teaching the emotions themselves it is desirable to provide children with a vocabulary for easily expressing the emotions.

The lack of a vocabulary for expressing subtleties in emotional reaction may partly be a result of the structure of the English language. The common use of words to define emotion is rather vague and imprecise. People

frequently use affective words in idiosyncratic ways. One child's "fear" may be another's "panic" or a third's "concern." It is also helpful to check out what the child means by emotional words behaviorally, physiologically, and phenomenologically. Setting definitions of emotional words helps to prevent confusion as the sessions progress. One helpful suggestion is to use Wolpe's (1973) SUD scale (subjective units of discomfort) to describe the child's present emotional state and to provide a numerical rating that indicates the intensity of an emotion. In this way, children learn that affects can be named along a continuum and that their own emotional states can be compared with the desired goal of the treatment. Thus, a child may talk about becoming angry at an SUD 4. If this numerical system appears undesirable to the therapist, she or he can set a specific vocabulary to try to describe the different intensities of emotional states.

The following are suggestions culled from the REBT child literature on how to work at developing a therapeutic alliance with children while at the same time initiating REBT assessment and intervention.

1. Be empathic no matter how trivial child's concern/problem appears to be ("That must be hard"). Do not be too quick to move into problem analysis/solving.
2. Be non-judgmental (unconditional acceptance) of client when you hear about problem even when you disapprove of their behavior (if client broke law, engaged in sexual behavior). Do not feel you are judging them.
3. Respect resistance and move forward to build trust. When experienced, move slower and back off from interpretation. Use more indirect methods (e.g., puppets; reference to problems of a friend).
4. Be patient as trust can be a slow process.
5. Show genuine interest in them. Ask them to share personal stories. Ask them to bring in work and other prize possessions to show you (e.g., CDs, books, yearbooks, artwork).
6. Do not act like a teacher or parent. do not communicate a negative tone about their behavioral infractions (e.g., Do not try to coerce change).
7. Build trust through mutual self-disclosure.
8. In early sessions, listen, listen and reflect back feelings and information.
9. Do not become over-involved emotionally; maintain objectivity.
10. As a rule, do not give treats.

Assessment Guidelines and Practices

The REBT approach to the assessment of childhood disorders consists of two identifiable stages (Bernard and Joyce, 1984).

Problem identification involves the use of both formal and informal tests and methods to determine whether a problem does exist or whether it is solely

in the mind of the parent or teacher who has referred the child. During the initial phase of assessment, the dynamics of the referral are untangled. It is not infrequently the case that parents and teachers refer a child who is exhibiting perfectly normal behavior. They may misdiagnose a problem because of ignorance of the normal patterns of child behavior, because of conflicts that they may be experiencing with the child, or as a sole consequence of their own psychological difficulties. During this phase, it is recommended that the practitioner collect information from a variety of sources to determine whether a problem exists and, if it does, whether it belongs to the child, the parents, or the teachers. A review of a child's cumulative school report, as well as interviews with a variety of people who know the referred child and the circumstances that surround the referral, is advisable. The identification of a problem as well as whether it seems to be a child problem or someone else's is a prerequisite to more thorough problem exploration and definition. The importance of determining problem ownership is revealed in the following excerpt from a case report:

> Mr. and Mrs. S. sought help about their children's behavior. Mrs. S. had been married twice before and the three children were the product of these previous unions. Mr. S. had no previous marriage and had no children. During the two years of their marriage Mr. and Mrs. S. fought frequently about the children. Mr. S. viewed them as "destructive, unkempt barbarians." He complained they talked too much, ate too much, played too roughly, and spoke too loudly. Mrs. S. felt angry at her husband and enforced rigid rules and harsh penalties to avoid his wrath.

A total assessment involving behavior analysis, psychological testing, and family and individual interviews was conducted. It revealed that the older daughter had a mild learning disability and considerable social anxiety, and that one of the sons was encopretic and had some minor school difficulties; the other son displayed no behavioral problems at all. The children's behavior at home which Mr. S. complained about most vehemently appeared to be quite normal. The problem seemed more to lie in Mr. S.'s low frustration tolerance and low anger threshold and Mrs. S.'s unassertiveness with her husband. The therapist made attempts to change some of the children's behavior (i.e., the encopretic behavior); however, most of the interventions were aimed at the parents. (DiGiuseppe, 1981, p. 54).

Once the practitioner has established that a problem does exist and who owns it, the *problem analysis* phase of assessment is conducted. Problem analysis results in a determination of the client's dysfunctional cognitions, emotion, and behavior of concern, which then become integrated into an overall treatment plan.

It is important to emphasize that *problem analysis is an ongoing part of therapy*. That is to say, although it is possible to arrive at insights into behavioral problems and their cognitive and emotive concomitants during initial interview sessions, it is often not until more advanced levels of rapport have been achieved between the practitioner and the child that the central

concerns of the client and their internal and external activating events are revealed. As new information is disclosed over the course of therapy, it is repeatedly analyzed into cognitive, emotive, and behavioral components as a prerequisite to problem solving.

As the practitioner analyzes the presenting problem, he or she is also tuned into the cognitive strengths and weaknesses of the child. Although the age of the client provides a very rough index to abstract reasoning capacities, the manner in which the young client describes problems is a direct guide to how the client arrives at knowledge, the degree to which behavior is under the control of language, and the capacity of the client to distance himself or herself from the problem.

Prerequisities

As indicated, many children have a limited cognitive schema for representing emotions at different levels of intensity as we as often present with a limited vocabulary to describe different emotional states. As such, it is recommended that before commencing a cognitive-emotional-behavioral assessment that young clients are taught two prerequisite skills.

1. An *emotional schema* for conceptualizing their feelings. Many young people have an "all or none" view of their emotions. For example, they believe they can either be angry or happy. You can use a 10-point scale from "Feeling nothing at all" to "Could not be anymore upset" to illustrate to young people they have options in terms of how upset they become when faced with negative events. Help them see that moderate levels of anger, anxiety and feeling down are not only normal but also helpful in solving problems but extreme levels are harmful and can lead to self-defeating behavior on their part. An Emotional Thermometer can be used for this purpose (see Figure 1).
2. Help develop in young clients an *emotional vocabulary* for describing and differentiating their feelings. Many young people are aware that they are upset but may lack the linguistic tools for analyzing their different emotional states.

When assessing emotions in children, it is important to normalize and validate their feelings. It is important for you to explain that everyone gets angry, worried and sad from time to time and that there is nothing wrong with them or bad about them if they get extremely upset. Later on, you will, of course, discuss the negative aspects of getting extremely upset as a way to motivate the child to work on emotional change.

In assessing emotions, the REBT approach is to help children not use the word "upset" to describe their feelings but to use their emotional vocabulary. It is essential for the practitioners to know whether the child is feeling angry, down, and/or worried in order for appropriate goals of treatment to be discussed and shared, but also to help guide the practitioner's cognitive

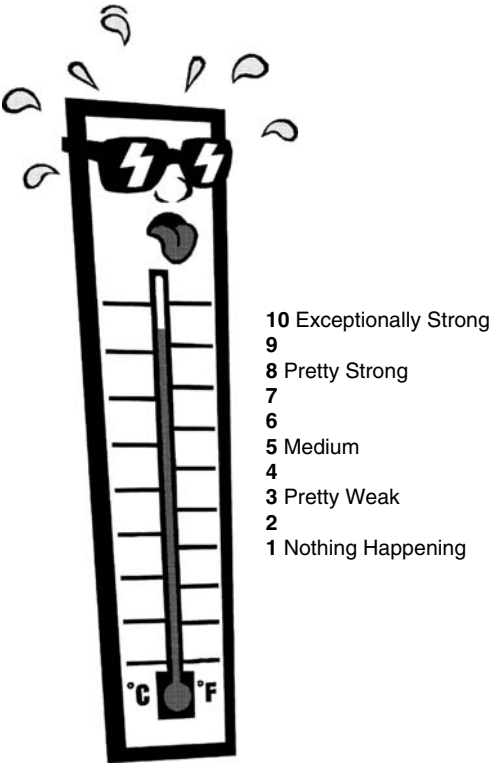

FIGURE 1. The Emotional Thermometer

assessment. For example, to know a child is down rather than angry alerts the practitioner to assess the child's degree of self-downing.

Different Targets for Cognitive Assessment

After the practitioner ascertains maladaptive emotions (including degree of upset) and behavior, the analysis of dysfunctional cognition begins. A variety of different types of cognitions are of concern. The REBT-oriented cognitive assessment is directed at identifying *faulty inferences* (incorrect predictions, conclusions), *absolutes* (shoulds, oughts, needs, musts) and *evaluations* (awfulizing, I can't stand it-it is, global rating of self, others, world) that are expressed in the child's irrational self-talk and beliefs. The REBT practitioner is also on the look out for *cognitive/thinking errors* that lead to reality distortion (e.g., arbitrary inference, selective abstraction, over generalization).

Another area assessed is the client's *causal attributions*. If a young client tends to believe falsely that negative events in his or her life are caused by internal and stable personal characteristics (i.e., ability), whereas positive

events and success experiences derive from external forces (i.e., luck), then a variety of self-defeating emotional and behavioral consequences are likely to manifest themselves.

When emotionally overwrought, children not only upset themselves by their own negative self-talk but also suffer from an absence of coping *self-statements*. It is important for the practitioner to be able to tap into the young client's self-talk in order to determine whether appropriate cognitions are available to combat anger, anxiety, and depression.

It is often apparent that young clients who are referred for behavioral problems lack *practical-problem-solving skills and solutions*. Behavioral repertoire deficits stem from the client's being unable to conceptualize other ways of reaching a goal or resolving an interpersonal difficulty. Through a variety of direct and indirect elicitational techniques, the practitioner determines the extent to which the client is to think his or her way out of situations (alternative and consequential thinking).

An example of a cognitive assessment is revealed in the case of John, age 11, referred to the second author for fighting and disruptive classroom behavior. As is not uncommon, John's school reports indicated that he had a moderate reading difficulty. A group-administered intelligence test (OTIS) revealed a test score of 106. When John's parents were initially interviewed, they indicated that he had a history of noncompliant behavior at home. When he was asked to do something, he would often get extremely angry and sometimes break something. John frequently fought both verbally and physically with his older brother, Andrew, though the intensity of the fights appeared to be moderate and the duration short-lived. John's father would become extremely angry with John when he refused to do what he was asked to do. His father would frequently slap John or use a strap on him. John's mother would attempt to get John to help around the house by being excessively nice to him. As a consequence, John appeared to have things pretty much his way—though at some cost. The therapy with parents, which was successful, involved the father's learning to control his temper largely by changing his belief that "My son must always obey me when I ask him to do something" and by teaching him to accept his son with all his imperfections. Both parents were taught to be more firm and assertive with John, and the use of logical and natural consequences as a punishment procedure proved effective in increasing compliant behavior.

John was seen for 16 sessions. A problem analysis revealed a complex set of cognitive deficiencies. John appeared to break rules and get into fights (consequent behavior) when he interpreted a situation as being "unfair" (antecedent events). At these times, his emotions were generally of anger and frequently registered above 8 on a 1-10 scale of intensity. John was quite open in discussing his thoughts and feelings. His expressive language was somewhat restricted, leading to an inference of an inadequate self-control inner-language system. Primary among his dysfunctional beliefs were (1) "Everyone should be fair to me at all times"; (2) "I should always get what I want"; (3) "I'm no good if I break a rule or make a mistake"; and

(4) "I must be comfortable at all times and I can't stand the discomfort I have when I have to work hard." This last belief resulted in undesirable levels of frustration tolerance and discomfort anxiety, which, because of John's pattern of work avoidance, led to a low level of educational achievement. When John was confronted with situations with his peers in which he believed they wanted to "take the 'mickey' out of me," he could not think of any alternatives to fighting. When he believed that a teacher was saying something or requesting something that he felt was unfair, his only response was simply to refuse to comply with the teacher's instruction. Moreover, when he became aroused, he failed to consider at that moment the range of negative consequences that would result from his misdeeds. At times when he became angry, his self-talk was highly provoking, and he lacked appropriate self-statements for keeping his anger in check. Therapy was partially successful in helping John to give up his "demandingness" and was very successful in improving his self-esteem. He acquired the ability to control his temper by the use of coping self-statements and was "caught" only once for fighting during the remainder of the school year. During treatment, he became more aware of the perspective of others, began to recognize when situations were fair and when they were not, and began to realize that the world did not always have to revolve around him. He began to accept the behavior of others, understood the notion that it is unfair to get angry with people who make mistakes, and was seen by both parents and teachers as being more cooperative.

It is very important for the REBT practitioners to be thoroughly familiar with the different types of cognitions (inferences, absolutes, evaluations) that REBT hypothesizes as leading to different emotional disorders as this will assist in helping young clients become more self-aware of the specific cognitions leading to their specific emotional reactions (see review in Chapter One). While REBT's cognitive assessment questions are never meant to put words in a young client's mouth nor is it the goal of the practitioner to have the child agree with what the practitioner intimates the young client is likely to be thinking, REBT theory of emotional disorders does help the practitioner formulate questions used in cognitive assessment.

When the REBT practitioner is faced with a child who cannot report on his/her thinking in situations where she/he became extremely upset, the REBT employs the theory in the form of hypothesis-driven questioning (e.g., "Many children when they are very angry with a classmate think they really cannot stand it when they are called a name. When you get very angry with Richard when he calls you names first thing in the morning do you think something like that?").

Different Methods of Assessment

In both the assessment and the treatment phases, it is most important that the practitioner be able, when necessary, to tap into the self-talk of the young client. Many children have probably never been asked to report their

thoughts to someone else. Most do not have a sufficient vocabulary to describe the thoughts they experience when they are upset. Moreover, children who manifest a variety of different conduct disorders appear to very quickly subvocalize anger-producing ideas in problem situations and, as a consequence, are unaware that they are thinking anything at all. In both assessing dysfunctional cognitions and preparing the young client for the teaching of emotional-problem-solving skills, the practitioner has the tasks of (1) helping children to be more aware of their feelings and (2) enabling them to tune into and report their self-talk.

There are a number of *informal methods* that you can use to assess how upset a child was when confronted with adverse, negative events. The REBT practitioners is on the lookout for both healthy and unhealthy emotions. Healthy negative emotions are generally those that are moderate in intensity and that do not lead to problematic behaviors. Examples include a child being annoyed but not furious with a sibling for perceived unfair treatment on the part of a parent or a child who felt sad but did not get extremely down when not being invited to sit with classmates at lunch.

The REBT practitioners asks targeted questions to locate extreme degrees of anger, feeling down or anxious. "At its worst, how angry where you were with your brother?" "At other times, do you ever get extremely down about not being invited to be with your classmates?" *A crucial aspect of REBT assessment is knowing that it is only when children experience inordinately extreme negative emotions that they are likely to be harboring irrational beliefs*.

In assessing anger, REBT practitioners always make sure they identify the dysfunctional behavior of children at the time when they were extremely angry. They then make a point of identifying with children the negative consequences of their anger in terms of the environmental response (what people say or do) when they behave in a very aggressive fashion. Negative consequences are the prime factors for angry young clients to be motivated to change their emotions, behaviors and anger-creating beliefs. The Anger Thermometer is often used to represent these relationships to children (see Figure 2).

Assessing Cognitions

REBT practitioners use the REBT model of an emotional episode (see Chapter One) to guide their cognitive assessment. That is, REBT assessment is designed to identify three distinct types of cognitions: faulty inferences (predictions, conclusions), absolutes (shoulds, oughts, musts, needs) and evaluations (awfulizing, I can't-stand-it-it is, self rating, other rating, global rating of world).

Once you have identified a specific Activating event and Consequence (emotional) to work on, assess client's thinking. You will want to "gather" as many examples of client's faulty inferences (conclusions, predictions), absolutes (shoulds, oughts, musts, needs) and evaluations (e.g., awfulizing, I-can't-stand-it-it is, global rating of self, another, world).

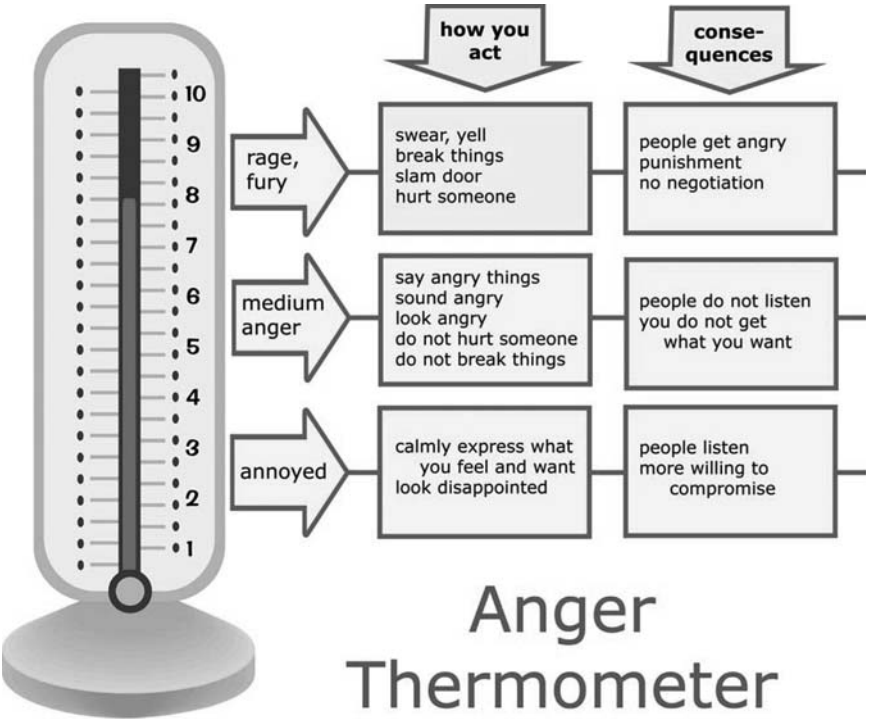

FIGURE 2. The Anger Thermometer

Irrational beliefs—especially the absolutes—are frequently out of conscious awareness of young clients as well as other irrational evaluations. For young clients who have difficulty reporting on their thinking, you will need to use directive questioning and probing to get at these core irrationalities. Do not expect your clients to always provide them for you when you ask: "What else were you thinking?"

When children are unaware of their irrational beliefs, you can use a hypothesis-testing form of questioning sometimes called *deductive interpretation* as can be seen in the following. "When people get angry, they often think to themselves that people really *should* act respectfully and fairly. Did you have this idea when your father refused to listen to your point of view?" If the client agrees, use client's verbal and non-verbal language to validate whether client is merely agreeing to agree and please you or whether client really had the irrational thought during the time he/she was upset. If the young client gives you negative feedback, start over again to formulate a new hypothesis.

A number of assessment methods, described below, have been developed to elicit feelings and thoughts from young clients; to enable them to describe their thoughts orally in a manner that will facilitate and further their self-understanding; and to provide the practitioner with the young

client's conceptual outlook and verbal-linguistic repertoire, which provides the basis for cognitive restructuring.

Standardized self-report surveys: The Child and Adolescent Scale of Irrationality, (see Bernard, M.E., and Cronan, F. The child and adolescent scale of irrationality: Validation data and mental health correlates. *Journal of Cognitive Psychotherapy: An International Quarterly,* 1999, *13*, 121–132) and The Idea Inventory (see Kassinove, H. et al., 1977,) Developmental trends in rational thinking: Implications for rational-emotive school mental health programs. *Journal of Community Psychology, 5,* 266–274).

Thought clouds (e.g., cartoon characters in various problematic situations with empty thought clouds above their head for young clients to write in their thinking).

Incomplete sentences (e.g., "When your father swore at you, you thought to yourself, _____").

Instant Reply (e.g., "Can you replay in your mind what happened last Saturday when your father swore at you? What time of day was it, who was around, what exactly did he say and do, and what did you think?").

Inference chaining is a common strategy for assessing irrational beliefs of children. Assume the young client's inferences (e.g., predictions, conclusions) are true and ask the young client what would it mean to him/her if his/her inference were true. An example of inference chaining used with a boy with learning disabilities who was depressed:

CLIENT: "I know I'll fail today's test."

THERAPIST: "And what do you think would happen if you did fail it?"

CLIENT: "Well, I might fail all the tests."

THERAPIST: "Well, let's suppose that would happen. What might you think then?"

CLIENT: "I guess I would think that I'd be stupid or dumb."

THERAPIST: "Well, what would it mean to you if you were not as smart as you would like to be?"

CLIENT: "I'd be no good."

ASK: *"When _____ happened, you felt _____ because...?"* When client provides answer (e.g., "I was angry because he acted so unfairly") elicit additional cognitions by asking "and" and "because" questions.

Thought bubbles can be employed to convey the general idea that thoughts create feelings; it can also be used to elicit responses from the unforthcoming child. For example, in a series of cartoons, it is possible to illustrate different temporally related scenes that illustrate a problem that the child may be having. Empty bubbles then can appear over the child in the next scene. The emotional expressions on the faces of the characters help to dramatize the scenes, and the child is asked to fill in the bubble with what he or she thinks the child in the scene is thinking.

The sentence completion technique is employed to elicit a variety of cognitions including copying self-statements, irrational beliefs, and practical-

problem-solving and emotional-problem-solving skills. The practitioner develops a number of incomplete sentences that tap into the relevant content area (e.g., "When I find my math homework hard, I generally think . . .").

Think-aloud approaches (Genest and Turk, 1981) involve the practitioner's assigning the child a task to complete and requesting the child to think out loud at the same time. For example, a child who is having difficulty with his mathematics could be asked to work for fifteen minutes on some difficult problems. Aside from being able to examine the child's mathematical algorithms, the practitioner can also get an idea of the affective quality of the child's self-talk, such as "This is hopeless; I'm dumb; I'll never get this done."

The TAT-like approach (Meichenbaum, 1977) is an elicitational method that may be helpful when more direct techniques are not successful. This method uses pictures of ambiguous social situations selected for their relevance to the target behaviors. The child is asked to make up a story, including the thoughts and feelings of the characters and what they can do about the situation.

Expansion-contraction (Bernard, 1981) is a procedure that attempts to expand the abbreviated and elliptical self-talk of young clients through the use of verbal prompts. The youngster is directed to describe in his or her own words the thoughts that he or she has during a problem situation. As the youngster begins to describe these thoughts, (the practitioner provides verbal instructions and questions such as "What do you mean when you say 'you thought that . . .'?" "Why do you think that . . . ?" "What did you think after that?" "Describe to me the first thing that comes into your mind when you think about . . . ?" Contraction refers to the need to be sure that therapeutic instructions and ideas are expressed in a linguistic-conceptual form that can be meaningfully and non-arbitrarily incorporated by the young person.

Peeling the onion (Bernard, 1981) can almost be viewed as a component of expansion-contraction and can be described as involving the peeling away of the layers of thought until one reaches the level that is activating emotional upset. Often, hidden behind a facade of rational thought statements are layers of thought not immediately accessible to the client. It is recommended that the practitioner not be dissuaded, fooled, or discouraged in searching for irrational thoughts and that she or he keep focusing the youngster's attention on thoughts through the use of verbal prompts.

"And," "but," and "because" (Hauck, 1980) are extremely useful words that practitioners can use to help young clients to tune into and report automatic self-talk. If the child pauses at the end of what seems to be an incomplete sentence about what he or she is thinking, the practitioner coaxes and prods the client along with words such as *but, and,* and *because*.

Instant replay (Bedford, 1974) is a therapeutic technique developed for use with parents and children. Bedford requests that each member of the family keep track of situations and events during the week that result in unpleasant emotions ("rough spots"). During the next meeting, each member of the family is requested to do a "rerun" or "instant replay" of the rough spot.

Children and parents are asked to describe the feelings and thoughts that they had in relation to the problem.

Guided imagery (Meichenbaum, 1977) involves the practitioner's asking the youngster to relax and then to imagine as vividly as possible a problem situation and to focus on feelings and self-talk. The client is asked to describe the scene and is encouraged to experience and communicate the feelings and thoughts associated with the setting.

Methods of Treatment

We will now detail special consideration in using REBT treatment methods with children. We have included several illustrative case studies on using REBT with children.

Goal Setting

Once you have identified different emotional-behavioral problems of a child, determine which shall be the first problem to work on. Indicate that problems will be worked on one at a time. Help client to set a goal for emotional-behavioral change. Ask: "The next time _____ occurs, rather than feeling extremely (down/anxious/angry) how would you rather feel and behave?" Seek agreement from client that rather than feeling extremely down/anxious/angry (8-10 on the Emotional thermometer), it would be better to feel only moderately down/anxious/angry and for his/her behavior to change from negative to positive.

The Importance of Teaching Prerequisite Critical Thinking Skills

REBT is concerned primarily with epistemology, the philosophical study of knowledge. In therapy, we are constantly asking clients, "How do you know that what you are thinking is accurate?" Disputing assumes that the client and the therapist share criteria for determining the truth or falsity of a statement. Many children have failed to develop critical thinking skills. Even if they have developed critical thinking skills and logic about the objective world, they may not have transferred these logical manipulations to the intrapersonal or interpersonal realm. As a result, they may have separate epistemologies for judging objective data and psychologically interpersonal statements. Children often have quite simple personal epistemologies. They may believe that things are true, so that they think they are true. Or just because they think them. Or because Mommy or Daddy says that they are true. Or because some other people think they are true, and, for adolescents, because their peers think they are true. All of these philosophical positions can get one into trouble.

Before attempting to dispute a child's irrational beliefs, it is a good idea to check out whether he or she can tell the differences among facts, opinions, and hypotheses and to ascertain if he or she can follow logical arguments in verifying statements or in discovering illogic. If they are like most adults, children may find it easier to be logical about external matters and may find it easy to believe that all automatic negative thoughts are true because they have thought them. The idea of examining and questioning one's thoughts about private, personal issues may be new to many young clients. It may be best to start teaching these skills by modeling and parable rather than by first challenging their irrational creations.

One strategy is to present the irrational ideas of other clients when one has helped and to talk about how their errors were spotted and how they learned to challenge them. It may also help to talk about the therapist's own irrationalities and how he or she tested these out and discovered that they were false.

A common REBT technique for teaching children that what they are thinking may or may not be true and the difference between assumptions and facts is to discuss how people from ancient times used to think the world was flat and as a result did not sail very far away from home for fear of falling off the side of the world. However, through evidence such as some provided by intrepid or reckless explorers of the day sailing around the world and returning safely, people realized their assumption that the world was flat was incorrect and they changed their way of thinking to accommodate reality. We also sometimes play a game with a young child called "Thought Detective" with the aim of discovering which thoughts of the child are true and which are false.

Cognitive Methods

REBT therapists try to help clients of all ages reach the elegant solution of changing broad, pervasive beliefs and to realize that even if life's events are bad, they need not upset themselves and that they appraise these events less negatively. In working with children, this is still our goal; however, it is less often accomplished. Ellis has commented many times in supervision that not all clients reach the elegant solution, and some appear particularly resistant no matter how hard they try. Children are less likely to reach this goal because of their inability to handle the degree of abstraction necessary. When the elegant solution appears unreachable with a child, there are three alternative solutions:

1. To change the child's appraisal of the one particular activating event about which she or he is upset.
2. To change the child's inferences when distortions of reality precede negative appraisals and disturbed effect. This approach is easier than elegant disputing because the empirical solution is more concrete.

3. To settle for verbal self-instruction that guides the child toward non-upsetting emotional responses and more adaptive behavior. This approach requires no disputing of the child's cognitions, but it does require an overriding cognition that directs the child to react differently. It is likely to be successful for a single stimulus or a narrow set of stimuli.

The main REBT treatment methods (described in Chapter One) used with young children include: a) teaching rational self-statements, b) empirical disputing (and empirical problem solving) of faulty inferences (predictions, conclusions), c)semantic disputing of absolutes and evaluations, d) logical and empirical disputing of absolutes and evaluations in concrete situations, e) rational role play/rehearsal, f) practical problem-solving skills including interpersonal cognitive problem-solving skills and g) homework assignments.

Some case studies may help demonstrate the use of these methods with children.

Sara was a 9-year-old who was particularly depressed because of the infrequency with which she saw her father. Her parents had been divorced for six years, and her mother and father still continued to argue. Sara had a large number of siblings, all of whom were much older than she and who felt a great deal of animosity toward the father. The father reacted by avoiding them. Our discussions revealed that Sara believed that as her father did not love or care for her mother or her siblings, he could not really care for her. Empirical disputing of this inference revealed quite the opposite. While the father made little attempt to see the siblings and continued to argue with the mother whenever he came to visit Sara, he came to visit Sara quite regularly. Although he was not the most demonstrative person, he was much more dedicated to this child than to any of his other children and spent a considerable amount of time visiting her, calling her, and taking her places. Sara's upset was caused, first, by her inference that her father's behavior toward other members of the family indicated that he felt the same way toward her and, second, by her appraisal that, if he did not care for her, that would be catastrophic. Sara was quite unwilling even to discuss this last possibility. Challenging the idea that it would not be terrible if her father did not care for her led to silence and withdrawal. However, the empirical solution here interested her in collecting data to verify her inferences. She was pleased with the results. This strategy was acceptable because of the therapist's inference that the father really did care for Sara. If the empirical disputing had not led in the direction that it did, a more elegant approach would have been necessary. However here, it was acceptable to limit ourselves to the empirical solution.

Greg was a 9-year-old who was referred by his parents for temper tantrums, pouting, and noncooperative behavior. Greg had a family history of extreme noncontingent reward. During most of his life, his parents had pampered him and he had been allowed to do what he pleased. Although this behavior had been cute when he was younger, with maturity it became more

unacceptable. Greg's parents attempted to have him follow rules and to behave appropriately. They punished him whenever he did not complete chores or show age-appropriate behaviors. Greg believed that this meant that they no longer cared for him. He also thought that it was terribly unfair that he should have to do such mundane things as clean his room and put his dirty clothes in the hamper. These things were just too difficult. Greg was a nonverbal child with low average intelligence, and he had difficulty following many of the disputing strategies. However, he was able to role-play these situations with the therapist. During these role plays, the therapist modeled verbal self-instructions such as "My parents care for me, they are only trying to do their job and help me grow up," and "I don't have to feel upset about these things because I can do them." Through practicing these self-statements and through reinforcement for appropriate behavior, Greg slowly learned to stop pouting, and this reaction provided the impetus for more mature, independent behaviors.

Thomas was a 13-year-old student with a history of behavioral and academic problems. Thomas reported that his teacher had a great dislike of him, and she *had* become quite disgusted with him. As therapy progressed, Thomas made changes and behaved more appropriately in school. He became less angry and less disruptive. However, empirical disputing of his thoughts that the teacher did not like him showed them to be accurate. Given the way he had been behaving, it was hard to blame her. When Thomas made some improvements or behaved well, she frequently did not acknowledge the change or still accused him of behaving inappropriately. Thomas became angry at this point and had the action potential of giving up and acting badly again. His irrational beliefs leading to this anger were somewhat along the lines that "people should be fair." My attempts to dispute this idea with Thomas got nowhere. He believed that people should be fair. After all, how would the world survive if people couldn't be trusted. Fairness was necessary for social life, so he said. Rather than trying to convince him that unfairness was a fact of life, which it is, and that there were probably millions of unfair people out there, we focused on a more narrow set of beliefs, that is, that this particular teacher had to be fair. We discussed the particular reasons that she should be unfair; the fact that we could not change her even though we thought most people should be fair; to have an ordered world, we could not demand that she be fair and, that there was no way we could force her to be so. Although Thomas was not willing to accept the fact that unfairness would survive in the universe, he was willing to concede that this particular individual would remain unfair and that he could tolerate that little degree of unfairness. Thus, although we did not reach an elegant solution in changing his appraisal to a wide span of stimuli, we did teach him to appraise this particular stimulus in a very different way. His anger was reduced, and he continued to make behavioral gains throughout the school year.

Disputing Inferences: A Cautionary Note

Focusing on changing children's misperceptions of reality including their conclusions and predictions through empirical testing and disputing is often the easiest for children to grasp. Because of this ease, it is the strategy taken for many cognitive-behavior child therapists. A caveat is in order. A serious problem can arise in using this approach when the child gets upset about the behavior of significant other adults, as children so frequently do. Children are apt to become upset when they believe that important adults in their lives do not love them, behave unfairly, or display serious personality disturbances. We have noticed a disturbing tendency on the part of child therapists to assume that the child incorrectly perceives such events. Rather than assuming that the child may be correct ("Let's suppose you're right that your mother doesn't love you, but why is that so awful?" as Albert Ellis so often says) and pursuing the elegant solution, the therapist sticks to the disputing of the inference even though the data may indicate that the child is correct. Many therapists do this because *they believe* that the realization that their parents are uncaring, unfair, or disturbed may be too much for the child to bear. Such a realization, they believe, would present an insurmountable obstacle to the child's emotional health.

Suppose children do confront situations in which a parent really does not care for them, or in which a parent does love another sibling more than the identified client, or in which a teacher or parent is grossly unfair toward the child, or in which a parent is severely disturbed. When such situations are reality, the empirical disputing the inference could cause iatrogenic damage. If a child is not cared for by a parent and we try to reduce that child's depression by (1) relabeling the parent's behavior as caring, (2) attempting to find good in this parent and to deny the uncaring behaviors, or (3) convincing the child that the parent really does care, are we not creating a disturbed perception of love and caring in that child? If a parent does behave unfairly and we pursue an empirical strategy to reduce the child's upset by presenting the parent as possibly fair, are we not also creating a distorted idea of fairness if we succeed? In the above two situations, the therapist may choose to avoid the issue and may choose not to corroborate the child's perceptions one way or the other. If this strategy is pursued, are we sending the child a nonverbal message that this is a topic not to be talked about and that one cannot criticize parents or recognize their faults? Who knows what other solutions or conclusions the child may draw and how healthy they may be? Thus, not to comment on the child's perceptions may lead to unknown conclusions on the part of the child and unknown iatrogenic side effects.

Some children correctly perceive that they have verifiable adversity in their lives. Uncaring, capricious, and disturbed parents exist. They are not only characters in Grimm's fairy tales. Therapists are often unwilling to pursue the elegant solution in such cases because they believe that it must be awful to live

in such a situation. Empirical solutions for the children of these parents are unlikely to help and are likely at best to lead to reduced rapport because the child will know that the therapist cannot or will not help. At the worst, the therapist may succeed and leave the child feeling temporarily better, but with some distortions about love, fairness, and authority. Another therapeutic intervention often tried in such cases is to provide the child with a supportive relationship, again, temporarily making the child feel better. According to rational-emotive therapy, this strategy is merely palliative and leads to no permanent resolution. When children's adversity is verified by the therapist, it may be best largely to seek the elegant solution. Children may be more resilient than we believe, and at least, we may do them no harm. A case summary (RD) illustrates this point:

Jack, a 9-year-old, was also depressed. His father worked long hours at a very successful practice. Jack believed that his father did not love him. My initial intervention was to help Jack to make an operational definition of loving behaviors and then to see how many of these behaviors his father performed and how frequently. After a few sessions of defining the list and empirically verifying his father's responses, we unfortunately came to the conclusion that Jack's father did not fare too well on this empirical test. Although he performed most of the behaviors on the caring list, he did so at a very low frequency.

Did the father love Jack? That was the next question that Jack struggled with. How many loving behaviors does one have to perform toward another to demonstrate love? How frequently does one have to perform loving behaviors toward a person to receive that person's love? I tried to convince Jack that any decision we made about a cutoff score of frequency of loving behaviors and types of loving behaviors was arbitrary. My cutoff score might be different from his. Someone else's might be different altogether. Love is what one person defines it to be. Any definition that we made of love would be just that, our definition, and might not represent a universal reality. We could not define whether or not Jack's father loved him, and we also did not know how Jack's father *felt*. Although we could infer his affective state toward Jack from his behavior, the result would be just that, an inference. I used lots of examples to show how Jack very often felt quite differently from the way he acted. Jack was still left with one real adversity. He experienced fewer loving behaviors from his father than he wanted. It was evident that Jack's father demonstrated caring behaviors much less frequently than the fathers of Jack's peers. So Jack's lack of received affection was real. The important issue I pointed out to Jack was not whether his father loved him, but how miserable he was going to make himself over the way his father reacted. I challenged the ultimate irrational belief that one has to experience love and loving behaviors from one's parents in order to be worthwhile and even to be happy. Jack's father might never change; he might always prefer work to family involvement, but Jack learned to be less upset about this fact and to enjoy other things in his life.

In this case, several aspects seem clinically important. Children often have negative perceptions about their parents that are emotionally charged. Unless the therapist shows a willingness to entertain these ideas and acceptance of the child for thinking them and speaking about them, it is unlikely that the child will be open with the therapist. Some therapists may feel frightened about confirming the child's ideas. Other therapists have often told me that the discussion of such situations would be too traumatic for a child to face. We maintain that an openness and willingness to discuss such issues will get to the true irrational beliefs that are often upsetting children and to the true evaluations that they make.

Homework

The final phase of REBT treatment, practice and application, involves the practitioner's helping the young client to practice his or her newly acquired skills in problem situations at home and in school. In seeking to foster generalization, the child is given a variety of homework assignments (e.g., Waters, 1982).

You will want to explain to all your young clients that as a part of your work with them in helping them solve problems and to overcome difficulties as well as to feel better, it is vital that they put into practice the ideas you will be discussing with them during your sessions. These "homework activities" are crucial in helping them move from cognitive insight to active practice and application of new ways of thinking, feeling and behaving.

Assign homework that you are reasonably sure your young client can perform. Do not assign too many tasks and activities for your client to accomplish. If your client fails to perform homework, identify the excuse(s) and help eliminate the reasons your client offers for not doing homework before assigning new homework. Be prepared for your young clients to "forget" or otherwise fail to perform weekly homework assignments. This is especially likely for young clients with low frustration tolerance who routinely procrastinate doing chores and/or homework.

Below are examples of REBT child-oriented homework exercises culled from the literature.

Examples of Cognitive Homework Assignments

Each day, rehearse rational self-statements (write rational statements on card for young client to remember and practice).

For young clients who get angry, have them rehearse rational self-talk when they do not get their way (e.g., "Nobody can do everything they want whenever they want." "It is disappointing when I can't do what I want, but it isn't terrible and awful." "Talking back only makes things worse." "I still love them anyway even though I do not like the way they are acting."

Assign stories to read that illustrate rational thinking of the protagonist.

Present clients with thought clouds above illustrations of characters that are experiencing problems similar to theirs. Have them write in examples of irrational, and also, rational self-talk that will help the character deal with a difficult situation.

Present young clients with a blank Happening→Thinking→Feeling→Behaving chart and have them complete one that illustrates how they dealt with a problematic situation during the week.

Invite young clients to teach their parents what they have been learning about rational thinking.

Make a list of personal demands.

Examples of Emotive Homework Assignments

Provide child a simple chart for recording their feelings during the week

Have child practice changing feelings and thoughts in a real situation

Suggest that the client gather data about his anger by keeping track of its frequency, location, outcome, as well as who else was involved (self-monitoring).

Have child use rational-emotive imagery during the week. (The client is asked to vividly imagine a situation where they experience a hurtful feeling. While they are imagining the scene they are asked to change the feeling to a more appropriate one and to become aware of the changes in their self-talk).

Have clients practice rational self-statements using evocative and forceful language ("I *can* stand it when my brother teases me!!").

Have young clients agree to working on getting only moderately upset (angry, anxious, worried) during the forthcoming week.

Examples of Behavioral Homework Assignments

Take a responsible risk.

Design an experiment where young clients agree to do something during the week they do not believe they can stand doing (e.g., working 10 minutes on their math homework).

For clients subjected to peer group pressure, provide them with a list of phrases dealing with how to say "No" and have the client practice their use during the week (e.g., "No thanks, I don't want to, if you want to, go ahead. I don't." "I don't think we should be doing this." "Please don't touch me like that!").

For perfectionists, gain agreement on something they will do during the week where they have a high likelihood of failing (risk taking exercise).

For approval seekers, design a shame attacking exercise where they agree to engage in a behavior that will, with high likelihood, invite negative comments and laughs from peers/family members. The fact that they survive the episode will provide evidence to dispute their belief that they need people's approval and it would be awful to be criticized or thought badly of.

Design an experiment where the client agrees to gather evidence to support or contradict a belief they have that is more than likely irrational. For

example, if a child believes as a result of repeated criticism from his mother "My mother doesn't love me," help the child agree upon a list of maternal loving behaviors (e.g., cooks for me, picks me up from school, asks me about my date, gives me a hug/kiss, buys me something I need). Then, provide the child with a chart that lists these behaviors and have the child record the number of times each day he observes his mother engaging in the behavior. Once the child can see that despite his mother's criticism, she still engages in different loving behaviors, the child will have concrete evidence to dispute his belief about his mother not loving him (not to be used in cases where you believe that the child will not observe any loving behaviors).

Have clients practice assertive behavior while employing rational self-talk to manage anger and/or anxiety.

Behavior Management Training for Parents

REBT has always been a cognitive-behavior therapy. Even though Ellis (1979, 1994) stressed the role of cognitions in pathology, he has frequently acknowledged that for change to be lasting, one had better get clients to start acting differently. Because children are not self-referred, are likely to be less motivated for change, and are less responsible, it is incorrect to assume that they will carry out their behavioral assignments alone. However, their parents are usually willing to cooperate and can be enlisted to help structure the behavioral components of therapy. In almost all cases, except where the parents are uncooperative, one can use a behavioral modification program to reinforce the desired target behaviors while doing REBT. Whether the emotional problem is anxiety, depression, or anger, the parents can provide structured, systematic rewards for the nonoccurrence of the target behaviors and for behaviors that are incompatible with the target behavior, or they can provide response costs when the target behavior does occur. Behavioral programs that reward or penalize behavior may not only help children to behave better but may also help them to become more motivated to cooperate with the therapist and learn cognitive strategies to control their emotions and to internalize behavioral gains—now there will be some payoff for overcoming their fear, depression, or anger.

The case of Karen, a school phobic, is a good illustration. She experienced extreme panic whenever called on in class to give an answer. As a result, she did not wish to attend school. She developed stomach pains and had a few days off, and the illness seemed to linger. Her mother, realizing that the ailment was more than an upset stomach, kept Karen home and felt sorry for her daughter when she realized the extent of Karen's emotional reaction to school. Karen was allowed to stay home and experienced no response cost for this behavior. During school hours, Karen watched TV, played alone, or listened to her records. After school, she met friends and joined in their activities. Not a bad life! Karen felt no desire to attend school and was not interested in any of the rewards that this institution dispensed. Why should she want to change? She listened carefully to a discussion of how thoughts caused feelings and

how her catastrophizing about making mistakes caused her to feel frightened. She agreed. However, this is as far as we got. There was no negative consequence for her staying home and plenty of secondary gains; therefore, she had little motivation for her to overcome her fear. Disputing was out of the question. After a few sessions with Karen's mother, we succeeded in lessening her sympathy for Karen's fear. We then set out the following rules. Karen was denied access to her TV and stereo whenever absent from school. She was not allowed to join her peers unless she attended class that day. Once these rules were in effect, Karen was more willing to start disputing those irrational beliefs that she had identified earlier and was now willing to attend school and control her anxiety with the procedures we had used. Once she was inside school, there was really no reason for Karen to attempt to raise her hand and answer questions, and she continued to make excuses to avoid answering questions when called on. We had made some progress, but the lack of any continued motivation stalled treatment. At this point, a reinforcement system was provided for answering in class. The teacher sent home daily feedback on the number of questions Karen attempted to answer. For each question, she was allotted a certain degree of money. Although this reinforcement did not help Karen to overcome her problems completely and she still experienced fear, again she was more interested in discussing her irrational beliefs and in attempting to overcome them because she wanted the money.

Behavioral incentives may provide the motivation for children to attempt to search for alternative strategies to overcome their emotional reactions. Although behavioral approaches to fear have achieved some success, it has not been the total improvement that one would expect. A cognitive-behavioral program, though, may be more successful. The behavioral incentives provide the motivation to change, and the cognitive interventions help to foster that change and to reduce the fear.

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