Rational Emotive Behavioral Approaches to Childhood Disorders

Theory, Practice and Research

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About the Editors

Dr. Albert Ellis holds a Ph.D. in Clinical Psychology from Columbia University and is President of the Institute for Rational-Emotive Therapy in New York City. He is the founder of rational-emotive therapy (RET) and the grandfather of cognitive-behavior therapy (CBT). Several professional societies have honored him: He holds the Humanist of the Year Award of the American Humanist Association, the Distinguished Psychologist Award of the Academy of Psychologists in Marital and Family Therapy, and the Distinguished Practitioner Award of the American Association of Sex Educators, Counselors and Therapists. The American Psychological Association has given him its major award for Distinguished Professional Contributions to Knowledge (and the American Association for Counseling and Development has given him its major Professional Development Award.) He has published more than 70 books and over 700 articles on psychotherapy, sex, love, and marital relationships. Still going strong, he sees about 70 individual clients and conducts 5 group therapy sessions each week at the psychotherapy clinic of the Institute, supervises interns, and postdoctoral fellows, and gives numerous talks and workshops in the United States and abroad.

Professor Michael E. Bernard is the Founder of You Can Do It! Education, a program for promoting student social-emotional well-being and achievement that is being used in over 6000 schools in Australia, New Zealand, England, and North America. After receiving his doctorate in educational psychology from the University of Wisconsin, Madison, he worked for 18 years in the College of Education, University of Melbourne, Australia. In 1983, he was appointed as Reader and Coordinator of the Master of Educational Psychology Program. From 1995–2005, he was a tenured professor in the Department of Educational Psychology, Administration and Counseling, College of Education, at California State University, Long Beach. Professor Bernard has worked as a consultant school psychologist helping families and schools address the educational and mental health needs of school-age children. He has spent extensive time counseling children with emotional, behavioral or academic difficulties. Professor Bernard is a co-founder of the Australian Institute for Rational Emotive Behavior

Therapy and is the author of many books on REBT. For eight years, he was the editor-in-chief of the *Journal of Rational-Emotive and Cognitive-Behavior Therapy*. He is the author of over 50 books, 15 book chapters, and 30 journal articles in the area of children's early childhood development, learning, and social-emotional well-being as well as parent education, teacher professional development, and school improvement. Today, Professor Bernard is an international consultant to universities, educational authorities, organizations, and government. He is a professor at the University of Melbourne, Faculty of Education.

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Preface

It is now over 20 years since the publication of the first edition of this book and almost 50 years since the first use of rational-emotive behavior therapy (REBT) with a young person was described in the literature. Throughout these years, child-REBT and adolescent–REBT practice has existed in many parts of the world.

I (A.E.) have always believed in the potential of REBT to be used in schools as a form of mental health promotion and with young people experiencing developmental problems. After all, irrational thinking both in children and as it manifests itself in adolescence contributes to a bewildering array of emotional problems (e.g., childhood depression, anger), behavior problems (e.g., anger, oppositional defiance, conduct disorders), and academic problems (e.g., underachievement).

Over the past six decades, REBT and its educational derivative, Rational Emotive Education, has been embraced by a wide variety of child-oriented and adolescent-oriented mental health practitioners. Those who incorporate and integrate REBT in their individual work with young people have seen that REBT's essentials enhance their practice.

What are the essentials of REBT when applied to young people? Which aspects of cognitive-behavior, child and adolescent therapy (CBT) as currently practiced do we believe are founded on these essentials? How will you know that you are practicing REBT as you embrace the CBT orientation? Today, CBT is practiced as the treatment of choice by many and we would like REBT's distinctive contributions to the practice of CBT not to be lost. Moreover, we believe that there are distinctive aspects of REBT that add value to the practice of CBT. For example, there is little question in our minds that REBT's espousement of a core set of rational beliefs that contribute to mental health of young people (e.g., self-acceptance, high frustration tolerance, unconditional acceptance of others) as well as its focus on core irrational beliefs that contribute to psychosocial and mental health problems (e.g., needs for approval/achievement, self-depreciation, low frustration tolerance, demands for consideration, justice, fairness, respect, global rating of others, world) adds value to our understanding and treatment of the problems of

young people. We believe that CBTers may underestimate the strength of children's irrational beliefs when they instruct children and adolescents in the use of positive self-talk and verbal self-instructions without working on the deeper level of helping them gain insight on and change their more powerful irrational beliefs and self-talk. We believe that layering positive self-talk on pre-existing irrational beliefs can in many instances be palliative.

REBT's differentiation of "hot cognitions" associated with very unhealthy emotions and dysfunctional behaviors found in absolutes, awfulizing, I can't-stand-it-itis, global rating of self, others, world from "warm cognitions" (e.g., perceptions, conclusions, predictions) that give rise to less extreme emotional intensity is distinctive to REBT's approach to assessment and treatment.

We believe the essentials of child and adolescent REBT practice can first be found in its theory that distinguishes rational from irrational aspects of the psyche of young people and directs the practitioner to distinguish in their assessment rational from irrational thoughts. Also, its theory of emotional upset (see Chapter 1) directs the practitioner though REBT hypothesis-driven questioning to root out both *automatic thoughts* that reflect distortions of reality (e.g., "I have failed and will always fail") *and* what REBT considers to be thoughts that are deeper and less accessible to introspection; namely, irrational evaluations and beliefs ("I should be successful, it's awful that I am not, I can't stand it, I'm a loser."). REBT's theory of different irrational beliefs that give rise to different problems of childhood provides the practitioners with advanced accurate empathy. REBT helps you to anticipate likely cognitions of the young person depending on the presenting problem. This is one of the most "appealing" aspects of the practice of REBT.

Other distinctive aspects of child-REBT and adolescent-REBT practice some of which have helped define the field of CBT include:

1. Teaching young people an *emotional vocabulary* and an *emotional schema* (feelings vary in intensity from strong to weak) and that they have behavioral and emotional options when something bad happens.
2. Using the ABC framework (sometimes revised as Happenings→Thoughts→Feelings→Behaviors) to help young people conceptualize relationships among thinking, feeling, and behaving and for the purpose of assessment and intervention.
3. Explicit teaching of "emotional responsibility"; namely, you, not others, are the major influence on how you feel and behave.
4. Using disputing/challenging strategies to help identify and change irrational, negative thinking/self-talk *before* moving to instruction in rational, positive thinking/self-talk (for children older that 6 years of age).
5. Instructing young people in rational self-statements.
6. Through homework assignments, practicing new ways of thinking, feeling and behaving in the "real world."
7. Perhaps, the most unique aspects of REBT with young people is how it advances the argument that young people will be happier and more ful-

filled when they are taught (in therapy, in the classroom, at home) rational beliefs including *self-acceptance*, *high frustration tolerance*, and *unconditional acceptance of others*.

There are several misconceptions about REBT and its practice with young people that we believe this book helps to correct. Some of these include:

REBT when practiced with young people is simply a downward extension of REBT adult methods. It is not as many of its methods and activities have evolved from the pioneering work done at the Living School where REBT was taught by teachers in the form of REE to all children. Moreover, as discussed in Chapter 1 of this book, child-REBT and adolescent-REBT takes into account the developmental level of the child in prioritizing problems and selecting assessment and treatment methods.

REBT and REE focus too much on intellectual insight and change. REBT has always considered that beliefs be they rational or irrational never exist on their own but rather are intimately connected to emotions and behaviors. As such, when irrational and rational beliefs are discussed with young people, their impact on emotions and behaviors, and the reciprocal impact of emotions and behaviors on beliefs are always emphasized. Moreover, REBT always has used not only cognitive change methods (e.g., disputing, rational self-statements), but emotive (e.g., rational-emotive imagery, forceful, evocative repetition of rational self-statements) and behavior methods (cognitive-behavioral role play/rehearsal, homework assignments including practicing new behavior in difficult circumstances).

There is no research supporting the efficacy of REBT with younger populations. As Chapters 1, 8 and 13 reveal in this volume, since the 1970s, numerous individual studies and several important meta-analyses have been conducted. While the quality of studies has varied and the studies represented in meta-analyses have been selective (have not included all available studies), it will be seen that there is sufficient array of studies that demonstrate the positive effects of REBT and REE to qualify it as an evidence-based practice.

Now to this book. We have asked many of the original contributors to the first edition to update their work. Furthermore, we have identified some new contributors and new topics relevant to child-REBT and adolescent-REBT practice.

Section I of the book contains chapters addressing the history, rationale, practice, and issues surrounding the use of REBT to treat disorders of childhood. The opening chapter presents the most up-to-date statement of the theory and practice of REBT as applied to younger populations and includes the latest meta-analysis of available studies. In the second and third chapters, special considerations in using REBT with children and adolescents are reviewed. The author of Chapter 3, Howard Young, is now deceased and we reproduce his original chapter in its entirety as it is still today an excellent exposition of ways to effectively use REBT with adolescents. Chapter 4 by

Bill Knaus reviews for the reader one of REBT's cornerstone "constructs" for understanding childhood disorders; namely, low frustration tolerance. Chapter 5 presents recent child developmental research and practice addressing emotional resilience and coping skills training and discusses how it can be integrated in REBT.

Section II contains specialized chapters by leading REBT practitioners on the treatment of depression, anxiety/fears/phobias, aggressive, ADHD, and under-achievement. It will be clear that REBT is now being integrated with other CBT and ecological approaches (e.g., family therapy) in the treatment of childhood disorders.

Section III contains chapters addressing the use of REBT with parents as well as with the parents and teachers of exceptional children. The final two chapters discuss the applications of REBT in group work and in the schools in the form of prevention, promotion, and intervention mental health programs.

Finally, we would like to acknowledge a number of REBT scholars who over the years have helped to demarcate REBT's use with younger populations. There is little doubt that Ray DiGiuseppe has made enormous contributions to its clinical practice and Ann Vernon to the practice of REE in schools in the form of developmental curriculum. Bill Knaus continues the work he initiated in writing "the manual" describing the applications of REBT in educational settings by teachers (Rational Emotive Education). Over the years, Paul Hauck has been very instrumental in outlining the use of REBT with parents. In the early 1980s, Virginia Waters helped pave the road for the use of REBT with children and their parents while Howard Young did the same for working with adolescents. Many others (Jay and Harriet Barrish, Terry London, Jerry Wilde, John McInerney, Marie Joyce) have embellished the REBT field with their stimulating ideas and child-friendly and family-friendly practice.

Albert Ellis
Michael E. Bernard

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Section I

Introduction, Rationale, and Basic Issues

1

Rational-Emotive Behavioral Approaches to Childhood Disorders: History, Theory, Practice and Research

Michael E. Bernard, Albert Ellis and Mark Terjesen

The history of cognitive restructuring with children and youth doubtless goes back many centuries and may be traced to early philosophers and religious preachers. Socrates, let us remember, was persecuted by the Athenians for supposedly corrupting the youth of that ancient city. And the Greek–Roman Stoic Epictetus, who is often acknowledged as one of the main philosophical fathers of rational-emotive-behavior therapy (REBT) and cognitive-behavior therapy (CBT), pioneered in conveying significant cognitive teachings to the young people as well as the adults of his time. Because of his influence, some 2,000 years ago, the Roman Emperor Marcus Aurelius was raised from childhood in the Stoic tradition and consequently was later led to write his famous *Meditations*, one of the most influential books of all time, outlining the principles and practice of cognitive restructuring.

In modern times, methods of teaching children and adolescents to talk more sensibly to themselves, and thereby to make themselves individually and socially more effective, were pioneered by Alfred Adler. Not only was Adler (1927) one of the first cognitive therapists to specialize in direct psychological approaches to youngsters, but he and his associates, starting in the 1920s, saw the importance of using cognitive approaches in the school system and of teaching them to parents to employ in the rearing of children. Today, the field of child therapy and adolescent therapy has embraced the cognitive model and, indeed, therapy has been operationalized as any intervention designed to alter the attitudes, thoughts, feelings and actions of the young person who has sought or been brought to treatment with distress and/or maladaptive behavior (Weisz et al., 1995).

History of Rational-Emotive-Behavior Therapy with Children and Adolescents

It is interesting to note that although many behavior therapists (Craighead, 1982) appear to date the beginnings of the cognitive-behavioral movement around the late 1960s and the early 1970s, the application of cognitive methods in the form of REBT to parenting and to the psychological treatment of youngsters was pioneered by Ellis in the mid-1950s. Soon after he started to use REBT with adults, at the beginning of 1955, he saw that it could also be employed with children either directly by a therapist or indirectly by a REBT practitioner working with the children's parents. He therefore included some cognitive parenting techniques in his first book on REBT, "How to Live with a "Neurotic" (Ellis, 1957). When he began making tape recordings of REBT sessions, he recorded a series of sessions with an 8-year-old female bed wetter (Ellis, 1959), which were widely circulated and encouraged many other therapists to use RET methods with children. In the 1960s, cognitive restructuring with youngsters was promoted by a number of REBT-oriented writers who showed how it could be effectively employed by therapists, parents, and school personnel (Doress, 1967; Ellis, 1967; Ellis et al., 1966; Glicken, 1967, 1968; Hauck, 1967; Lafferty et al., 1964; McGory, 1967; Wagner, 1966).

By and large, the only cognitive restructuring approach being employed with school-age children through the late 1960s was REBT. By the late 1960s, behavior therapists began to open their minds to cognition, and as a consequence, widely practiced and researched behavioral methods of helping youngsters overcome their emotional and behavioral problems began to be combined with REBT and other cognitive methods.

During the 1970s, a large number of articles, chapters, and manuals appeared that explained the use of REBT with children and adolescents (Bedford, 1974; Blanco and Rosenfeld, 1978; Brown, 1974, 1977, 1979; Daly, 1971; DiGiuseppe, 1975a,b; Edwards, 1977; Ellis, 1971a,b, 1972a, 1973a, 1975a,b, 1980b; Grieger et al., 1979; Hauck, 1974, 1977; Knaus, 1974, 1977; Knaus and McKeever, 1977; Kranzler, 1974; Maultsby, 1974, 1975; McMullin et al., 1978; Miller, 1978; Nardi, 1981; Protinsky, 1976; Rand; 1970; Rossi, 1977; Sachs, 1971; Smith, 1979; Staggs, 1979; Waters, 1980a,b, 1981; Young 1974a,b, 1977).

Indeed, because of the observed success of REBT that was found in early clinical and experimental investigations, the Institute for Rational-Emotive Therapy in New York started the Living School in 1970, a small private grade school where all the children were taught REBT along with the usual elementary-school curriculum. The school flourished for five years, in the course of which it was found that teachers (not therapists) could teach young children REBT in the regular classroom situation and thereby help them (and their parents) improve their emotional health and live more hap-

pily and efficiently. Publications on the use of REBT in this school setting have been published by DiNubile and Wessler (1974), Ellis (1971a, b, 1972b, 1973b, 1975b), Gerald and Eyman (1981), Knaus (1974), Sachs (1971), and Wolfe and staff (1970). In order to have a greater impact in classrooms both in the community and across the country, the Living School was transformed in 1975 into the Rational-Emotive Education Consultation Service, which provides (1) in-service workshops for teachers and counselors; (2) consultations to schools, classes, and teachers wishing to implement a program of RET; and (3) materials and techniques for use in classrooms and/or school counseling settings (Waters, 1981).

In the 1970s, large number of case studies and quasi-experimental and experimental outcome studies have appeared in the REBT literature (Agosto and Solomon, 1978; Albert, 1972; Bernard, 1979; Block, 1978; Bokor, 1972; Brody, 1974; Cangelosi et al., 1980; Costello and Dougherty, 1977; D'Angelo, 1977; DeVoge, 1974; DiGiuseppe, 1975a; DiGiuseppe and Kassinove, 1976; Forman and Forman, 1978; Harris, 1976; Jacobs, 1977; Katz, 1974; Knaus and Bokor, 1975; Kujoth, 1976; Maes and Heinman, 1970; Maultsby et al., 1974; Miller, 1978; Ritchie, 1978; Sharma, 1970; Solomon, 1978; Sydel, 1972; Taylor, 1975; Wagner, 1966; Warren et al., 1976; Zelie et al., 1980). A review of many of these studies by DiGiuseppe, Miller, and Trexler (1979) led to the following conclusion:

> These studies provide support for the hypothesis that elementary school children are capable of acquiring knowledge of rational-emotive principles and that the modification of a child's self-verbalizations or irrational self-statements can have a positive effect on emotional adjustment and behavior. Certain critical factors relevant to rational-emotive therapy procedures have not been thoroughly investigated. These include the specification of the relative contributions of the behavioral components within rational-emotive therapy (i.e., behavioral rehearsal and written homework assignments) and the degree to which a child's intellectual ability is related to his acquisition of the cognitively oriented principles of rational-emotive therapy. (p. 225)

From the early 1980s with the publication of the first edition of this book, *Rational-Emotive Approaches to the Problems of Childhood* (Ellis and Bernard, 1983) and Bernard and Joyce's (1984) *Rational-Emotive Therapy with Children and Adolescents*, through the 1990s and early part of the twenty-first century, clinical and educational applications of REBT have been written about extensively (Barnes, 2000; Barrish and Barrish, 1985, 1989; Bernard et al., 1983; Bernard, 1990; Bernard, 2004a,b,c, and Wilde, Bernard and Joyce, 1993; Bernard, 2004a; Burnett, 1994, 1996; DiGiuseppe, 1981; Ellis and Wilde, 2002; Kelly, 1996; Lucey, 1995; Shannon and Allen, 1998; Vernon, 1980, 1983, 1989a, b, c, 1990, 1993a, 1997, 1998a, b, c, 1999, 2000, 2002, 2004a, b, 2006a, b; Warren et al., 1988; Wilde, 1992; Zionts and Zionts, 1997). A special issue of the School Psychology Review was devoted to the implications of REBT and Rational-

Emotive Education (REE) for the role of school psychologists (Bernard and DiGiuseppe, 1991). Bernard and DiGiuseppe's book (1993) *Rational-Emotive Consultation in Applied Settings* contained a variety of chapters detailing ways in which REBT could be used by practitioners to address the mental health needs of primary caregivers of young people (parents, teachers) with emotional and behavioral disorders as well as ways in which the ABCs and rational beliefs could be introduced by primary caregivers to young people. Hajzler and Bernard's (1991) review of research concluded that REBT leads to decreases in irrationality, anxiety and disruptive behavior among students in 88, 80 and 56% of the studies, respectively. Internal locus of control and self-esteem increased in 71 and 57% of the studies, respectively. Gonzalez et al. (2004) found in their meta-analysis of 19 REBT studies with children and adolescents that the overall mean weighted effect of REBT was positive and significant with the largest effect of REBT found for disruptive behaviors and children benefiting more from REBT than adolescents (see final section of this chapter).

Today, it is abundantly clear that within the fields of school psychology, school counseling and guidance, REBT is a preferred methodology incorporated within the tool boxes of counselors and psychologists who work with children and adolescents. In the field of school-wide prevention and promotion programming, REBT in the form of You Can Do It! Education (YCDI) (Bernard, 2001a, 2002, 2005, 2006) in a preferred theoretical framework in Australia with over 5,000 primary and secondary schools employing YCDI programs (see last chapter of this book). Over 50,000 four to six-year-old children are learning rational, positive beliefs as a result of participating in the REBT-based YCDI early childhood program (Bernard, 2004b). Over the past several decades, the Albert Ellis Institute in New York and affiliated training REBT centers throughout the world have offered the Child and Adolescent Certificate in Rational-Emotive-Behavior Therapy to a large number of practitioners. Additionally, professors throughout the world who have received training in child-oriented and adolescent-oriented REBT, incorporate REBT in their counseling, counseling psychology, clinical and school psychology, clinical psychology, and social work graduate programs. In the field of cognitive-behavioral child treatment, clinical psychologists have not embraced REBT as extensively as in other mental health professions due in part to a perception that REBT has no research base to speak of and, as a consequence, REBT has been ignored by CBTers (Reinecke, 2005). Hopefully, the material presented later on in this chapter will dispel this notion.

As shown in this book and revealed in the results of meta-analytic studies reported later on in this chapter, REBT is being used to treat a variety of emotional, behavioral and achievement-related problems of children. This chapter will now present an overview of the existing REBT child and adolescent treatment literature pertaining to the theory and practice of REBT with younger populations.

Theoretical Considerations in Applications of Rebt to Childhood Disorders

In this section, we examine important theoretical foundations that underpin the practice of REBT with younger populations.

REBT Developmental Model of Childhood Disorders

There is little question that REBT is developmentally oriented and meets existing criteria for establishing a therapy's developmental credentials (Holmbeck et al., 2003; Holmbeck and Updegrove, 1995; Shirk, 2001; Weisz and Hawley, 2002). REBTers who work with children and adolescents strive to stay current with the developmental literature (Vernon, 2004c), take into account the critical developmental tasks and milestones relevant to a particular child's or adolescent's presenting problem and have the flexibility to be able to choose which presenting symptoms to prioritize, depending on the degree to which each of the symptoms is developmentally atypical. REBT is developmentally sensitive with its assessment and treatment methods tailored to take into account the developmental levels of the child or adolescent (Bernard and Joyce, 1984). For example, REBT does little disputing of irrational beliefs in children younger than six and reserves more sophisticated disputing of general beliefs until after the age of 11 or 12. As can be seen in the chapters of this book, REBT has always thought *multisystemically* and always considers the need to involve peers, teachers, parents, and the whole family (Woulff, 1983) while treating the child. A final point concerning the REBT therapeutic methods employed with children and adolescents. Rather than being merely downward refinements of REBT verbal techniques used with adults such as Socratic disputing, the tool box of thinking, feeling and behaving methods, activities and techniques used with younger populations have been either developed in consultation with teachers of children and adlescents.

Ellis and other REBT theorists (Bernard and Joyce, 1984; Ellis and Bernard, 1983; Vernon, 1993b) have adopted the perspective of *interactionism* in conceptualizing the origins of childhood maladjustment. As reflected in this volume, REBT practitioners believe that emotional disorders and abnormal behavior in childhood can be best understood in terms of an interaction between "person" and environmental (e.g., parenting, peer) variables. Bernard and Joyce (1984) characterized this perspective as follows:

> Children demonstrate characteristic ways of thinking about and relating to their environment which exert an influence on their environment. Similarly, situations themselves modify the behavior and attitudes of people by providing (or not providing) appropriate learning experiences and enrichment opportunities as well as rewarding and punishing consequences for behavior within certain contexts. We believe that there is an almost inexorable reciprocal relationship between abnormal behavior and

a deviant environment such that abnormalities in either the person or the environment of the person tend to bring out abnormalities in the other. It would seem, therefore, necessary to determine how persons and environments interact and covary together in analyzing childhood psychopathology.

Similar sentiments are expressed by Bernard (2004a).

The extent to which children's thinking and associated beliefs are dominated by irrationality rather than rationality depends upon their age, their biological temperament (e.g., feisty, fearful, flexible), their home environment including their parent's style of parenting (e.g., firm/not firm, kind/unkind), the extent to which their parents model, and communicate irrational or rational beliefs and whether there are negative events present in their lives (e.g., divorce, persecution). Children who manifest social-emotional-behavioral and achievement problems often present with developmental delays in their capacity to think rationally and logically concerning affective-interpersonal issues (e.g., have difficulty keeping things in perspective, personalize negative experiences) as well as in the development of other emotional self-management skills (e.g., relaxation, finding someone to talk with). They also are dominated by a range of irrational beliefs including self-downing, low frustration tolerance, and the lack of acceptance by others.

Child Factors

According to REBT theory, children are born with an innate capacity to think irrationally and illogically. This human disposition exerts its influence across the life span and precludes the possibility of perfect mental health. What moderates the influence of irrationality is the development of rationality and logical reasoning abilities which emerge around the age of six (Piaget's concrete operational stage of development) with abstract reasoning abilities developing more fully around the age of 11 or 12 (Piaget's formal operational stage of development). There are relationships between a child's level of cognitive development as defined by Piaget's stages and REBT therapeutic methods. Whereas we employ rational self-statements with children of all ages, we generally do not dispute irrational beliefs with children who are less than 7-year-old, and we do not often logically dispute irrational beliefs in the abstract with children much below the age of 11 or 12.

There are a number of interesting overlaps between the theories of Ellis and those of Piaget. Both share the assumption of constructivism. They also place great "faith" in the scientific method of investigation and the power of formal logical reasoning. Both appear to be in agreement concerning the importance of cognition in the experience and expression of emotions. Piaget (1952) wrote that "it is, in fact, only a romantic prejudice that makes us suppose that affective phenomena constitute immediate givens or innate and ready-made feelings similar to Rousseau's 'conscience" ' (p. 12).

In his writings, Ellis (1994) discusses the idea that the strength of one's propensity for irrational thought and the strength of conviction one has in

one's irrational beliefs is heavily influenced by genetics. That is, while parenting practices as well as the influence of peers and one's culture definitely condition the beliefs of young people through modeling and direct communication, the tendency for beliefs be they rational or irrational to be fully integrated within a young person's phenomenology or view of the world and the extent to which a young person's cognitive processing is characterized by absolutism is not learned but is biologically determined. The evidence provided by Ellis to substantiate nature over nurture when it comes to the origins of an individual's irrational thinking is partly found in the many instances of families seen by Ellis where only one child is presented with an internalizing or externalizing problem. In these families, other siblings of the referred child presented as problem free while the parenting styles of parents remained constant and there was no evidence that the parents or family experienced unusual upheavals during the developmental years of the referred child. Some children who experience distress and demonstrate maladaptive behaviors have parents who appear to be reasonably well adjusted, who have positive attitudes toward their child, and whose child-rearing practices appear to be sound. We also do not receive referrals for well-adjusted children whose parents, because of their problems, would back at long odds to produce disturbed offspring. Research (Kagan, 1998; Rothbard and Bates, 1998) indicates temperamentally difficult children who, as a result of their frustrating behavior, literally create conditions that drive their parents to distraction.

As already indicated, REBT has historically recognized the importance of the young person's cognitive developmental level of maturity in treatment. On the assessment side, a recognition of child development enables the practitioner to judge whether a presenting problem is a transient and/or a normal developmental phenomenon (i.e., fear of the dark) or whether it represents something more serious. The level at which the REBT intervention is used (rational self-statements, disputing of inferences, or abstract disputing of irrational beliefs) depends on the linguistic and cognitive maturity of the young client.

Rational Emotive Behavior Therapy recognizes, as do the proponents of many different approaches to childhood psychopathology, that there is a reciprocal relationship between mental and emotional development. When children are very young, the quality of their subjective emotional experience is very much limited by their capacity to think about and understand the meaning of experience. The cognitive limitations of the early childhood period can often result in children acquiring beliefs about themselves and their surrounding world that are untrue and irrational and that if not corrected can have an extremely deleterious effect on their future well-being. That is, children construct their own theories and arrive at their own conclusions based on inferences from what they have observed. The child's conception of the world is idiosyncratically organized and derives from the child's limited capacity to make observations and draw logical conclusions.

In working with children, we are struck by the pervasive influence that their ideas and beliefs have on their emotions and behavior. These beliefs are

often implicit and frequently result from the child having formed a conclusion based on limited evidence and having used the conclusion as an "unquestioned" rule for guiding subsequent behavior. The beliefs, be they rational, or irrational, that are formed early in life may become firmly fixed, and they represent part of the, phenomenological framework of children that provides the basis for self-evaluation, for the demands they place on others, and for the interpretation they make of the behavior of others. Young children's incapacity for rational and logical thought limits the types of ideas that they acquire and frequently reinforces a variety of irrational beliefs which take many years to overcome.

A cognitive analysis of maladjustment in children and adolescents frequently reveals beliefs about themselves, others, and the world, as well as logical reasoning processes that appear to be either a holdover from or a regression to preconcrete operational levels of thinking and primitive belief systems. Characteristics of preconcrete operational thought include:

1. Drawing arbitrary inferences—conclusions not based on evidence or when evidence contradicts conclusion
2. Selective abstraction—focusing on a detail taken out of context, ignoring salient features of the situation
3. Magnification/minimization—errors in evaluating significance of event
4. Personalization—tendency to relate external events to themselves when no basis for making connection
5. Overgeneralization—drawing a conclusion based on limited and isolated events
6. Dichotomous thinking—tendency to place events into opposite categories (e.g., good-bad)

The advent of formal operational thought capacities in adolescents also brings with it its own problems. Adolescents in their early teens begin to experience a form of egocentrism, a "naive, idealism" (not dissimilar in effect from the egocentrism of the early childhood period), that frequently leads to a variety of emotional and behavioral problems. The struggle for a personal identity and for new definitions of social relationships that accompanies the increased capacity for reflective and abstract thought often results in adolescents' acquiring sets of beliefs concerning themselves (self-rating) and others (demandingness) that accompany some people throughout life.

Parental Factors

According to REBT, parents as role models and reinforcing-punishing agents can play a major part in preventing, minimizing, or exacerbating emotional and behavioral problems in their children. As indicated earlier, this is not to say that poor parenting is the only cause of psychological maladjustment in children. We agree with Bard's (1980) comments:

Some children seem especially prone to make themselves miserable about their parent's relatively minor imperfections. I emphasize this point at the onset to attack the myth that parents are always to blame and to alert practitioners to the fact that parent-child problems may be extremely complex. (p. 93)

Ellis has consistently maintained that the worst thing that parents can do to their children is to blame them for their mistake making and wrongdoing. Such blaming encourages children to continue to blame themselves and inevitably leads to chronic feelings of anxiety, guilt, and low self-esteem for some children and hostility and bigotry in others. Ellis (1973c) wrote:

Parents or other early teachers usually help a child plummet down the toboggan slide toward disturbed feelings and behavior by doing two things when he does something that displeases them: (a) they tell him that he is wrong for acting in this displeasing manner; and (b) they strongly indicate to him that he is a worthless individual for being wrong, and that he therefore deserves to be severely punished for his wrongdoing.... For if they were really sensible about bringing up their children, they would obviously show their child that: (a) she is wrong when she engages in activities that displease them and other members of their social group, and that (b) she is still a highly worthwhile individual who will merely, if she wants to get along well in the community, eventually have to discipline herself and learn to be less wrong in the future. (pp. 239–240).

Irrational beliefs of parents can influence their behavior in two basic ways. One is through their emotions.

Parents frequently get very upset when their child breaks a rule because they believe that: (a) "My child must be good all the time"; (b) "I find it awful or horrible when my child is not—I can't stand it," and (c) "My child deserves punishment because he has made me so angry and for being such a bad child." The belief that children must never break a rule leads to extreme anger which produces intense and non-constructive disciplinary action. (Bernard and Joyce, 1984)

Alternatively, parents may employ inappropriate and counterproductive methods of child management because of ignorance. That is, they believe that what they are doing is the correct thing to do, and often, it is the only way that they can conceptualize relating to their children. Their maladaptive behavior is not associated with extreme emotional arousal but motivated directly by their "unjustified" and "outdated" assumptions. Bernard and Joyce (1984) have noted:

We have worked with several fathers who would administer physical consequences to their children whenever they caught them misbehaving. At these times, they were not particularly angry though they may have felt mildly irritated. These fathers held the simple belief that "children who break rules need to be punished severely to learn a lesson" and employed this rule as a basis for knowing what to do in problematic situations.

Irrational beliefs of parents can, therefore, lead directly to behavior without the intervention of significant emotional arousal. The practitioner can

help objectively to dispute the rationality and adaptiveness of these beliefs without considering the emotional involvement. This is not to say, of course, that there are not more pervasive, absolutistic beliefs underlying these parenting beliefs that do occasion high degrees of emotionality, such as, "To be a perfect parent and a worthwhile person, my child must be totally obedient at all times." Both types of influences had better be considered in understanding the role of parental beliefs.

Paul Hauck (1967, 1977) is a REBT practitioner who has written extensively regarding irrational beliefs that underlie ineffective parenting. REBT practitioners have followed his lead in identifying a number of erroneous parental beliefs concerning child management that are irrational not only because they are inaccurate and empirically unsupportable, but also because they lead to dysfunctional styles of parenting. Also Hauck and others have discussed how destructive extreme parental emotional upset can have on parent-child relationships and the ability of parents to parent effectively including the teaching of socialization and self-management skills.

According to Hauck, the *Unkind and firm pattern* ("unquestioning obedience toward authority combined with a kick in the ego) involve parental behavior of setting of rigid rules, never letting their child question their authority, focusing on the wrongdoing of their child, attacking the personality of their child, strictness and little praise ("Children must never disagree with their superiors"). As a response to this style, children may come to regard themselves as worthless and inferior and view everyone else as superior; they experience feelings of anxiety, insecurity and guilt and may demonstrate avoidant, dependent and submissive behavior.

The parental beliefs that underlay an overly strict and harsh style of parenting

1. Getting angry is an effective way to modify my child's behavior.
2. Anger helps get things done.
3. Children are naturally undisciplined and behave like wild beasts. Parents must beat them into shape to make them civilized.
4. A child and his behavior are the same.
5. Since a child should do well, praise and reward are unnecessary and spoil the child.
6. A parent is always correct and, therefore, children must never question or disagree with them.
7. As a parent, I have the power to make my children do whatever I want.

The *kind and not firm* child-rearing practice involve parents who while showing love and affection makes few demands and set few limits. Parents who demonstrate this pattern appear to do so out of either not wanting to frustrate their child ("Children must not be frustrated") or out of guilt ("I am responsible for all my child's problems and, therefore, I am hopeless.").

Children of such parents may become "goofers" who are weak, egocentric, emotionally infantile and dependent, have low frustration tolerance, and shirk responsibility.

The parental beliefs that underlay an overly permissive and undemanding style of parenting include:

1. Children must not be frustrated.
2. All punishment is wrong.
3. Children should be free to express themselves.
4. Parenting should be fun and easy.
5. Whatever feels right is right.
6. I'm too weak and helpless to know what is the right thing to do, so I'll leave it to the moment.

With the *unkind and not firm* child-rearing practice, parents harshly criticize their children for misbehavior and hardly ever praise them when they behave well.

As a result, their may become chronic rule breakers, trouble with law, angry and frustrated for never being able to please parents, test limits to get parents to show they care.

Hauck has written that the *kind and firm* child-rearing practice is the preferred and skilled form of parenting. Parents who raise their children in this fashion talk and reason with them about objectionable behavior, focus on the behavior but do not blame the child, set limits with clear consequences for rule violations, set punishment that is related to rule learning, not blame, sometimes frustrate their child when necessary, apply reasonable pressure to teach self-discipline and delay of gratification, never punish out of anger and frequently praise and show love. Children raised under this regime often experience positive social-emotional well-being and achieve to the best of their ability.

REBT Conceptualization of an Emotional Episode

Incidents of emotional upset are complicated psychological phenomena. Ellis (1994) has provided his now famous ABC model to help clients grasp the role of their thoughts in causing emotional disturbance. Wessler and Wessler (1980) expanded the ABC model to help therapists to a fuller understanding of these complex psychological events. At the start of every emotional event, a stimulus is presented to the child:

Step 1: Stimuli are then sensed by the person's eyes, ears, sense of smell, touch, etc.

Step 2: Sensory neurons process the stimuli and transmit them to the CNS.

Step 3: Not all sensations enter consciousness. Some are filtered out and others are perceived. Perception is Step 3. Perception, however, is not an exact replication of reality. Perceptions consist of equal parts of information provided

by the senses and information provided by the brain. At this point, all information is organized, categorized, and defined. Perception is as much a peripheral as a CNS function.

Step 4: People usually do not stop thinking after they have perceived information. In most cases, they attempt to extract more information than is present in the perception, so some interpretations or inferences are likely to follow perceptions.

Step 5: Humans are not just passive processors of information. Inferences and conclusions usually have some further meaning associated with them. Conclusions and inferences may vary in their importance to an individual. Almost all inferences are appraised by the person either positively or negatively in relation to the person's life. Irrational appraisals consists of *absolutes* (shoulds, oughts, musts, needs) and *evaluations* (awfulizing, I can't standit-it-is, global rating of self, others, the world).

Step 6: According to rational-emotive behavior therapy, affect or emotion accompanies appraisal. We feel happy or sad or mad at Step 6, after we have appraised something as being beneficial, threatening, etc.

Step 7: Emotional states are not separate psychological phenomena. Emotions have evolved as part of the flight-fight mechanism and exist primarily to motivate adaptive behavior. Therefore, emotions usually include not only the reactions of the autonomic nervous system and the phenomenological sensations, but action tendencies or behavioral response sets that are learned.

Step 8: Responses, once they are made, usually have some impact on the external world. This effect can be desirable or undesirable, and feedback of our action tendencies serves as a reward to strengthen or extinguish a response set.

Elements of the Emotional Episode:

(1) Stimulus,
(2) Sensation,
(3) Perception,
(4) Inference,
(5) Appraisal,
(6) Affect,
(7) Action tendency, and
(8) Feedback

Given this model, emotional disturbance develops because of one or two types of cognitive errors: empirical distortions of reality that occur at Step 4 (inferences) and irrational, exaggerated and distorted appraisals of inferences at Step 5. According to REBT, it is primarily the appraisal that is necessary for emotional disturbance. This is the B in Ellis's ABC. Ellis has noted, however, that, many times, the appraisals are about distortions of reality. Faulty inferences usually do accompany exaggerated appraisal, but the appraisal alone is sufficient to arouse disturbed affect.

Let us take a hypothetical clinical example to explain how these two cognitions operate. George, a 14-year-old, has moved to a new neighborhood and has not met new friends. He is sitting quietly in the neighborhood playground while the other teenagers are talking amongst themselves or playing basketball. He feels very anxious and his associated action potential is withdrawal. He sits alone leaning up against a wall, reading a book. As he sees others gather nearby, George thinks, "They'll never like me, they'll think I'm weird, and they won't want to speak with me no matter what I do." George has drawn these inferences from his peer's behavior. In fact, they are predictions about what might happen but never actually has happened. Inferences alone are not sufficient to arouse high levels of anxiety. Some adolescents, although not George, might be perfectly happy to sit by themselves and read books, but George appraises this situation quite negatively and irrationally. His implicit absolute "I need people to like and approve of me" leads him to catastrophize "It's awful that I don't have anyone to play with" and, then, to put himself down "I must be a jerk if they won't play with me."

Defining "Beliefs"

In REBT, the terms *belief* and *belief system* refer to that aspect of human cognition that is responsible for the mental health and the psychological well-being of the individual. Beliefs are a central explanatory construct of REBT, and it is important that the meaning of the term be as clear as possible.

Ellis (1977) has elaborated an ABC (DE) theory of emotional disturbance that describes how a person becomes upset. REBT starts with an emotional and behavioral consequence (C) and seeks to identify the activating event (A) that appears to have precipitated (C). While the commonly accepted viewpoint is that, (A) caused (C), REBT steadfastly maintains that it is the individual's beliefs (B) about what happened at (A) that more directly "create" (C). Disputation (D), one of the cornerstones of the RET practice of therapeutic change, involves employing the scientific method of challenging and questioning anti-empirical and untenable hypotheses, as well as imperative and absolutistic assumptions (irrational beliefs) that individuals may hold about themselves, about others, and about the world, which lead to the particular interpretations and appraisals that the individual forms about the activating event. When individuals who hold irrational beliefs begin to change their unsound assumptions, to reformulate them into more empirically valid statements, and to believe strongly in the validity of the new ideas, they wind up with new cognitive (philosophical), emotive, and behavioral effects (E's).

Belief may be viewed as a very broad hypothetical construct that embraces at least three distinct subclasses of cognitive phenomena: (1) thoughts that an individual is thinking and is aware of at a given time about A; (2) thoughts about A that the individual is not immediately aware of; and (3) more

abstract beliefs that the individual may hold in general (Bernard, 1981). Eschenroeder (1982) was in essential agreement with this analysis when he wrote that the ABC scheme is a simplification of the complex processes of the perception, interpretation, and evaluation of events and the activation of emotional reactions and behavioral responses:

> The B-element of the ABC refers to rather different phenomena: (1) *thoughts and images*, which can be observed through introspection by the individual; (2) *unconscious processes*, which can be inferred post hoc from the individual's. feelings and behavior ("unconscious verbalizations"); (3) the *belief system* underlying the person's thoughts, emotions, and behaviors. (p. 275)

The more abstract beliefs that people hold are unspoken and constitute the assumptive framework by which they evaluate, appraise, and form conclusions about what they observe to be happening to themselves, to others, and in the world around them. These abstract beliefs are not expressed in the self-talk of people but can be considered relatively enduring personality traits that affect people's interpretations of reality and often, in so doing, guide subsequent behavior. They are inferred from the types of thought statements that clients are able to articulate to themselves and to the practitioner as well as from their pattern of behavior. For example, people who strongly hold the belief that they desperately need others to depend and rely on tend to interpret situations in terms of whether they offer particular sorts of personal security and also search for environments and relationships that satisfy this self-perceived need.

Abstract beliefs can be differentiated on the basis of whether they reflect absolutistic and imperative qualities (irrational) or relativistic and conditional qualities (rational). Those beliefs that lead to self-defeating emotional and behavioral consequences are almost always expressed as unqualified should's, ought's, must's, command's, and demand's and are deemed "irrational." Ellis, who has referred to these beliefs as a form of "musturbatory thinking," has indicated that if people hold rigid views and beliefs about how they, others, and the world should or must be under all circumstances, then they are likely to experience some form of disturbance. Beliefs that are expressed not as commands but as preferences and that are viewed as' conditional on and relative to a set of circumstances are defined as rational and lead to more adaptive levels of emotionality and appropriate behavior.

In terms of the ABC model, rational beliefs generally lead to moderate emotions that enable clients to achieve their future goals by facilitating constructive behavior, although rational beliefs may result in extreme levels of some emotions that are appropriate, such as extreme sadness and regret. Irrational beliefs lead to extremely stressful emotional consequences (intense anxiety, anger, or depression) and behavioral reactions (aggression or withdrawal), which make it quite difficult for the individual to improve the situation (see Figure 1).

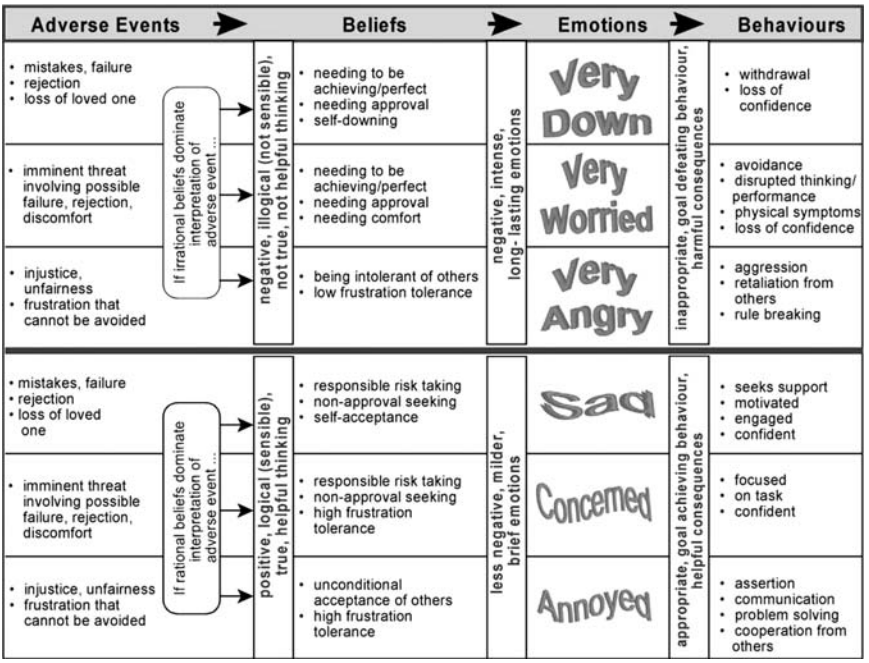

FIGURE 1. The relationship of children's irrational beliefs to their emotions and behaviors (Bernard, 2004c)

Rational-emotive behavior theory states that irrational beliefs in the form of *absolutes* (shoulds, oughts, musts, needs) are the psychological core of children and adolescent emotional and behavioral problems (see Bernard, 2004a). For example,

- I must be successful.
- I need love and approval.
- The world should give me what I want comfortably, quickly and easily.
- People must treat me fairly and considerately.

Ellis indicates that there are a number of derivatives of absolutes that also contribute to the intensity of emotional problems including *awfulizing*, *I can't-stand-it-it is* and *global rating* (self, others, world). For example,

- It's awful to make mistakes.
- I can't stand to be criticized.
- I can't stand having to do boring homework.
- People who treat me badly are bad people and deserve severe punishment.
- School is stupid.
- I'm stupid.

As a result of their irrational beliefs, young people are prone to misrepresent reality (errors of inference including faulty conclusions, predictions). Sometimes, inferences are referred to as *automatic thoughts*. For example,

- I will always make mistakes.
- My teacher doesn't like me.
- All homework is boring.
- People always act unfairly to me.
- I'm a hopeless student.

The tendency for young people to selectively attend to and remain overfocused on the negative aspects of their environment is strongly influenced by their core irrational beliefs and feelings. For example, they pay attention to:

- Children who are not wanting to play with them
- Mistakes and other negative comments offered by their teacher concerning school work
- The boring aspects of homework
- Classmates who are mean to them
- Negative aspects of the way they look

Common Irrational Beliefs of Children include (Waters, 1982)

1. It's awful if others don't like me.
2. I'm bad if I make a mistake.
3. Everything should always do my way: I should always get what I want.
4. Things should come easy to me.
5. The world should be fair and bad people should be punished.
6. I shouldn't show my feelings.
7. Adults should be perfect.
8. There's only one right answer.
9. I must win.
10. I shouldn't have to wait for anything.

Common irrational beliefs of adolescents include (Waters, 1982):

1. It would be awful if my peers did not like me. It would be awful to be a social loser.
2. I should not make mistakes, especially social mistakes.
3. It's my parents' fault I am so miserable.
4. I can't help it. That is just the way I am, and I guess I'll always be this way.
5. The world should be fair and just.
6. It's awful when things don't go my way.
7. It's better to avoid challenges rather than risk failure.
8. I must conform to my peers.
9. I can't stand to be criticized.
10. Others should always be responsible.