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Working with the Parents and Teachers of Exceptional Children

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Since the advent of the Individuals with Disabilities Education Act (IDEA) in 1990, with subsequent revisions in 1997 and 2005, parents and teachers of specially challenged children have been called to face new demands. IDEA emphasizes, among other things, the importance of early intervention for the development of full potential in exceptional children and requires parental participation in all aspects of special education. This increases the need for collaboration between parents and schools to new and, at times, even more stressful levels.

The literature on early intervention (Cunningham and Slopper, 1980; Hayden and McGinnis, 1977) stresses the role of change agent played by the parent of the specially challenged child. Most early intervention programs include supportive parent-counseling services in recognition of the emotional demands of this role. It is the central contention of this chapter that the basic techniques and philosophy of cognitive-behavioral therapy, generically and specifically Rational Emotive Behavior Therapy (REBT), can assist those working with these parents to better address their emotional demands. REBT provides a rationale for the development of parent counseling programs based on an empirically derived theory of emotional distress, assessment constructs that allow a clear conceptualization of parents practical and emotional problems, and a variety of specific therapeutic techniques of demonstrated utility with similar problems in other populations.

Parents of specially challenged children face many demands in their daily efforts to meet the needs of their child. The supportive counseling so often advocated for such parents, although of some value, usually makes no specific attempt to teach parents the relationship among rational thinking,

reasonable emotions and purposive behaviors. Although some parents may temporarily feel better with support, they frequently do not necessarily cope better or work more effectively with their exceptional child. Parents' distressing negative emotions can result in patterns of behavior that defeat their expressed purposes. These goals are to stimulate their child for maximum development and to effectively play their part in their child's educational planning. As pointed out by Ellis and Greiger (1977) cognitive behavioral approaches, best exemplified by REBT, have considerable potential in teaching parents and others working with specially challenged children as it demonstrates ways to manage emotions so that they may better meet the child's many requirements for care and stimulation.

Special education and related services are provided within a service delivery system whose critical components include not only parents and children, but also special educators and a variety of related service professionals. Current legislation mandates parent participation in team planning as well as teacher accountability for educational services that most effectively meet the child's needs. REBT informed parent counseling as suggested here will also reciprocally create new challenges for special educators in the given system. Despite this teachers, no less than the parents, experience a variety of distressing negative emotions that can interfere with the effective completion of their critical responsibilities. Angry, frequently anxious or "burned out" teachers and related services professionals may behave in self-defeating ways that adversely affect their students, students' families and themselves. Teachers, like parents, can be taught to manage their excessive negative emotions and self-defeating behaviors through individualized consultation, group counseling and/or training experiences based on the principals of REBT. It is the contention of this chapter that such training has a practical utility for special educators, is resource efficient as in-service education and takes advantage of the demonstrated clinical effectiveness of the REBT approach with other similar populations.

Parents of Specially Challenged Children

In his critical review of literature on parent training, Henry (1981) noted that there is an increasing emphasis on efforts to intervene in the problems of children by working with their parents. A variety of systematic training programs, as well as theoretical guidelines, have been advanced for helping parents help their children (Arnold, 1978). The literature on Rational-Emotive Consultation (REC) as described by Bernard and DiGuiseppe (1994) focuses on specific techniques for assisting children, both directly and indirectly to improve the management of their own thoughts, feelings and behaviors so that they may function more effectively. McInerney (1994) has described an REC informed approach to helping with emotional and behavioral problems through helping their parents apply basic REBT principals in their own lives

and in child management. While there is now substantial literature on parent counseling with REBT, there are few specific programs for the parents of specially challenged children (Joyce, 1995). However Greaves (1996) describes such an application for parents of Down's syndrome children that provides an excellent example of the potential of this approach.

Basic Therapeutic Considerations

Rapport and Relationship Issues

An important initial step in working with all parents of specially challenged children involves establishing a relationship in which the parent will openly share their thoughts and feelings as well as accurately report their behavior. Although REBT practitioners do not believe that there is therapeutic magic in "empathetic understanding" few would argue that the quality of the therapeutic relationship or alliance is of no importance. Many parents of specially challenged children have had rather negative experiences with professionals and may be understandably defensive initially. Further some parents may have misconceptions about the therapeutic process, perhaps viewing therapy as a treatment imposed on the "sick" and therefore not appropriate for them. Some resent what they see as the implication that they, not their child, require help. It is useful then for the therapist to address these issues from the outset by clearly and simply stating what the parents can reasonably expect from their participation. Below is an example of such as statement:

Psychologists over the years have found that people do not do difficult jobs very well when they are upset, angry, or depressed. Your job, as a parent of an exceptional child, is certainly a difficult one. Like anyone in your situation, you probably do your job better at times if you learned some proven ways to manage your own fears, resentments and guilty feelings in addition to learning how to stimulate and work with your child. In our work together, I am going to help you learn to manage your emotions better so that you can do a better job working with your child.

Statements like this help to establish a self-help atmosphere. Parents will more readily expect to help themselves by openly discussing their thoughts, feelings and actions in relation to their child and by sharing ideas on how to change these if they see a purpose to it. If parents at least tentatively agree to this effort, then a therapeutic contract can be established which gives the therapist permission to proceed with action-oriented, directive therapy towards this goal. In future work this contract can be reviewed as indicated. Furthermore the author has found group counseling to be particularly effective because discussion among parents with similar practical and emotional difficulties encourages a supportive and non-judgmental atmosphere while maintaining the basic contract. It has also been found that voluntary parent participation is most appropriate and effective. Practical considerations that

encourage voluntary participation such as convenient scheduling and transportation may need to be addressed. However while one might find it necessary to try to strongly persuade a given parent to participate in the interest of the child, it may be ultimately self-defeating to require parent participation.

In the interest of initial rapport, it is often useful to reinforce verbal disclosure. This can be done in a variety of ways, including direct encouragement through specific topics of discussions, personally modeling self-disclosure and re-enforcing self-statements by active listening or an empathetic restatement of the parent's thoughts or feelings (Walen et al., 1980). A respect for the parent is communicated through statements accepting their thoughts and feelings as unconditional facts, although one may later suggest how these might be changed. Verbalizations that promote the parent's positive view of the therapist also help to establish a rapport (Wessler and Wessler, 1980). For example, the therapist may demonstrate knowledge and expertise relevant to the parent's concerns. It is also important to express genuine concern about the progress of both the parent and the child, although one should not be dependent on this progress. This trustworthiness is further aided when the therapist plays other roles in the child's total program; the parent then views the therapist as an expert with training and experience in work with children similar to their own. As in other applications of REBT, the therapist can be most persuasive when seen as a specialist with pertinent training and experience who shares a genuine interest in the child and the family's overall progress.

Disputation

Teaching individuals to recognize and dispute their irrational self-statements, as well as persuading them to do so vigorously and often, lies at the core of REBT. As pointed out by Wessler and Wessler (1980) disputation or "dissuasion" is a matter of both technique and therapeutic philosophy. The stereotype of the "argumentative" REBT practitioner is inaccurate; the main focus of REBT with the parents of exceptional children is to persuade them to effectively think and feel differently about the facts of their lives so that they can be less distressed and more effective. It is clear that trying to simply argue parents out of their feelings is short-sighted. Given appropriate attention to relationship issues and the establishment of a contract to proceed, REBT with these parents is not significantly different from work with other clients. In many ways the philosophy and technique of disputation are the same. Given the often traumatic facts involved in the lives of these families, philosophically there is even more reason to use all of one's persuasive skills, and the most proven methods available, to help parents learn to minimize their own distress and thus better cope with the experience of daily living.

Many parents of specially challenged appear especially sensitive to what they view as criticism of themselves or of their child. Disputation, therefore, must be done bearing this in mind, with attention to both the content and the

timing of therapeutic disputes. Directed, Socratic dialogue is ideal for this purpose. Parents may misperceive disputation as (1) an attempt to get them to deny their strong emotions (2) a dismissal or trivialization of their thoughts/feelings (3) disapproval of their distress in the first place. These misconceptions need to be listened for, particularly when disputation fails. They must be corrected either directly or through further dialogue. Sometimes these reactions, once confirmed, may indicate that some of the relationship issues previously mentioned require reexamination and remediation. In other cases, it may indicate not that disputation has not worked, but that it has not worked yet. Persistence is required. Disputations can be varied in type and content to maintain interest.

The following are some practical suggestions for disputations often found to be effective with the parents of specially challenged children:

1. Use rational self-disclosure to model concrete examples of the disputation process, particularly at the initial stage.
2. When presenting the disputation process didactically (e.g., the ABC-D model), use relevant examples of practical value to the parents themselves.
3. Use pragmatic, relevant, although somewhat inelegant cognitive disputations instead of more abstract, philosophical ones.
4. Build in the generalization by providing the connection between the disputation process and the content from various practical problems. Use questions to encourage conclusions about generalizations and new applications.
5. Ask for feedback and listen for misconceptions. Be flexible and use all types of disputation, particularly when one approach is unsuccessful.
6. Do not hesitate to use the dissonance between expressed parental values ("it is important to stimulate my child") and self-defeating ones ("it should be easy") in disputation.
7. Be persistent, although a "hard sell" approach may be easily dismissed by parents.
8. Use homework assignments as well as reading oriented toward self-help to augment disputation.

Assessment

Bernard and Joyce (1984) and DiGiuseppe (1981) both noted the importance proper assessment in cognitive-behavioral therapy with children and their parents. It seems no less important in individual and group work with the parents of exceptional children. One can begin assessment by asking open-ended questions like, "What are your major concerns about your child?" Given a modicum of rapport and a supportive atmosphere, most parents will volunteer things such as, "I worry about his health" or "I am concerned about her lack of speech." Further guided discussion will help define the dimensions of the parents concerns. The second question to pose is whether

these concerns are reasonable as defined by their efforts or whether they are excessive and self-defeating. Considerable judgment on the therapist's part must be exercised here in order to avoid work on "non-problems" as defined by the parents frame of reference. A hypothesis-testing approach is recommended to define operationally the cognitive, emotional, and behavioral meaning of the parents' concern and to allow for its subsequent exploration. For example, parents may worry about their child's "health", having a realistic concern about a sick child's many physical problems and requirements for medical care. On the other hand, a parent may mean by "worry" an excessive preoccupation with relatively minor health problems, to the point of creating excessive, dysfunctional fear that prevents the parents from handling and stimulating that child. This type of "worry", more correctly defined as anxiety, creates distress that is self-defeating of the more general goal of helping the child develop as fully as possible.

Assessment should also address the parents motivation for change as well as the resources available to assist them to do so in order that intervention can be planned appropriately and with realistic expectations. Initially many parents are relatively unwilling to give up feelings, even negative ones, which they feel they "should" have under their given, often objectively difficult, circumstances. They often say something like, "you would worry too, if your child had brain damage" or " I have to worry all the time because if I don't no one will care". An important determination here is to assess whether the parents are content with their feelings or not. One can ask in a variety of ways, "what are these feelings costing you?" Can the parent, at least intellectually, accept the idea that there are other ways or degrees of feeling possible and desirable for practical reasons? If not, intervention may need to begin with very concrete, experiential disputes of the parents belief in the inevitability of their negative emotions. Often this can be accomplished by introducing the parent to other, more experienced parents of children with similar children whose feelings are less self-defeating. Also a realistic inventory must be taken of the resources available for change. For instance, is one parent in the couple more open to change than the other? In single-parent situations, are others involved (such as grandparents)? These others may be involved productively in the counseling process. In other cases, arrangements can be made for supportive services, or practical problems can be solved so that the parents can participate more actively.

Issues of Program Development

Program planning requires an assessment of the service delivery system characteristics and resources in addition to an assessment of both parent and therapist variables. Clearly the context of service delivery may limit the professional time and resources allocated to a given therapeutic program. Although the approach presented here is applicable within an individual consultation or group discussion format, practical considerations often determine which for-

mat is selected. The author's preference for structured, time-limited group counseling in combination with brief individual consultation was initially established to accommodate both parent need and a specific system resource priorities (McInerney, 1983). A realistic appraisal of the limits of services provided will help parents, other staff and therapists to develop and set realistic goals and expectations. In addition, it can be used to develop guidelines for referral to other therapeutic resources (i.e., mental health resources) where appropriate. None of us can do everything for everyone; this is especially true of those employed within public settings, such as schools or treatment centers where funding can be limited.

Common Themes in Work with Parents of Exceptional Children

Experience using REBT, both with individuals and in groups, with the parents of specially challenged children and adolescents indicates that there are several common problem themes, or cognitive road blocks, causing difficulty for these parents. These themes are not unique to parents of special children, but they do seem to occur with more frequency and around certain practical issues common to this group. These common themes include self-defeating cognitions surrounding the following issues: denial versus acceptance, fear versus active concern, anger versus rational assertion and guilt versus self-acceptance.

Denial Versus Acceptance

Many authorities suggest that the most common initial response of a parent to having a specially challenged child is denial (Cunningham and Slopper, 1980). The psychoanalytic concept of grief and mourning (Solnit andStark, 1961) is often used descriptively in this context. This view postulates that there are stages of grief that a parent must work through before being able to accept the child. Many parents of exceptional children describe initial shock and disbelief as a reaction to their child, but in most cases this seems to dissipate with time and experience (Featherstone, 1980). It seems unwarranted for the therapist to assume that all or even most parents have difficulty accepting their child after this initial shock. In the author's experience, the concept of "acceptance" is misused to explain a family's lack of progress. Overwhelmed, uncooperative or simply less-able parents are sometimes blamed for this lack of progress by being labeled as being "unaccepting" of their child. Misuse of this concept is untherapeutic and self-defeating; it should be avoided as parents understandably resent it.

Careful assessment is required to determine if a problem in this area does, in fact, exist. For example, although some minimization of the child's condition may be natural in the initial stages, it is not necessarily a self-defeating defense.

However, a prolonged disregard of the extent of the child's problem may lead to ineffective intervention. It is important to assist the parents in looking at the logical consequences of their behavior and help them to clarify their thoughts, both rational and irrational, about their child's problem. Denial does produce self-defeating distress for some parents but rarely are these problems the result of simple denial of the facts. Often there are secondary emotional dimensions (anger, guilt, depression) that require identification and treatment.

If the therapist does find that the family is struggling with acceptance of the child's condition, it is necessary to dispute some of the irrational misconceptions and attitudes held by parents. Providing parents with guided experiences in interacting with their own child, as well as with parents of other exceptional children can help to counter both basic misconceptions and the "awfulizing" of the condition. Other parents and specially challenged adults can present models of acceptance in a way that didactic presentation and cognitive disputes presented by the therapist cannot. Both their words and their actions can demonstrate that disability does not mean disaster or an inevitably worthless existence.

Fear Versus Active Concern

Featherstone (1981) pointed out various types of fear experienced by the parents and families of specially challenged children. She points out that though these fears may be at times debilitating, they are not necessarily "neurotic". Many parents are quite sensitive to this issue as they see their fears surrounding their child as based on reality. They also, at times, see their fears as a necessary motivator for action in their child's interests. Hara (1975) expressed the outrage felt by many parents when they are told by professionals to "stop worrying." Parents view this as the dismissing of their fears as neurotic maladjustment rather than an important element of a parent's active concern. The cognitive-behavioral approach presented here can make a clear distinction between fear that is excessive (often debilitating) and concern, which is appropriate and motivating. This approach can help parents learn techniques to manage self-defeating fears and a philosophy of assertive, active concern.

The REBT perspective on fear has been well described by Hauck (1975) and others. It is most important to encourage an open discussion of fears and to ascertain the parent's perspective. Then a didactic but practical presentation can be made regarding the nature of fear and the role of "awfulizing" thoughts in its genesis. It is then worthwhile to have the parents re-examine their fears in the light of this perspective and to begin to make judgments about their fear's utility, perhaps questioning the ways in which these fears are helping them in their everyday lives. While reassuring them that overconcern is human and not "crazy", it is imperative to point out that it is neither always necessary nor useful.

REBT informed intervention helps parents to learn how to confront and actively dispute the irrational self-statements behind their fears. A most prac-

tical dispute involves variations of the idea that fear, in itself, rarely prevents a feared event from happening (McInerney, 1995). A good example to use is that of a parent who is so afraid that their child will be hurt while playing with other children and therefore deny the child the play experience. However, it is this socially inexperienced, overprotected child who is most likely to be hurt in play with other children. In this way, that parent's irrational fear is actually contributing to the likelihood of the feared event's occurrence. This issue of "overprotection" must be dealt with sensitively though because, in many cases, a degree of protection is warranted by the objective reality of the child's disability. The concept of *normalization* with regard to maximizing the child's social development and independence can be a helpful context within which to present to problem of overprotection. Most parents are in complete agreement with normalization and the cognitive dissonance between it and fearful overprotection can be therapeutically utilized.

A related misconception about fear held by some parents is that fear is a necessary motivator for behavior. Some appear to believe that, without fear, they would not be motivated to care for their child. It is important to point out that this is not the case; few parents would stop caring for their child if fear were reduced. Also there is sometimes a misconception surrounding the word "fear"; it is used throughout REBT work to teach ways of discriminating degrees of emotional experience. Teaching parents a simple "1 to 10" rating scale for their emotional experiences can be helpful in illustrating the difference between "concern" and "fear". Although this scale is individual for each parent, generally 7 to 10 can be labeled "excessive fears", 4 through 6 "realistic concerns" and 1 through 3 may be denoted "small concerns". Parents can be asked to place a variety of fears in each category and should be encouraged to identify the thoughts precipitating their "excessive fears". It can be demonstrated that the relationship between anxiety and performance dictates that performance tacks are most successful when aligned with realistic concern. However, pervasive or excessive fears do not yield the best performance. In this way therapy may be utilized to help parents scale down their "excessive fears" (fears that they have awfulized) to "realistic concerns".

While fearful thoughts are being extinguished, care should be taken that more rational thinking and problem solving are reinforced. A variety of related cognitive-behavioral techniques such as systematic desensitization, thought stopping, and implosion and paradoxical intention can be demonstrated and practiced. Rational assertiveness trainiing is also useful in providing the behavioral component for expressing realistic concern as an alternative to debilitating fear.

Anger Versus Rational Assertiveness

Anger is a major issue for many of the parents of exceptional children. The enormity of the "injustice" visited on the parents by the birth of the child can activate considerable rage. Parents may cry out for someone or something to

blame for the circumstance. Although this anger may be a common stage in the grieving process mentioned above, it can nonetheless be troubling for families.

Many parents, while not perpetually angry, find themselves most distressed when other people are not as they "should be" and therefore merit punishment. They mistakenly think that anger works when, in reality, it most often only generates anger and resentment in others. Parents of exceptional children are not, as a group, less tolerant of frustration than others. They are simply confronted with many more frustrating circumstances. As in other areas, dealing successfully with anger issues requires a careful assessment so that the intervention may be appropriately directed.

Initial work with such parents must begin by creating conditions in which parents can express anger and resentment openly. The central message to convey at this point is that anger is a natural human response to frustration, but that it is not inevitable and is often self-defeating. It is important to explore the costs of anger lest some parents incorrectly confuse anger with standing up for your rights and see it as desirable. Anger is extreme and pervasive when it has psychosomatic consequences, interfere with problem solving or communication, interfere with personal relationships or leads to undesirable secondary emotions like guilt or depression (Ellis 1977, Waters, 1980). All of these costs can be concretely illustrated by discussion, personal example and directed role-playing of concrete situations common to the parents experience.

Once parents see a practical reason for addressing their anger, the rational-emotive psychology of anger can be presented (Hauck, 1974; Ellis 1977, Ellis and Tafrate, 1997). This is best done with practical examples of how we upset ourselves. Rational-emotive imagery can also be used to demonstrate both that it is not events that upset us but that it is our irrational thoughts about the events that are largely responsible for our anger. It is critical to discuss real-life anger issues whenever possible. If parents are encouraged to make explicit their self-talk in anger situations, they can become further aware of the relationship between one's "shoulds" for people/things and anger. As noted earlier, role playing can be particularly useful in this context. These can be played out with instructions for both angry and non-angry self-talk. Discussion can focus on the self-talk that leads to anger, the likely logical consequences of the anger and alternative thoughts and behaviors.

In disputing the angry self-talk of parent of exceptional children, it is often most useful to stay with the concrete facts of a given situation. Self-talk such as "this is awful! I can't stand it!", which gives rise to anger is simply not consistent with the facts. The fact that these parents do "stand it", as well as successfully cope with such circumstances, on a daily basis can be persistently pointed out. Coping with frustrations by giving up demanding that they not exist, rather than eliminating the frustration or anger, is the more appropriate focus. It is often important to point out to parents that acceptance of an unjust reality does not mean approval of it. Ultimately philosophical acceptance of the reality is the goal.

Therapeutic treatment of anger is not complete without providing experience and practice in rational assertion as an alternative to anger. Rational, assertive behavior can be encouraged through the well-established techniques of rational assertiveness training described in detail in several sources (Hauck, 1979, Jakubowski and Lange, 1978; Lange and Jakubowski, 1976). The situations used in this training can easily be tailored by the therapist to reflect the experiences common to the parents of exceptional children. It should be emphasized that annoyance, not rage, most often results in assertive behavior. Assertiveness is no guarantee of getting what one wants, but it generally works better than angry demands.

Guilt Versus Self-Acceptance

Many parents of specially challenged children report feelings of guilt about their child difficulties, particularly early in the child's life. Some parents believe that they could have or should have done something to prevent the child's disability. Despite the uncertain etiology of many conditions, some parents believe that their child is being punished because of their own inadequacies. The initial guilt may be a time-dependent part of the natural grieving process, but in some cases, the problem generalizes to other areas. In these cases the guilt may generalize in one or both parents to symptoms of clinical depression. Because of this, a frank discussion of the problem of guilt should be included in virtually all therapeutic work with the parents from the REBT perspective. More than the other negative emotions, the irrational self-talk at the root of guilt seems to respond only to vigorous, persistent and pragmatic disputation (Ellis and Harper, 1975).

Rational thinking about responsibility can be reinforced in a variety of ways. Didactic exposition of REBT perspective on depression (Ellis and Harper, 1975; Hauck 1973) and the psychological difference between guilt and responsibility is useful to discuss in detail. Responsibility can be explained as a concept of the relationship between identifiable actions and their probable consequence. Further, responsibility also implies that the consequences are usually identifiable before hand and that the actions in question are a result of some choice. When people fail to live up to these types of responsibilities, the logical consequence is irresponsibility and negative events. Guilt, on the other hand, implies much more than irresponsibility. Guilt implies that human beings should omnipotently know the right thing to do in every situation and invariably do it. When they do not, they have done something so awful that they lose all worth or value as a person and should be "damned" for all time.

Much of the guilt experienced by parents of exceptional children results from misinformation surrounding the child's disability. More often this guilt is a result of an impossibly broad definition of the parent's responsibilities. Through therapeutic dialogue, misconceptions can be factually corrected and a more realistic concept on responsibility can be developed. For example a

parent might say, "I feel guilty because I'm not doing enough for my child". It is useful then to question concretely what they mean by "enough". Often "enough" in the parent's mind means "everything". In a variety of concrete ways, the impossibility of doing "everything" should be pointed out. Further the self-defeating nature of obsessing about doing "everything" can be made readily apparent to most people. "Do you want to spend all of your time and energy thinking about everything that should be done but hasn't or in doing the things that are important and *can* be done?". Even when the inevitable mistakes are made, there is no utility in making a bad situation worse by feeling guilty about it. An attitude of self-acceptance whereby the parent learns to evaluate his or her behavior only in terms of usefulness rather than for what it is incorrectly assumed to demonstrate about their personal worth ought to be reinforced.

Many parents are not aware of all that they are doing to cope. An assignment may be to keep a "coping log" in which they are instructed to record in simple behavioral terms all their daily accomplishments for the child, the family or themselves. This and other variations of Beck's pleasure and mastery techniques (Beck et al., 1979) can be most useful because, in many cases, the daily accomplishments of the family are quite remarkable, even though they are often devalued by the family itself. The coping log provides concrete evidence that contradicts their belief that they are failures Why are the other accomplishments, ones not related to the child in need, any less important than the ones that are? Clearly it all depends on the way one views them. That is the major point to get across: it all depends on the way one views his or her own accomplishments.

It should also be pointed out that a parent's guilt-driven obsession with doing "everything" for the exceptional child may lead to a relative neglect of other family members. This self-defeating imbalance in the family system can best be addressed by focusing on both the reduction of guilt-driven, over-involvement in the exceptional child and by providing behavioral assignments to help parents redistribute attention. Although resistance can be expected, the likely reduction in distressing guilt and family tension provides its own reinforcement once the process begins.

Parents troubled by problems of guilt in relation to their children have often lost perspective on their own value as a person. They no longer see themselves as being of any worth except in relationship to their child. Such a view may be accompanied by clinical symptoms of depression. Sexual, marital and family adjustment problems are significantly related considerations. In such cases, the cognitive-behavioral approached used in the treatment of depression are most appropriate and referral for comprehensive treatment may be indicated. The nature of depression and helplessness often need to be concretely pointed out. The contradiction involved in devaluing oneself to the point of dysfunction, which prevents the accomplishment of one's original goal (to help one's child develop fully) should be vigorously made explicit. Suggested homework assignments could include direction to be good to

yourself while exploring the importance difference between "selfishness" and "self-interest". There is value in exploring this difference with all parents of exceptional children.

Teachers of Exceptional Children

Special educators, though competent in their area of expertise, have most often received very little training to help them cope with the emotional demands of their complex role. They are expected to plan and implement individualized classroom instruction, coordinate related services and participate with parents, administrators and various specialists in programatic decision making for the child. This is not a simple task. At times the ultimate goal of the process is obscured by the irrational demands of individual participants and excessive negative emotions may be generated. Special educators have been committed to in-service training for some time but the issues of emotional survival skills are rarely addressed. As Bernard (1990) has shown, teachers who are better at managing their own emotional stress are better at teaching.

Experience as a consultant to both teachers and parents of special children has suggested that they share several emotional and practical problems. Teachers, like some parents, find it difficult to motivate themselves to consistently follow through on simple, often commonsense, behavioral recommendations. When one talks frankly with special educators about their feelings about themselves and their jobs, they describe feelings not unlike those described by the children parents. Teachers report feelings of self-criticism, anxiety about failing the child, guilt over not doing "enough", anger at the "injustice" of the child's condition and anger at others who are not doing what they should be doing to help. Like the parents and other helping professionals, they run a higher than average risk of burnout, along with its deteriorating job performance and symptoms of depression. The burnout issue alone justifies providing therapeutic experiences like those discussed above for parents. REBT has been proven to be both relevant and powerfully therapeutic for stress management; such should be true for special educators.

Common Themes Expressed by Teachers

Special education teachers often experience self-defeating anxiety when they feel that they are being evaluated negatively. They appear to fear criticism because of three distinct and irrational self-statements: (1) "I must be approved of all the time; I've earned it by my care of this child" (2) "criticism is so devastating that I can't stand it" and (3) "I must fear criticism in order to prevent it". These statements can be disputed by directed dialogue, including questions concerning the absolute need for approval, the presumed catastrophic consequences of criticism and the value of worry in presenting it.

These self-statements can be disputed experientially by role-playing common situations in which criticism occurs (i.e., supervisory conferences, parent interactions etc) with irrational instructions as well as more rational coping strategies. Cognitive-behavioral strategies for rebutting criticism may also be practiced. Specific homework assignments may include doing an ABC analysis of several criticism situations paired with later discussion.

Anger is a frequently discussed issue. Teachers often anger themselves at colleagues, administrators, parents and their students in a variety of contexts. Suffice it to say that special educators, no less than the rest of us, often need to be vigorously persuaded that anger is self-defeating. Teachers may need to be inelegantly asked, "is your anger changing his behavior?" and/or "did she ever criticize you again?" until the logical consequences of anger are appreciated. This is important because, as we all know, anger does sometimes work in the short run. However, attention must be paid to the long-range personal consequences of frequent, excessive anger in terms of psychosomatic distress, fatigue, impaired interpersonal relationships and guilt feelings i.e., burnout. It has also been found that concrete discussion of alternatives to anger in terms of both rational thinking and assertive behavior may be useful. Given the host of frustrations involved in the job of a special educator, coping with frustration philosophically and behaviorally is an all important skill.

Related to anger is the problem of blame, both of self and of others. The rational alternative to blame is acceptance of reality as what it "is", instead of what it should be, while trying to change what can be changed. The essential point here is that human beings largely create their own emotions, an idea that can be demonstrated effectively through rational-emotive imagery and other methods. The point that one is responsible for one own emotions allows for a more complete consideration of the anger-guilt cycle as experienced by many special educators. This is particularly true when one gets angry at people who they "should" not get angry at, most especially their specially challenged students. Unacknowledged anger at the child is then often misdirected at the child parents. The guilt stemming from this self-defined unacceptable anger leads to a variety of self-defeating compensations that may have consequences on the child's behavior and adjustment. Unconditional self-acceptance is the elegant solution to the problem; more immediately one might be less self-damning in order to break up the anger-guilt cycle. This includes recognizing that, "I'm angry and I should calm down," instead of berating oneself as, "a rotten teacher and person for being angry at this poor kid".

A final area of importance for special educators involves strategies for rational problem solving. These can be presented in a structured way, with emphasis on removing the largely emotional element of the problem through rational thinking prior to tackling the practical issue. For example, a teacher who is facing a very difficult parent conference becomes anxious and defensive. This reaction clearly has the potential for making an already difficult situation far worse. Instruction and practice in dealing with this and other similar situations can be provided.

Special educators, not unlike the parents of educationally challenged children, appear to benefit from therapeutic experiences grounded in REBT. This approach has the advantages of efficiency, flexibility and practical value as seen by the participants as well as demonstrated efficacy with other populations. It is amenable to use in the satisfaction of existing professional development requirements and provides a clear methodology for addressing staff concerns regarding stress management and burnout.

Conclusion

REBT as it is, and as it continues to develop, is as applicable today to the experiences of those working with specially challenged children as it was when then original version of this chapter was written (McInerney, 1983). Parents, educators and professional support personnel can benefit from the interventions described above. Furthermore, the basic principles and techniques described in the present work can be integrated into school-based programs to support parental involvement in special education programs, as a supportive intervention for the parents of emotionally and behaviorally disturbed students as well as more generally disaffected or substance misusing adolescents not typically part of a school's special education population. In the future, the authors hope to see school-based programs grounded in the priciples of REBT implemented in both regular education and special education settings.

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