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Rational-Emotive Behavior Group Therapy with Children and Adolescents

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Humans are social creatures and we begin functioning as members of groups the moment we are born. We continue to work, play, and live in groups for the entire span of our lives. Therefore, it is not surprising that group therapy has been a common and popular treatment option for over half a century. There are a number of key considerations about the application of group therapy when working with children and adolescents, and, more specifically, about the application of REBT and cognitive change methods in these groups.

According to Ellis (1997), Rational-Emotive Behavior Therapy (REBT) and Cognitive Behavior Therapy (CBT) lend themselves particularly well to use in group settings. Ellis (2002) stated that:

> Rational-Emotive Behavior Therapy (REBT) and Cognitive-Behavior Therapy (CBT) are efficient kinds of group therapy, because they involve people who regularly meet together with a leader in order to work on their psychological problems, they focus on the members' thoughts, feelings and behaviors, and they encourage all the participants to help each other change their cognitions, emotions and actions. (p. 51)

Ellis has been successfully using REBT in groups since 1959 (Ellis, 2002) and claims that it is usually more effective than individual REBT. Its use in child and adolescent groups has been described in the literature over the past three decades (e.g., Elkin, 1983).

Initially, we will present an overview of group therapy, followed by a discussion of some of the specific applications of it when working with children,

specific discussion of REBT when working with children and adolescents, a brief discussion of the research regarding the effectiveness of group therapy in comparison to individual therapy as well as control groups, along with the effectiveness of REBT group therapy.

General Considerations in Group Therapy with Children and Adolescents

The advantages of and disadvantages of group therapy with children and adolescents will now be briefly reviewed

Advantages

Group therapy is a common method used with children and adolescents due to its numerous advantages over individual therapy. Several authors, most notably Yalom (1994), have identified specific therapeutic factors that exist in groups. Corey and Corey (1997) refer to these factors as "the special forces within groups that produce constructive changes" (p. 239). "Universality" is one such powerful factor and it can be used in group therapy, as when students recognize that other members of the group share in some of the same afflictions as they do and, as a consequence, it may help them to feel less isolated in their struggle. In this and other ways, students in group therapy can serve as excellent support for each other. Children and adolescents who have already made progress toward overcoming universal hardships (such as divorce of parents or death of a loved one) can also provide hope and inspiration for those who are still struggling.

An additional advantage of group therapy is that children and adolescents receive feedback from a number of people as opposed to only receiving feedback from the clinician in individual therapy. Giving and receiving feedback helps members to understand "the impact they have on others and decide what, if anything, they want to change about their interpersonal style" (Corey and Corey, 1997, p. 243). We have found that students are very frank in their giving of feedback to their peers and are readily comfortable in "calling out their friends" when they are not being forthright, something that as clinicians we may not always be able to pick up upon.

An example of where feedback can be helpful may be seen in an REBT-based study group, in which homework is discussed as well as beliefs that interfere with completion. Students in group therapy may receive several critiques of their homework and actively participate in reviewing the work of others, which can facilitate increased awareness and improved critical thinking. The mild competition that exists in groups with children and adolescents can also be beneficial, especially in its ability to motivate members to work harder toward completing their homework, as well as toward reaching personal goals. At the same time, students may receive feedback from multiple

sources on how to better challenge their faulty logic that interferes with their homework completion. See Appendix A for an example of a REBT group format utilized by Forte et al. (2004).

It is our experience that some group members tend to learn therapeutic techniques better than those in individual therapy may, which may be particularly true for children and adolescents. This also holds true for problem solving aspects and REBT techniques.

Students in groups observe modeling not only by the therapist but also by other peers. Such modeling by other members of the group can be especially advantageous as children are more likely to identify with other children than with the therapist. Modeling can also increase the amount of sharing and disclosure that occurs in groups. When one group member opens up to the group, for example, other members often open up as well. Modeling of effective challenging of unhealthy thinking and the development of logical, rational thoughts may help individual students in the group setting develop more healthy approaches to handling potential adversity.

Another benefit of groups is that they can be educational beyond the structured intent of the group. For example, in a task oriented group (test anxiety) having a mixed gender group may allow students an opportunity to learn about members of the opposite gender. In addition, groups can be a source of school environmental knowledge, where members learn about various aspects of the school (classroom, teachers, etc) that different group members have experienced. Furthermore, groups provide a safe environment for members to share and grow. This environment allows students who are trying to alter some aspect of their behavior an opportunity to test new behaviors and receive constructive feedback from the group leader and their peers.

Specifically, when working with children and adolescents, group therapy has a further important advantage over individual therapy in that it allows the therapist to observe the group members in action interacting with one another. This provides the therapist with important information on members interpersonal skills and styles, which can be more accurate and helpful than the child's self-reports of behavior provided in individual therapy. Direct observation also enables the group leader to report on any discrepancies between what the person is reporting and what they actually carry out.

Disadvantages

Despite its popularity, group therapy is not for everyone, and it certainly has its limitations in working with both children and adults. Perhaps, the most obvious disadvantage of group therapy is that, by its nature, it reduces the amount of time spent addressing the individual needs of each student. Thus, this reduction in time for direct intervention leads many to consider group therapy to be an inefficient method. While this may be true in some cases, it is important to recognize that many if not most groups are comprised of clients with similar needs or complaints. Consequently, it is often the case

that though only one group member's specific needs are addressed at a time, the majority of the members can benefit from the general information supplied. Later in this chapter we will discuss the differences between having homogeneous and heterogeneous groups for children and adolescents in terms of content, membership, and presenting problem.

Another possible concern about group therapy is that the idea of therapy in a group format may intimidate a student who could benefit from the approach. The limited degree of confidentiality that can be guaranteed is one of the reasons some children are wary of the group setting for therapy. Students in individual therapy are reassured that for the most part everything they reveal (excepting child abuse and the intention to harm oneself or others) will remain confidential by the fact that the therapist is bound to legal and ethical codes and can face severe consequences for breaking confidentiality. However, it is far more difficult to secure complete confidentiality when therapy is conducted in a group. This may be even more true when considering children and adolescents in groups. One way to address the issue of confidentiality in groups is to create written contracts that all members must sign at the start of the group (see Appendix B). This can help ease the minds of those who may be hesitant to enter the group due to fears about confidentiality.

Compulsive talkers or interrupters can also be a potential problem in groups. Therapists can reduce the risk of constant interruption by certain group members by setting up specific "ground rules" for the group in the first session. These rules should stress the importance of being respectful when each member has the floor and should specify appropriate and inappropriate times for members to make comments. We have found that students sometimes do a good job of policing other group members and providing feedback when they think that other members may be monopolizing the group therapy. This may be particularly true for adolescents, and we use this feedback as part of the therapy process. In addition, group leaders may wish to pull a student aside at a later time and point out that they may be monopolizing the group process and encourage them to self-monitor their own behavior.

Other areas of caution in group therapy have to do with the potential high level of suggestibility of some members. It is important to recognize the specific needs and persona of individual group members and anticipate how they may be affected by group participation. For example, some students may only do their group assignment (we eschew the word homework, as do students) because, "they MUST have approval of the group leader and/or group members." While this serves the purpose of getting the group assignment completed, it is important to address the motive, or potential irrationality, behind the behavior. In addition, group members may give bad advice or provide the wrong solution. This can be detrimental to highly suggestible members.

Another obstacle that can hinder the progress of some groups is the existence of narcissistic members, which does occur with some regularity in working with adolescents. Narcissistic group members, members who only

care about themselves and their problems, and members who are simply uncaring can hamper other members ability to improve and can be destructive to the entire group process. However, appropriate pre-group screening (to be discussed later in this chapter) should eliminate this potential problem by preventing these individuals from entering the group.

Overall, we have found that groups can be an important resource in working with children and adolescents. Additionally, the structure of the approach of REBT lends itself nicely to the format of group therapy. We will briefly discuss the theory of REBT and its core assumptions as they relate to groups and then present some general guidelines for running groups with children and adolescents.

REBT Applied to Child and Adolescent Groups

At this point in the book, readers will be fairly familiar with the REBT model and how it is applied when working with children, adolescents, and parents. However, we would like to provide a brief review of the model as it pertains to group therapy when working with these populations.

REBT in Child and Adolescent Groups

REBT operates under the premise that individuals possess disruptive, dysfunctional/irrational cognitions about events that negatively impact their behavior and affect. That is, cognitions mediate emotions and behaviors. This is different from a cognitive deficit model, which implies that typical normal development involves the acquisition of certain cognitive processes that have failed to develop in these children who experience difficulty. To illustrate the difference between the two, we will consider the case of a child who is socially anxious from that of a child who is diagnosed with Asperger's disorder.

In order to meet their criteria for Asperger's disorder, a child needed to have impairment in reciprocal social interaction (Gillberg and Gillberg, 1989). According to the DSM-IV-TR (APA, 2000), the diagnostic criteria include a "severe and sustained impairment in social interaction" (p. 80). The ability to engage in appropriate social interaction with others is a skill that failed to develop in the student with Asperger's. This is different from socially anxious students. These students may in fact know what the correct behavior to engage in is, but fail to do so. The dysfunctional cognitions model would propose that this may be because the student is thinking: "If I say something and mess up and others think poorly of me . . . it would be terrible" or "I *have to*/*must* have approval of others, because not to would be intolerable." These cognitions are irrational in nature and would interfere with the students' ability to engage in a socially appropriate behavior.

The reason that this distinction is important for group therapy is that the kind of therapy group that students might be assigned to may vary

dependent upon whether they never acquired/learned the appropriate cognitive, social, and behavioral processes or if they engage in distorted interpretations and perceptions of reality. If a students' primary disorder stems from cognitive deficits, the therapy group may be more skill focused, with rehearsal of behavioral and cognitive coping strategies; that is, teaching students what they failed to develop. The groups may be staggered in terms of skill acquisition level, to allow other students who have demonstrated some level of competency in skill acquisition to provide a model for their peers. These deficit driven groups appear to be more often focused on behaviors that are externalizing in nature as they are the ones that can receive direct feedback from others, whereas the internal cognitions are based upon insight and ability to report one's own cognitions. For example, if they have not formed cognitions and appropriate strategies to effectively manage anger, these deficits will be remediated in this group.

In group therapy, the clinician is able to see the interaction of the students' cognitions, their behaviors, and the environment (their peers) that these behaviors actually occur in. This opportunity allows for a greater understanding of the dynamic interaction of these variables and for an opportunity to practice/rehearse effective cognitions and behaviors in more natural contexts than present in 1:1 therapy.

Some Distinctive Features of REBT Groups

REBT group therapy with children and adolescents, like individual therapy, is more psychoeducational than motivational. The group leader is not just there to inspire the group members but rather to provide them with knowledge and information to help in achieving goals. That is, the goal is to inform and educate members of the group on the dysfunctionality of their present cognitive schemas, teach them strategies to actively challenge them, and work with them on developing more appropriate affective and behavioral responses to go along with these more healthy cognitions.

REBT proposes that regardless of the origin of emotional disturbances we focus in the group on the irrational beliefs and cognitive processing underlying these emotions. Through a group format, peers may help group members readily identify the cognitive schemas/irrational beliefs that maintain the disturbance. This is one particular benefit of the group format, as peers may be better at understanding what some of the underlying cognitions are that lead to the unhealthy emotions experienced by their peers than an adult clinician. In REBT groups, students go through a number of exercises, which will be detailed later, that assist to direct change of cognitions that will help facilitate emotional and behavioral change.

As mentioned previously, REBT groups are psychoeducational and seek to increase students' knowledge about the cause of destructive emotions and behaviors. That being said, early on in REBT groups with children we focus on the REBT theory of emotions, and assist students in understanding the

differences between functional and dysfunctional emotions. This is where we suggest the clinician think about the level of functioning of the group members and cater their language in therapy to a level that the student will understand. While words like "functional", "dispute", and "irrational" may be appropriate for older students, their use may really serve to hinder the understanding of some of the core principals of REBT with younger children. We suggest more user friendly terms that, while not consistent with the actual terminology used in REBT-speak, do share the same content/message. As such, we use "helpful", "challenge", and "healthy thinking" in place of the terms above.

Developing an emotional vocabulary is an important aspect of REBT psychoeducation. The group leader, especially with younger children, may spend some time helping foster their emotional vocabulary. We have found many students, when asked what they feel, offer "bad" as a response. The group leader, through didactic instruction as well as experiential exercises, will help students see a range of feelings (anger, sadness, frustration, anxiety). At the same time, the group leader and group members assist students in understanding the four aspects of every emotion:

1. Phenomenological—how the emotion feels.
2. Social Expression—how we communicate our goals and upset to others.
3. Physiological Arousal—biological response.
4. Behavioral Predisposition—emotions are often important cues that we must act on problems. They may lead to behavior coping strategies that may be adaptive or dysfunctional in nature.

In addition to helping students become aware of their emotional experiences and develop an emotional vocabulary, REBT groups also focus on teaching students that irrational beliefs are what lead to these dysfunctional, disturbed emotions. Using the Happening-Thinking-Feeling-Reaction/Behavior framework, students are taught the differences between irrational beliefs and the more rational, healthy cognitions that may lead to negative emotions, but ones that are more functional in nature. However, before one begins a REBT group, or any group for that matter, there are a few things that we believe warrant consideration.

General Guidelines for Forming REBT Groups

The screening and selection of individuals to participate in the group is a very important aspect of group therapy, especially in REBT, which utilizes focal groups with very specific goals. Elkin (1983) provides some important guidelines for group formation that we have expanded upon below. We suggest that the group leader hold a preliminary session with potential members either prior to the start of the group (in the case of a closed group) or before a new person joins the group (in the case of an open group). The main goal of this preliminary session is to determine whether the goals of the potential

member are consistent with group goals. This preliminary meeting also provides an opportunity for the potential student to interview the group leader. At this time, potential group members can ask questions that may help them decide if they want to join the group. When screening for a group of children or adolescents, it is important to involve both parents and children in the initial meeting. As with adults, this preliminary meeting with parents and children should discuss confidentiality, the goals of both the child or adolescent and the group, and answer any questions that may arise.

Prior to holding a preliminary session, leaders should be sure that potential members do not meet the exclusionary criteria of the group. The exclusionary criteria of any group are entirely dependent upon the group, its leaders, and its goals. REBT groups often have exclusionary criteria that may be more stringent than other groups. First, leaders may wish to rule out potential members who are psychotic, suicidal, brain damaged, or sociopathic. In addition, students who are uncommunicative or silent may be excluded from groups, as neither they, nor other students will benefit from their participation (or the lack thereof). At the same time, students with some of the more extreme external disorders (conduct disorder, oppositional defiant disorder) may be excluded as well. An important exclusionary criterion specific to REBT groups is unwillingness to do group assignments or therapy homework. Group assignments are a central aspect of REBT groups and individuals who are not willing to participate in this aspect of the group would generally benefit more from an alternate approach.

Potential group members must also meet the inclusionary criteria, which, like the exclusionary criteria, are dependent on the specific goals of the group. In order to be included in an REBT group, potential members are informed of the general REBT framework, to ensure that this is something in which they wish to participate. Since these are essential components of REBT, potential members agree to work on assignments and actively participate in all aspects of the group, especially disputing their own and other members' irrational beliefs. What's more, it is essential that students have very specific goals they want to work on during the group. We find that the ability to set goals is easier done with adolescents than with younger children. Younger children are often told what their goals are by others and may expect that to continue to be the case in therapy.

Inclusionary criteria can become extremely specific for some groups. In a closed group, for example, it is important that members agree to attend all sessions. Furthermore, a group addressing social anxiety will screen for students with some level of fear toward interacting with others and would probably exclude a person who is very comfortable socially and the next candidate for Mr. Popular in the yearbook.

In a REBT group, the initial meeting also provides an opportunity for the leader to familiarize potential group members with the REBT model. Leaders should provide a brief history of REBT and a synopsis of the REBT techniques that will be used in the group. This helps to ensure that members

come to the initial group session informed, prepared and ready to work. In addition, the preliminary session is an optimal time to inform potential students of any ground rules that may exist in the group. For example, the group leader may have specific rules about attendance, socializing outside the group, etc. All potential members are to agree to abide by these rules prior to joining the group. It may also be helpful to provide students with a written list of the rules, or even have them sign a contract in which they agree to abide by the rules. See Appendix B for an example of a group contract.

The preliminary meeting also provides the group leader with the opportunity to discuss and reinforce the important issue of confidentiality. Leaders are to inform potential group members of their rights regarding confidentiality as well as the limits of confidentiality, including the circumstances in which clinicians become mandated reporters. In addition, it is important that all potential members be reminded that they are responsible for assuring that all information revealed by fellow students remains confidential. Unfortunately, given the social nature of a school, our impression is that confidential issues are not always kept secure with students when groups are run in a school setting. Given that the group members regularly see and interact with one another throughout the school day affords more opportunities for confidential issues to be expressed. When this occurs, we recommend that it is addressed both with the student individually and in the group, and we suggest that it provides an additional opportunity for review of the rules of confidentiality. It is also at this time that the decision to allow a student to remain in the group following this breach of confidentiality is discussed.

Some other issues that must be decided before beginning the group include the time, dates, and location of group meetings and the group size. While these decisions will vary dependent upon setting, typically we have found that groups of younger students (up to age seven) should have no more than 4 to 5 members, while groups of older students (over age eight) should have a 7 to 8 member maximum. Groups held in school should not be during major academic areas nor should they compete with other school related activities that students find desirable (i.e., gym class). Creative ideas are also helpful, for example, Flanagan et al. (1998) held their group during a lunch period and provided popcorn. It is also important that the leader determines in advance what methods will be used for data collection to evaluate change and administers all pre-test measures.

In addition, the group leader must determine the group type: open or closed. In an open group, students can join anytime there is space in the group. An open group can run for as long as the leader is willing to hold it and there are sufficient members. This method has the advantage of allowing students to stay until they have attained their goals. However, this potentially never-ending group can become expensive when not done in a school setting which may deter some potential members (Corey et al., 1992). Another disadvantage of this method is what Corey, et al., (1992) refer to as the, "cozy-nest syndrome," in which students are, "always 'working' and

perhaps never changing." (p. 35). Closed groups have a set number of sessions and all members begin and finish together. The obvious disadvantage of a closed group is that the group will end whether or not the student has reached his or her goals. However, this can also act as an advantage in that the knowledge that the group will end at a set time may be a source of motivation to begin actively making changes (Corey et al., 1992). Another advantage of closed groups is that they are more cost effective than groups lasting for over a year.

Types of REBT Groups for Children and Adolescents

REBT has been applied to many different types of groups, both short-term as well as long-term (e.g., Elkin, 1983). Where REBT groups with children and adolescents may differ from REBT groups with adults is the fact that with adult REBT groups, the goal may be to provide individual therapy within a group setting with several members talking to one member, disputing, etc. While this can and does occur in child and adolescent groups, they appear to involve more group tasks with less boundaries/structure than those that exist in the adult groups. That is, we tend to do more group experiential exercises focusing on interaction and development of healthy thinking and appropriate behaviors in child groups as compared to adults groups.

REBT groups for children and adolescents may be viewed as both content and process focused. That is, group leaders are concerned with the content in order to successfully teach students more effective means of thinking, feeling and behaving. However, REBT groups are also process-oriented in that many of the in-group exercises will ask students to address how they are feeling and thinking at that moment. Identification of these thoughts will also assist in generating alternative views and accompanying adaptive emotions and behaviors.

Smead (1995) discussed three different types of groups for children and adolescents. Even though they were not formally designed as groups through which to run REBT, we believe that REBT can potentially play an important role in these group typologies in facilitating emotional and behavioral change. As such, we will briefly discuss these below.

Counseling/Therapy Groups

Here, the focus is on behavioral and emotional change. Groups can deal with general, wide-range problems or can be geared towards specific issues: divorce, relationship issues, grief. These are the groups that we believe REBT is most closely associated with and they may assist students in developing better coping strategies and a healthier way of looking at the world. The more general groups may be for students who are just having a difficult time on a fairly regular basis, while in the issue driven groups, students are aware of the content focus of the groups. General groups are often helpful, as

students get to hear peers work through an area of difficulty (e.g., college selection) that may not currently be an issue for them, but may become one in the future, at which point they will hopefully be able to recall the effective solutions of their peers. Content specific groups are helpful because students hear and help others who are at varying stages of distress when exposed to similar environmental stressors. They help students see that they are not alone, they are not the only ones experiencing difficulty, and it normalizes their affective experiences and may provide a resource for support outside the structure of the group.

Task Groups

Task work groups strive towards a specific goal that is not necessarily emotional in nature, but may be more of the academic/achievement sort. These tasks may be specific group tasks (e.g., create a violence prevention program), or all members of the group may be working towards the same task (e.g., SAT preparation). While this type of group is more practical in nature, we also focus on the emotional components that may interfere with working towards the task. REBT may assist in helping clarify which goal(s) to work on (e.g., college selection) and identifying potential practical and cognitive/emotive blocks ("it's too difficult") to goal attainment. We have found that these groups work better if they have a clear objective and a limited time frame in which to achieve that objective. At the beginning of these groups, group leaders may serve as a facilitator in helping the group clearly identify and define the goal, identify the irrational beliefs that lead to self-defeating, goal impeding extreme negative emotions and behaviors, restructure irrational to rational beliefs, and brainstorm effective strategies to meet this goal. At times, students may wish to select strategies that are impractical in nature and the REBT group leader may help them examine all potential solutions and evaluate which ones have the highest degree of success, are practical, and are acceptable to the group philosophically. This last point we believe is important as the REBT group leader will work to make sure the tasks chosen have a high degree of acceptability on the part of the group members, as low acceptability will lead to low effort towards goal attainment. After selecting an intervention, task groups will assign specific tasks to individual members of the group.

Much REBT group work has students engage in "risk taking" or "shame attacking" exercises, often done to help socially anxious students overcome their need for approval. In task oriented groups, we encourage students to go "out of their comfort zone." While not necessarily the goal of the task oriented groups, this is consistent with other aspects of REBT. Students are encouraged to select a task they are not necessarily comfortable with, which helps promote risk-taking. At the same time, we do not have group members select tasks that have a low probability for success. Given that these may be a group task (i.e., one task for all members to achieve), we try to assist students

in achieving the task. If groups, either as a whole or individually, fail to achieve the selected goal, the REBT clinician will use this as an opportunity to discuss feelings and cognitions, differentiating between healthy and unhealthy responses to the lack of goal attainment. That is, working towards more self-acceptance and avoiding self-defeating beliefs. If an individual is allowed to select a task that they may not be particularly well suited for, this may lead them or the group to blame the individual for the failure to achieve the goal. While this may be true and could be used for further discussion about managing disappointment, if the goal of the group is to successfully complete a task (e.g., develop a conflict resolution forum), the group leader will help the group work towards that goal, while continuing to educate group members about the core concepts of REBT.

Psycho-education/Guidance Groups

These groups work with "at-risk" populations. This may involve students who are at risk for a number of potential disorders and may take on less of an academic focus as Task Groups. This could include dealing with students who are at risk for eating disorders, drug and alcohol abuse, or may possibly involve AIDS education. In some settings, these may be students who have shown some of the early warning signs of developing a disorder but may not be eligible for formal services at this point. In these groups, REBT assists students in overcoming faulty thinking that may put these students at risk, developing frustration tolerance, and in increasing their ability to engage in consequential thinking. Education is a major part of these groups and the REBT clinician can better serve these groups if they have a good balance of knowledge of the theory of REBT along with knowledge about the specific area that students need guidance in. Additional work can be done with families to reduce the exposure to factors that may elicit risk-taking behavior. As an example, for students who are at risk for drug and alcohol abuse, these groups may focus on helping students learn how to express their feelings, develop effective coping skills to resist peer pressure and learn strategies on how to interact more effectively with others. At the same time, children and families will also receive comprehensive information on drugs and alcohol and learn about the dangers associated with them. In family based sessions, these programs may involve parent training, family skills training, and family self-help groups to learn how to reinforce the lessons at home.

Developing a Therapeutic/Working Relationship with Children and Adolescents in Groups

We have found that the greatest challenge facing clinicians working with children and adolescents in groups is to establish the therapeutic alliance. The three main components of the therapeutic alliance are: (1) agreement on

the goals of therapy; (2) agreement on the tasks of therapy; and (3) the relationship bond. Despite the importance paid to the topic of the therapeutic alliance (also referred to as the working relationship) with children, very few empirical studies on the topic exist. Unfortunately, while we have a rich, voluminous literature on the therapeutic alliance with adults, we currently know much less about this topic with children.

What is exceedingly clear about developing the therapeutic alliance is that it is a far more difficult task when attempted with children and adolescents than when done with adults, and may be even more difficult in a group setting. DiGiuseppe, Linscott, and Jilton (1996) have identified the two main barriers to forming the therapeutic alliance with children and adolescents: (1) most children and adolescents are mandated to therapy; and (2) children and adolescents usually enter therapy in a pre-contemplative stage.

Elkin (1983) describes how difficult it may be for the clinician to keep members interested in the group. The level of motivation for change of children and adolescent in REBT group therapy is seen as an important moderator of treatment effectiveness. Most children and adolescents entering therapy do so against their own will as they are usually brought into therapy because they present with externalizing problems that are disturbing others (peers, teachers, family). For this reason, they generally do not believe they have a problem, do not wish to change, and may be completely unmotivated for treatment. This presents a major obstacle to the process of establishing therapeutic goals with children and adolescents, which is the first aspect of developing the therapeutic alliance (DiGiuseppe et al., 1996).

DiGiuseppe et al. (1996) have developed a cognitive-behavioral approach towards motivating children/adolescents to change based on the work of Prochaska and DiClemente (1988; as cited in DiGiuseppe et al., 1996). We believe that their approach has important implications when working with children and adolescents in group therapy as well. The approach utilizes a Stages of Change Model, which lists the five stages of change a person goes through as (1) pre-contemplative; (2) contemplative; (3) preparation; (4) action; and (5) maintenance. Students in the pre-contemplative stage have no intention of changing and usually do not recognize the issue at hand as problematic. Once the student reaches the contemplative stage, he or she is beginning to perceive a problem and may be seeking help. Then, during the preparation stage, the student intends to make some immediate steps toward change and has often already begun to do so. By the time the student reaches the action stage, change has occurred. Finally, in the maintenance stage the student is working toward sustaining the changes that have been attained. In an on-going group format, you will have students at varying stages of change who may be able to provide insight for their peers as to how change will benefit them.

Most people entering therapy have reached at least the contemplative stage, while, as was mentioned earlier, children and adolescents, like other mandated patients, enter the group at the pre-contemplative stage and, therefore, do not

perceive any problems. This is especially problematic in a group setting, as groups rely on active participation of members.

Although most approaches to establishing the therapeutic alliance focus on the development of the relationship bond between the therapist and client, cognitive-behavior approaches stress the importance of discussing goals with young clients in an open and frank manner. It is important that therapists seek to understand how the children and adolescents feel about these goals and target behaviors. This is a crucial step when working with children especially considering that these goals are almost always set by others and are likely to be different from, or even completely contradictory to, the child or adolescent's own internal goals. According to DiGiuseppe, et al. (1996) Jilton, "helping the children to explore the consequences of their behaviors and emotions and alternative ways of feeling and behaving, can help formulate the goals of therapy," (1996, p. 90). This can be an important step toward bringing children and adolescents from the pre-contemplative stage into the contemplative stage. In a group setting, this provides a unique interactive opportunity for other group members, as they may be able to point out consequences that the child or the therapist may not have been able to identify.

When working with children and adolescents, it is also important to recognize that age and developmental level can affect which aspects of the therapeutic alliance will be most important (DiGiuseppe et al., 1996). Agreement on the goals is likely to be most important with adolescents. However, establishing the therapeutic bond is more important in groups of young children (DiGiuseppe et al., 1996). Therefore, when working in groups of children it is often helpful to begin and end the group with an engaging task or game. Wilde (1992) suggests trying the following techniques: (1) each child writes something describing himself/herself, then the leader reads the descriptions and the children have to guess which belongs with whom; (2) play Simon Says with the group leader as Simon; (3) each child names his/her favorite song, movie, sport, etc., and explains why they like it; and (4) the child describes his/her feeling metaphorically like the weather. These are just some of the techniques that can be used to help establish the bond between the child and both other children in the group and the group leader.

Assessment in REBT Child and Adolescent Groups

We propose that assessment should be an on-going part of the group therapy experience; that is, before, during, and after treatment. Involvement of data collection at multiple data points increases the responsiveness of the intervention to meet the needs of the students, assesses effectiveness of intervention, and examines the stability over time and situations. As the group leader may alter the course of the group content to meet the focus of the group, we recommend that assessment should also be catered in consideration of the developmental level of the child to be able to assist in treatment modifications as

well as to allow the clinician to evaluate therapeutic change. We will briefly discuss some recommendations for standardized mental health batteries that we have found useful in working with children and adolescents, followed by more specific recommendations for REBT groups.

Standardized Batteries for Assessment

A review of all evaluation measures that may be beneficial for children and adolescents in group therapy is beyond the scope of this chapter. However, we would suggest that for general problem groups, the group leader consider a broad based measure, like the BASC-2 (Reynolds and Kamphaus, 2004) or the CBCL (Achenbach and Rescorla, 2001), while for more of the content specific groups, the group leader consider a measure that addresses the content of that group (e.g., the CDI [Kovacs, 1992] for Depression or the Revised Fear Survey Schedule for Children [Ollendick, 1983] for childhood anxiety).

Given that group therapy takes place with and fosters interactions with peers, we believe that it is important to know how a child understands the social expectations for their behavior as well as others. Literature on children's social goals has demonstrated that children who are "liked" report prosocial, effective, relationship-enhancing strategies and friendly goals, while rejected children have a tendency towards more aggressive and unfriendly strategies (Crick and Ladd, 1990). As such, we recommend a measure that assesses social perspective taking, such as the Self-Perceptions Inventory (SPI) (Soares and Soares, 1999), which describes the current affective dimension of children and adults primarily in regard to themselves and their relationships with others (Plake et al., 2003).

An area of recent exploration with regards to children and adolescents is the concept of emotional intelligence (EQ), as children with high EQ are believed to be better able to regulate their emotional distress and handle adversity more effectively. This is a concept that we believe is key to REBT work with children and adolescents and may be something that a clinician wishes to assess in an REBT group. The Bar-On Emotional Quotient Inventory: Youth Version (EQ-I:YV) (Bar-On and Parker, 2000) has a long version (60 items) and short version (30 items) self-report instrument that measures EQ in ages 7 through 18, yielding an overall EQ score which is subdivided into scores on four domains: Intrapersonal, Interpersonal, Stress Management, and Adaptability.

Finally, it is very important to assess students' irrational thinking. More specifically, this allows us to evaluate how effective the REBT component is with regards to changing unhelpful thinking, while also serving to assist in group treatment direction. With regards to irrational thinking in children and adolescents we recommend the Child and Adolescent Scale of Irrationality (CASI) (Bernard and Cronan, 1999). The CASI is a self-report measure of irrational beliefs of children and adolescents, which yields scores on six scales, including self-downing, dependence, conformity, demandingness,

low frustration tolerance, and discomfort anxiety, in addition to a total irrationality score. The sample utilized in the standardization of the CASI consisted of 567 children and adolescents grades 4–11 and ages 10 through 17, and the authors report good internal reliability for the revised edition of the CASI.

General Cognitive Behavioral Assessment Guidelines

Developmentally younger children may have difficulty in problem identification, emotional labeling, and introspection and require a slower pace, experiential exercises, and games to enhance assessment. That is why assessment in groups with children and adolescents is on-going in nature, allowing the clinician to gear assessment towards a student's current emotive, cognitive, and behavioral functioning. Asking students to recall events that occurred subsequent to the last session may be difficult. A relatively simple approach to collecting data about events occurred that has a greater likelihood of being accurate, is to have students complete an "emotion log" (see Appendix C). Another factor to consider in assessment is whether or not the students' behavior is manipulative in nature. That is, do students engage in these behaviors to change something in their environment (parent/teacher behavior) or do they perform these behaviors for endogenous reasons, be they biological or cognitive in nature? These logs (and the consequences received for behavior) may help in understanding this.

Prior to intervention, we have found that assessing problem-solving skills and deficiencies is important given that the solutions often selected by children and adolescents are poor. The REBT group therapist may want to determine whether the student knows effective ways of behaving but due to their irrationality they do not behave appropriately, or have they not learned alternative problem solving options. The direction you take clinically may vary dependent upon whether or not you need to teach emotional along with practical problem skills.

Later on in the group process, the group leader may utilize group exercises (discussed below) to assess whether or not a student has learned more effective, healthy ways of thinking and behaving. A rational role play in the group setting may be a way to assess the students' overt behavior as well as to determine whether they are able to think and therefore behave more rationally in this role play.

Core Content in REBT Groups with Children and Adolescents

As indicated earlier, the focus of the REBT group when working with children and adolescents may vary as a function of the developmental level of the students that comprise the group, the objectives of the group, and the presenting problems of the group members. What follows below are some

general areas that we have found are helpful for a group leader to consider when running groups as well as some group exercises and strategies that the group leader may wish to incorporate.

Obviously, the group leader would benefit from having a strong conceptual understanding of REBT and its techniques utilized as a mechanism of change. With student beliefs at the core of this group change process, the group leader may wish to distinguish between irrational evaluations and appraisals of misinterpretations (inferences, absolutes, evaluations). Depending upon the developmental level of the child, REBT practitioners could target for change: the distorted interpretations of reality ("They'll never like me"), the absolute ("I need friends to like me all the time") or evaluative beliefs ("It's awful that they don't like me"). Conceptually, these three cognitions are very different and the group process allows for the leader and the group members to effectively target one or all types of beliefs systems.

The distorted interpretations of reality (incorrect conclusions/predictions) are an example of a point in the therapeutic process where group therapy may be more effective in treating these beliefs than individual treatment. Peers are a great source of data collection and feedback and may help provide evidence that contradicts the belief. With regards to the challenging of absolutes and derivative evaluative assumptions, group therapy can be very helpful in that peers who share common absolutes and irrational evaluations can be helped by their peers to see that they are not alone in this experience. Often, hearing these evaluative beliefs come out of the mouth of peers may help them see how faulty/unhelpful that way of thinking truly is. In addition, the group therapy approach may expose children to peers who have successfully changed different types of cognitions and as such they may be able to benefit from this model.

We encourage the group leader to discuss the relationship of emotions, cognitions, and behavior early on in the group therapy process. We believe this is a key to facilitating change, as we have yet to encounter a child who enters group looking to "change their faulty thinking." They come, as stated earlier, because they have a problem (emotional or behavioral) or are perceived as having a problem by another, not to change cognitions. Therefore, we believe it is key for the group leader to demonstrate the role of cognition in emotion and that other options are available to students in terms of how we feel and behave.

Early on in the group, we present the idea that extreme negative emotions (such as high degrees of anger, anxiety, depression) interfere with overall healthy functioning and can transform reasonable students into those who say and do things they would rather not and develop problems at school, at home, or with friends. We might facilitate this conversation by asking group members to recall the last time they made a bad decision. We then will ask them what they were thinking and feeling when they made that decision and whether they ever let what they felt, emotionally, make the decision for them. We have found that students are pretty good at recalling bad decisions and

once one student is able to identify the role their affect played in this decision it opens the doors for their peers. We have also used video examples ("The Simpsons", "Spiderman") to help show how people may make bad decisions when they are extremely upset. We emphasize that stress, anxiety, anger, and depression interfere with their ability to make smart choices and may cloud some options, making their capacity to choose the best option unlikely. We help students see that while extreme negative emotions are normal, they are undesirable.

Early on in the group process, we point out the distinction between non-hurtful and hurtful emotions. Non-hurtful emotions involve students dealing with difficult situations when they are annoyed, irritated, or aggravated. These students are able to problem solve and manage things effectively in difficult situations. Whereas hurtful emotions involve escalating conflict, name calling, and a number of emotional (anger, depression, anxiety) and behavioral (avoidance, aggression) manifestations. As most children are aware of it, we will often use the television show "Star Trek" as an example of the continuum of emotions that one may experience. On the one hand you have Captain Kirk who makes very impulsive, emotionally charged decisions, while at the other end of the continuum, you have Mr. Spock, whose species (Vulcans), are highly logical and do not experience or express emotions. We make sure to highlight that neither approach is better, as it is expected that students will "feel" something when adversity occurs, we just work on helping them experience more of the healthy, appropriate negative emotions. We try never to give the impression that feeling bad is abnormal nor bad.

Doyle (2003) offers some suggested exercises for group settings that we think are excellent in general and that have specific applications to the REBT group therapy process with children and adolescents. We have highlighted a few below.

- **Introduction Exercises:** Have students finish the sentence, "One thing I'm hoping to gain from this group is . . . ." We have found that this is helpful in terms of goal setting and it also allows children and adolescents to hear what their peers are looking to work towards and may serve to further allow other group members to help them in the group process.
- **Comprehensive Self-Inventory:** Have each student use paper and pencil to assess their strengths and weaknesses; have them start on the weaknesses which they think might be remediable. With younger students you may have them draw pictures. This approach again helps with increasing insight into their problem as well as helping with goal selection.
- **Expectations/Fears:** Each student is asked to report his/her expectations and fears about participating in the group. We find this to be particularly helpful when working with children and adolescents, as it helps normalize cognitions they may be experiencing and may also allow for clarification of misperceptions of the group process that they may have. We also see this as

a way of further clarifying specific rules of the group therapy process that are often concerns of students (e.g., confidentiality).

- **Best and Worst Day:** Here, group members are asked to draw a composite of their best and worst day in the past month or so and share these with the group. The group leader facilitates a conversation about what kinds of experiences make a "good" day and what are the common ingredients in a "bad" day. The group leader may help in looking for patterns of thinking that may differentiate between the two.
- **Learning from Mistakes:** Students are asked to think of a situation that they believe they did not handle particularly well. More specifically they are asked to close their eyes and try and recall the feelings and thoughts that they had at the time. They are then asked to write them down and share them with the group and allow the group to help them identify any thought distortions. The group leader may have them discuss what they would have liked to have happened and have the group develop a list of rational beliefs and coping statements that might have been helpful.
- **Strongest Hour:** This we usually try to do right after the Learning from Mistakes exercise. In this exercise, students are asked to recall a time when they relied primarily on themselves to deal with a difficult situation. We ask them to bring the situation clearly to mind by recalling the details (the setting, the people involved, the time and place, the things said, etc.,). We help them experience both satisfaction and pride about their successful handling of themselves in the situation. This may work particularly well for students with Low Frustration Tolerance, as they may see that they can handle adversity and things are not too difficult. We ask them to recall what they told themselves during that situation and discuss how they can increase the likelihood of thinking and behaving that way again in the future. This is a very powerful exercise for child and adolescent groups as peers hear of the success of their colleagues, which may serve to motivate them.
- **Dear Dr. Rational:** Each student writes a brief letter about one of their problems, as though they were writing to Oprah or Dr. Phil (the Dear Abby reference gets lost on the youth of today). These letters are then passed around the room and each person answers someone else's letter in writing. We encourage that they help each other come up with a practical solution as well as a solution that utilizes the rational thinking they have been developing.
- **Evidence Against IBs:** In this exercise for older students, on one side of an index card we have students write down their irrational beliefs, while on the other side, they write five negative things that have happened to them because they think this way. Students are then encouraged to read the card several times a week to remind them of how that belief is not working for them.
- **Anonymous Disputing:** This exercise occurs with students who possess a good understanding of the REBT framework, and most specifically of disputation. Students are asked to write down their irrational beliefs and pass them forward on a piece of paper to the group leader. The group leader

reads them aloud and the group as a whole provides challenges or disputes for them. We have modified this at points to use a small ball as a "hot potato" exercise, in which group members throw the ball to their peers to try and involve all in the art of disputation.

- **Shame-Attacking:** This is one of the more well known of the REBT techniques and involves having individuals do something or tell the group to do something which they would normally never do (typically for fear of others' negative reactions). We have found the group format to be an excellent forum for this in that peers support one another and also do not let each other "off the hook" for non-completion of the exercise.
- **Round of Applause:** Have students applaud something or someone they are grateful for. We have used this exercise at the beginning and the end of the group, around holidays (Thanksgiving or New Year's resolution) and have found this to be a very fun and enjoyable exercise. The group leader leads standing ovations, whistles, cheering for positive things/people, and helps refocus the group members on positive things in their lives, which is contrary to what the focus is of many therapy groups. We actively reinforce group participants.
- **Positive Talk:** Usually done in conjunction with the round of applause and it often serves the same purpose. Each student is asked to talk positively about themselves for a full 2 minutes. (If they qualify or modify what they say, they get a penalty of an additional 30 seconds).
- **Role-Play:** Group members are asked to think of upcoming situations that they are apprehensive about (e.g., exam, social event) and act them out with other group members. Students can use this opportunity to provide feedback on behavior of their peers as well as offer hypotheses as to what they are experiencing cognitively.
- **Reverse Role-Play:** This exercise is usually done after group members are familiar with one another. In this exercise, one group member takes another's irrational beliefs and holds onto them rigidly and forcefully. The student who's IB it is has to try and talk the role-player out of the firmly held belief. This reinforces vigorous disputing for the individual and may further provide a model for their peers.
- **Hotseat:** One at a time, group members take the "seat" and as many participants as want to give feedback (both positive and negative), while the student remains silent. This helps students to learn to accept feedback from others and then as a group we process how the student felt and the validity of some of this feedback.

Parenting and REBT Groups

Although two other chapters in this book deal with parents, we thought that it would be appropriate to address a few specific aspects of REBT parenting groups. REBT practitioners appear to recognize that "disturbed"

parenting styles can produce problems in relatively "normal" children (Bernard, 1986; Bernard and Joyce, 1991). Often, an effective means of parent training can take place in a group format. Group sessions are used for more didactic teaching of the rationale and components of specific child-management skills, to be practiced at home between sessions.

The rationale for REBT based parent training group interventions includes: giving parents a source of support and a reference group through which they may see that they are not alone; providing knowledge and information regarding parental management strategies; and having parents become familiar with the REBT model and the role that cognitions and affect can play in parenting. We have found that training techniques that are mainly behavioral in nature, while they do have an impact upon behavior and disciplinary problems in parent-child interaction, do not change parenting attitudes, beliefs, and emotions. The REBT parent training groups emphasize both affective/cognitive and behavioral/disciplinary domains.

Beavers and Hampson (1990) report that group parent training may have led to a significant enrollment of people who would probably not be seen in clinics or in individual therapy. Although parents may become defensive if weaknesses are pointed out in front of others, the goal of a parent training group is education not embarrassment. For many of these clients, "education" and training" become acceptable descriptors of skill enhancement, since they do not "need" counseling or therapy. Wright, Stroud, and Keenan (1993) reported that group parent-training is more cost effective than individual and described essentially equal gains with both group and individual parent training (Brightman et al., 1982).

Furthermore, Bernard (1986) proposed that overly permissive child-rearing practices are based on a number of unfounded assumptions ("children should never be frustrated"; "I must always be loved and approved of by my child") and that they may lead to self-centered, demanding, easily frustrated children, with low self-esteem. Additionally, parents who are overly rigid, accusing, and unaffectionate hold a collection of faulty ideas ("Children should not disagree with their parents"; "Praise spoils a child"; "Children must do well and behave correctly all the time") which can lead to their children becoming anxious, tense, guilty, and depressed (Bernard, 1986).

REBT theorists (e.g., Ellis et al., 1966) have for many years described how certain parenting styles, along with parental emotions, hinder the children's development. Bernard and Joyce (1991) argued that child psychopathology results from an interaction of child temperament with parenting style and, in particular, that adaptive development occurs because of a good match between the parents' child raising approach and the child's temperament.

We would like to highlight two examples of research performed in a group format regarding parenting. Greaves (1996) investigated the effect of Rational-Emotive Parent Education on the stress of mothers of young children with Down syndrome. Greaves compared an REBT methodology with an Applied

Behavioral Analysis group and a control condition. The REBT condition reported a significant reduction in level of stress in comparison with the control and with the Applied Behavior Analysis condition in the Greaves (1996) study.

Terjesen (1998) compared the efficacy of a combined Rational-Emotive Behavior Therapy (REBT) and Behavior Management (BM) approach (REBT/BM) with a BM approach in reducing parent stress and increasing child compliance with thirty parents of children receiving special education services. Parental stress, parental emotional functioning, and child behavior were evaluated at onset and completion of 4 weekly group treatment sessions of 90 minutes each, and again at a 4-week follow-up for all three groups. Support was generated for the usefulness of REBT in a comparison with no treatment on all dependent measures at posttest and on all measures with the exception of child compliance at follow-up. While the results did not provide support for the REBT group intervention being more effective than the BM intervention in terms of child compliance and parent emotional functioning, the combined group (REBT/BM) reported higher life satisfaction at follow-up than BM. Given that behavior management groups are the highest standard or barometer for group parent training that we currently have, the fact that REBT stood up to this standard provides some support for its further use and investigation. For an example of the REBT group format used by Terjesen (1998), see Appendix D.

REBT Group Research with Children and Adolescents

Ford (2005) conducted a meta-analysis of 25 studies using group REBT with children and adolescents. The studies analyzed used REBT in the treatment of various disorders including anxiety, adjustment disorder, and learning disabilities, as well as in the normal population to help improve areas including self-esteem, study skills, and school discipline. Preliminary results of this meta-analysis found a moderate effect size of 0.59 in REBT group treatment of children and adolescents with anxiety. Furthermore, an effect size of 0.63 revealed that REBT group treatment was significantly more effective than a control group in treating anxiety. However, these effects are lower than those observed in adults (Ford, 2004).

A meta-analysis of REBT group therapy studies with children and adolescents conducted by Ford (2004) revealed a mean effect size of 1.12 across the REBT group therapy treatments as compared to a mean effect size of 0.81 across the REBT individual therapy treatments, indicating that although both methods were effective, group therapy led to greater gains.

In addition, it has been demonstrated that REBT and CBT approaches are effective methods when used in groups of children and adolescents. For example, Kachman and Mazer (1990) studied the use of a group Rational-Emotive Education (REE) program in a sample of normal eleventh and

twelfth grade students. The results of this study indicated that the REE group experienced greater increases in academic effort, grades, and use of constructive defense mechanisms than the control group.

In a study of group CBT with African-American seventh and eighth grade students, Sapp et al. (1995) demonstrated that CBT effectively reduced the number of days tardy, and number of absences, and increased grade point average in students identified as being academically at risk.

Furthermore, a study by Shannon and Allen (1998) indicated that group CBT is more effective than attention control at improving the math grades of African-American high school students enrolled in Upward Bound, a program aimed at increasing college enrollment of high-school students from low-income families.

Together these results provide significant evidence in support of the use of REBT and CBT in group treatment of children and adolescents across multiple disorders and presenting problems. Further research is needed to allow group leaders to understand specifically what it is about the REBT group therapy process that leads to change in working with children and adolescents. Clearly, written treatment manuals that lend themselves to research replicability and that have high practical utility with group leaders are further warranted. As a whole, REBT as a therapeutic approach works well with children and adolescents, and it is hopeful that we will continue to see further applications of REBT group therapy techniques with varied populations of children and adolescents.

Appendix A: REBT Study Group

Lecture One Outline

- Introduction of self and *goals of workshop series*
- Have students complete attached questionnaire. Discuss what they wrote. This should take up the most time.
- Explain rationale behind surveys. INSURE CONFIDENTIALITY!
- Go around the room, have students introduce themselves and discuss areas in which they are **experiencing difficulty** in school work, write these on a board/flip chart and try to categorize them.

Didactic/Interactive Discussion

Using the lecture notes below, lecturer is to discuss the importance of studying. Brainstorm this with them:

WHY SHOULD I STUDY?

Because studying can help you achieve your goals. The more you know the more you can do. Good study skills can help you succeed:

In School. Learning how to study can make you a better student.
In the Future: Many skills that make you a success in school can also help you succeed on the job.

The goal of the first lecture is not to get students into some of the specifics of REBT, but more to demonstrate the role of attitude towards studying and how these attitudes can and do affect how we prepare and how we perform.

- **Negative emotions** (such as stress, anger, anxiety) interfere with studying behavior. Brainstorm examples that they can think of when they get frustrated while preparing for an exam/paper or while taking a test.
- **Additional Stressors:** Sometimes we may experience emotions from a multitude of other stressors in daily life-family, friends, etc and regrettably, these can spill over into the other role of student.

Bad Thoughts Can Interfere with Overall Study behavior:

- Discuss thoughts that they may have and how these can and do interfere with their study preparation.

EXAMPLES:

1. I **MUST** do well or very well, at all times!
2. "Stupid is as Stupid does."When I act weakly or stupidly that makes me a bad, worthless, stupid person.
3. **I CAN'T STAND IT** when people are not fair.
4. **I CAN'T STAND** really tough tests.
5. **It's TERRIBLE and AWFUL** if I fail a test or do poorly.

Nonhurtful vs. Hurtful Thinking

- Nonhurtful thoughts involve approaching tests and studying in a healthy manner that helps students prepare EVEN IF THEY DON'T LIKE STUDYING.
- Hurtful thoughts lead to avoidance, procrastination, failure, etc. This often can cause long-term difficulty to the student.

Discuss Benefits of Working On Your Own Thoughts.

Appendix B: Pre-Group Contract for an REBT Group with Students

- I agree to attend all group sessions. If I will miss a group session, I will discuss this with the group leader in advance.
- I agree to actively participate in all group sessions and activities.

- I agree to actively work toward reaching my goals.
- I agree to complete all group assignments.
- I agree to be honest at all times in the group, both with myself and with other group members.
- I promise that I will not be physically or verbally abusive to either the group leader or other students in this group.
- *Confidentiality*: I agree to respect the privacy of all other students in this group. I promise not to discuss anything said or done in this group, except during group sessions. I understand that this applies even to talking to other group members when outside the group. The rules of confidentiality have been explained to me, and I understand and accept these rules.

I _____ (Print Name) have carefully read all the above rules about joining this group. I understand these rules, including confidentiality; I promise to follow them, and I accept that there will be serious consequences if I break any of these rules.

_____

Signature

Appendix C

Emotion Log

Student Name: _____ Date: _____

Date	Time	Activating Event	Beliefs	Emotion	Intensity (1–10)	Duration	Action
June 12	12:00	Parents said "no" to sleep-over	"It's Not fair"; "I should be allowed to go"	Angry	8	45 minutes	After yelling, I went and watched TV, did e-mail, and played with my older brother

Appendix D

REBT Parenting Lecture One Outline

- Introduction of self and *goals of workshop series*
- Have parents honestly **complete questionnaires** and answer questions individually
- Go around room, have parents introduce themselves and discuss the areas in which they are **experiencing difficulty** as parents. Write these on a board and try to categorize them into internal stressors, external stressors, and child behavioral difficulties
- Have parents **complete goal-setting sheet (Handout 1)**

Didactic/Interactive Discussion

Using the lecture notes below, lecturer is to discuss the relationship of emotions to behavior management and is to regularly be a facilitator in involving parents in the discussion. The goal of the first lecture is not to get parents into some of the specifics of REBT, but more to demonstrate the role of cognition in emotion and how there are other options in how we feel and behave.

- **Negative parental emotions** (such as anger, anxiety, depression) interfere with any type of behavioral strategies and can transform the most reasonable caring parent among us into harsh parents whom may say things they would rather they didn't, and develop gaps between us and our children.
- **Preparation for parenthood** is often poor, and especially for parental emotions. More so, we typically will get feedback in feeding, dressing, and behavioral issues but never much training in working on our emotions.
- **Additional Stressors:** Sometimes we may experience emotions from a multitude of other stressors in daily life-work, marital concerns, financial concerns, and regrettably, these can spill over into our parenting role.
- **Developing Rules for Children:** Imparting personal, familial and societal rules onto our children is crucial to parenting, almost as crucial as understanding that no matter how explicit and clear our rules may be, children will march to their own tune. This breaking of rules should be understood, yet oftentimes this can lead to a build-up of stress and emotions within ourselves. Catch you child following the rules and reward them justly, much like parents try to immediately punish the rule-breaking behaviors.
- **Admission of Emotions:** You make me so . . . . This is a lot of power to give children or others and may place us in a "permanent victim" type of role. Before we engage in any stress management training, we need to acknowledge that the responsibility of anxiety is within ourselves. Once we do that we see that anxiety is within our control and we can learn to manage our anxiety and improve our parenting ability and relationship with children. Children's misbehavior does not cause stress, rather it is the way that we perceive the misbehavior.

Stress Interferes with Successful parenting:

Stress, anxiety, anger, and depression interfere with your ability to make intelligent choices and may cloud some options and make your capacity to choose the best option unlikely.

- What happens when you direct your parental anger or stress at the children instead of at the inappropriate behavior?
- Child who withdraws, removes self from parents, or may put self down "I'm a bad person"
- May also get a parent who feels bad about expressing the anger, no one likes being the "Bad guy"

"My children only listen when I'm angry" or "I have no other choice but to get angry"

- These are frequent statements by parents, but these have faulty logic. Most of the time there are other choices, but those may be clouded or we may not be aware of the other options. We may have had poor role models ourselves growing up re: parenting skills and anger management.

Nonhurtful vs. Hurtful Emotions

- Nonhurtful emotions involve dealing with children when you are annoyed, irritated, or aggravated. These parents are able to problem solve and be assertive in focusing on their children's behaviors. Additionally, children are more likely to "hear" their parents when they approach them at this level as there is no need to be defensive.
- Hurtful Emotions involve escalating familial conflict, name calling, emotional and physical abuse. This often comes from reactively responding to the child as a person rather than to the child's behavior. This impulsive response can lead to a lowering of the self-esteem of the child and experiences of guilt and anxiety.
- Work on having parents understand the concepts **that: All children misbehave and My children will misbehave.** Oftentimes parents have difficulty understanding this in the sense that they think that they should accept these misbehavior and not try to correct them. That is not true! We would rather have parents accept the children but not the misbehavior. Firm consistent rules must be implemented unangrily to change the misbehavior.

Not taking your children's behaviors personally:

- Sometimes we tend to think that when our children behave this way, they are doing it **TO** me, when we think this way we are setting ourselves up for anger.

Summarize workshop

- Develop individually based **homework assignments** based upon what parents have reported during the discussion. Homework should involve

writing and tracking one's thoughts and emotions during the week and the circumstances involved around them.
- Present the REBT library and encourage parents to borrow REBT books or audiotapes.

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