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A Developmental, Rational-Emotive Behavioral Approach for Working with Parents

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The work of Albert Ellis and other Rational-Emotive Behavior Therapy (REBT)-oriented practitioners summarized in this chapter represent some of the earliest work published in the 1960s of cognitive-behavioral theory applied to understanding the influence of parents and parenting style on children's adjustment including problems of childhood. This work has led to the incorporation within REBT child treatment and adolescent treatment of a focus not only on the child but on the parenting styles of the child's parents and, more broadly, on the effect that overall family functioning has on the child.

Ellis et al. (1966) wrote about the role of parental beliefs about their children and how their beliefs influence their children's view of the world in "How to Raise an Emotionally Healthy, Happy Child."

> The worst care parents can provide their children is that of blaming them for their mistake making and wrongdoing. Parents or other early teachers usually help a child plummet down the toboggan slide towards disturbed feelings and behaviors by doing two things when he (child) does something that displeases them: (a) they tell him that he is wrong for acting in this displeasing manner, and (b) they strongly indicate to him that he is a worthless individual for being wrong, and that he therefore deserves to be damned and severely punished for his wrongdoing.

As well as calling for parents to communicate rational messages to their children, included in this work is a range of practical advice for parents on how to overcome a variety of their children's common childhood problems.

Another example of REBT, cognitive-behavioral theory applied to parenting is the pioneering text authored by Paul Hauck in 1967, *The Rational Management of Children* (1967). In this book, Hauck identified different irrational beliefs of parents that lead to distinct positive and negative styles of parenting.

Unkind and firm patterns ("unquestioning obedience toward authority combined with a kick in the ego) involve parental behavior of setting rigid rules, never letting their child question their authority, focusing on the wrongdoing of their child, attacking the personality of their child, strictness and little praise ("Children must never disagree with their superiors").

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

Kind and firm child-rearing practice is the preferred and skilled form of parenting. Parents who raise their children in this fashion talk and reason with them about objectionable behavior, focus on the behavior but do not blame the child, set limits with clear consequences for rule violations, set punishment that is related to rule learning, not blame, sometimes frustrate their child when necessary, apply reasonable pressure to teach self-discipline and delay of gratification, never punish out of anger and frequently praise and show love.

Today, in their practice, REBT-oriented practitioners spend time with the parents of children discussing and challenging irrational beliefs of parents with a view to developing a firm and kind, authoritative style of parenting. Further, parent psychoeducation provides parents with an understanding of how their children's emotions and behaviors are influenced by their children's beliefs and includes ways in which parents can challenge and change irrational beliefs and develop more rational ones.

Bernard and Joyce (1984) identified irrational beliefs of parents which are associated with ineffective parenting, for example, "I have little ability to control my feelings when things go wrong at home" (a belief underlying general parent upset) and "my child must always behave the way I demand" (a belief underlying parent anger). Alternative rational parent beliefs were presented which form the foundation for effective parenting.

Rational-Emotive Behavior Therapy consultation, an intervention which aims to help an individual or organization which has identified a problem, and is characterized by collaborative problem solving, has been described in detail elsewhere (Bernard and DiGiuseppe, 1994; Joyce, 1990; 1994; Meyers et al., 1979). Client-Centered Consultation between the practitioner and parent-consultee provides the parent with new ways to help their child who is the (absent) client. Consultee-Centered Consultation addresses aspects of the parent's functioning and practice to improve the parent's management of their own thinking and behavior in their parenting role.

Rational-Emotive Behavior Therapy continues to offer a unique contribution to understanding and intervening with parents who report problems in their relationship with their children or whose children have been identified as having problems. This chapter brings together REBT approaches with recent advances in theory and research on the role of parents in their children's mental health and well-being. It covers problems from the milder end

of the spectrum, which may involve psychoeducation only, through to more complex dysfunctional family problems. It brings a focus on the emotional self-regulation of parents and its relationship to the child's emotional regulation. Not every psychological disorder of childhood can be covered in the chapter but disorders common at particular stages of development will be used to illustrate ways to work with parents in alleviating the problems of their children.

Recent Advances in Understanding Parent-child Problems

From the earliest days of psychology, the importance of parents in the emotional well-being of children has been emphasized. It has been conceptualized in different theoretical frameworks, from the psychoanalytic which proposed overriding unconscious influences, to strict behavior theories which stressed learning via precise reinforcement regimes. An influential theory concerning the primary importance of early parenting influences on children's socialization and adjustment is attachment theory (Bowlby, 1988). This theory evolved from ethology and identified children's inbuilt behavior systems which promote responsive care of the child from early infancy. According to attachment theory, the foundation of trust upon which all relationships depend are laid in the early years. Of particular interest to the current topic is that the central mechanism, which attachment theory proposes that moderates the development of the child's emotional life in the context of primary care, is a cognitive one, namely internal working models (IWMs). According to attachment theory, IWMs which evolve within the child's mind are internal representations of attachment figures and their likely responsiveness to the child's needs. Healthy experiences in infancy and early childhood lead to secure attachment mediated by positive IWMs. Attachment theory proposes that these IWMs can be modified over time by experience. Further, intergenerational studies have shown that adults' experiences as children (and hence their IWMs) influence their parenting behavior and, therefore, these cognitive patterns can be carried over into the next generation (Serbin and Karp, 2003).

The cognitive revolution of the eighties and nineties transformed the possibilities of understanding the role of parents and families. The cognitive-behavioral framework provided by REBT (Bernard and Joyce, 1984; Hauck, 1967, 1983; Woulff, 1983) allowed new methods of assessment and intervention with parents, especially regarding detailed beliefs about their parenting roles (Borcherdt, 1996). It emphasized rational parent beliefs and emotional self-management as a prior condition for children's emotional well-being. Woulff further demonstrated the problems that can arise when children are treated in isolation from their family context.

For many decades the history of interventions with parents, especially school-based interventions, was dominated by a behaviorist approach which

emphasized teaching parents behavior management skills in an approach known as parent training (Patterson and Dishion, 1985). More recently, theory and research have focussed on parent cognition and parent emotion from a variety of perspectives. Gottman et al. (1996), Eisenberg et al. (2002), Dukes et al. (2003) and Flory (2004; 2005) have all linked cognitive factors in parents to emotional outcomes of their children through the concepts of emotional intelligence, emotional regulation and empathy.

Gottman and DeClaire (1997) in an approach linked to emotional intelligence, introduced the concept of parent meta-emotion. In their research studies, they identified a sub group of parents who engaged in meta-emotion, a reflective capacity which enabled them to regulate their own emotions in a conscious and deliberate way. These parents were aware of their own emotions and how they thought and acted to self regulate them, and were able to help their children to name and identify their emotions, as well as guide them to become more self-managing. Parents who were able to do this were conceptualised as "emotion coaches" to their children. The far-reaching positive outcomes associated with emotion coaching in a longitudinal study of preschool to early school years children included better emotional self-regulation, higher levels of academic success, better social competencies and better physical health (Gottman et al., 1996).

These diverse approaches contribute to the field's recognition of the importance of parent cognition and its influence on parent and child emotion. A systematic means of assessing and intervening with parents is provided by a REBT framework which focuses on beliefs and proposes rational and irrational (helpful and unhelpful) beliefs of parents and children as core constructs. REBT also recognises that beliefs of both kinds can be shared by parents and children to create a family culture. Thus, parents and extended families may induct their children into shared ways of thinking that perpetuate irrational patterns across generations. Little has appeared about this in the literature but clinical experience indicates this as a fertile ground for further exploration.

In assisting parents to reflect on their beliefs REBT focuses on both *inferences* and *evaluations* but emphasizes the dysfunctional effect of irrational evaluations which operate as unacknowledged, philosophical belief systems. It is a binary theory which uniquely includes both appropriate and inappropriate negative emotions (e.g., parental sadness versus depression; parental annoyance versus parental rage; parental concern versus parental anxiety) (David et al., 2005).

Common Underlying Difficulties of Parents

Before describing REBT-oriented parent interventions, some common experiences of parents that need to be addressed early on in therapy are considered. REBT theory alerts practitioners to be on the lookout for parental *guilt*

and parental *low frustration tolerance (LFT)* as both are unhelpful states for parents and often contribute to the establishment and maintenance of the problems of their children.

Cultural values, family norms and individual personality characteristics may influence parents to hold perfectionist standards and, therefore, experience guilt about their level of perceived success as parents (and as human beings) especially when they rightly or wrongly perceive that their children are not turning out perfectly. Parents rarely volunteer feelings of guilt but easily acknowledge such feelings as part of their current and past experience. Such feelings are likely to be to the fore when their child has a serious problem that requires them to seek professional help. This secondary emotional problem of the parent needs to be acknowledged by the therapist in a supportive way that helps the parent to ease their anxiety about failure and criticism. It can provide an excellent opportunity to teach the ABCs of REBT which can then form the basis of the wider intervention, as illustrated below.

A	B	C
Antecedent Event	Beliefs (Helpful or Unhelpful?)	Consequences (Feelings and Behavior)
I think about my child's problem. (He is not settling well at bedtime and hasn't for years. He keeps running around until our bedtime).	I should be able to get him to settle down to sleep.	Anger
	What if he never improves?	Anxiety
	Other parents don't have this problem so there must be something wrong with me.	Guilt Behaviors: Yelling at the child. Blaming others.
	I am no good.	Crying, misusing alcohol.

A good first step to help the parent overcome their guilt is to acknowledge both their responsibility and its limits (they cannot control their child in every way), and to teach them to challenge their unhelpful beliefs and replace them with helpful beliefs such as:

My child's problem behaviour does not mean I am a totally bad parent or a worthless person.
My commitment to gaining assistance shows I am concerned and responsible.
Just about all parents feel guilty sometimes about their children. No parent can be 100% perfect in raising their children!
I can learn new ways to teach and help my child.

Low frustration tolerance (LFT) is a less recognised dynamic in parent-child relations. It can be particularly pernicious as parents with strong LFT frequently also project it onto their children, believing that their children "cannot stand" what is expected of them. Irrational beliefs associated with LFT in parents include:

My child can upset me.
I can't stand it when things go wrong at home.

I can't stand my child's behaviour.
I can't stand my child.
I don't need this!
It's awful to have to put up with this.

As with guilt, it is important to teach parents that their own beliefs rather than their child's behavior are at the heart of their upset. Teaching them that they are upsetting themselves about their child's behavior is a good way of introducing the ABC model. The next step in intervention to assist parents to overcome their LFT when they begin to work on their problems is to ask them to check on the evidence: how long have they in fact been "standing" the behaviours and difficulties they *tell themselves* that they cannot stand? Even if it is a short time (and often it is quite long) they can be helped to reframe their thoughts and beliefs about themselves and especially what they *think* they can stand. Injecting some humour into the disputation assists parents to laugh a little at their arbitrary thinking.

Steps in REBT Parent Interventions

The general goals of REBT interventions with parents involve teaching parents the cognitive-emotional–behavioral links in their own parenting role and in their child's emotional distress and problem behavior. Parents receive psychoeducation to understand their child's problem and they learn to use the ABCD model to improve their emotional self-management as parents. A REBT approach to parent interventions can be conceptualized in seven steps by which a parent, guided by a therapist, may help their child with emotional distress and behavioural difficulties.

1. Receive psychoeducation regarding parents' and children's emotions.
2. Learn the *kind and firm* rational parenting style. Practice observing their own levels of emotion and monitoring their emotional expression.
3. Practice observing their child's emotional states.
4. Practice communicating with their child about specific emotions.
5. Model emotional management for their child.
6. Guide their child through ongoing emotional and behavioral learning.
7. Reinforce their child's efforts.

This learning process will foster in the parent: awareness, empathy, proactive thinking and appropriate, authoritative leadership in their family. From the child's perspective, there is an experience of emotional validation and acceptance as well as a sense of safety and containment.

This chapter next highlights some developmental issues and then moves to problems in children of different age ranges and specific problems common in children and young people. Drawing on from developmental theory (Kegan, 1982) and from my clinical experience, I have formulated goals of

parenting appropriate to different ages. These goals are presented and some case illustrations have been provided.

Developmental Issues

When children demonstrate problems in affect and behavior, these problems are often set in a context of age-stage asynchrony (Kegan, 1995). Such asynchrony occurs when the developmental tasks a child is yet to master are not the age-appropriate ones. An example would be a child of late elementary school age who cannot differentiate fantasy from reality. Another example would be a teenager who would not accept the rules of play in team games. Therefore, while the age-related goals presented below represent the contextual demands on the child at a given stage, it is important in helping parents to assess whether the child is in fact still struggling to master a previous stage. Most parents whose teenagers are experiencing problems are trying to achieve the parenting goals of previous stages. Helping parents to understand realistically where their child's development is along this path can bring them to a clearer understanding of why their child is not coping in their life context. However, it is important to clarify which goals they could most appropriately work towards given their child's current needs. For example, a child may be 16-years-old but may not have basic understanding of emotions or any skills in negotiation.

Working with Parents to Help Children of Different Ages

Before presenting a systematic account of specific REBT interventions with parents, it is important to review some general principles in relation to parent involvement or participation in therapy. Decisions about working with parents may vary according to the age of the child. Therefore, three sections are presented, one for each age range: young children (3–7), middle years (8–12) and young people (13–17). *A useful guiding principle is that the younger the child, the more important it is to involve the parents where possible*. In assisting older children, decisions can be guided by the severity of the problem, whether it is manifested at home as well as school, the willingness of the parents to be involved, and the wishes of the young person.

In this context it is important to help parents understand the goals of parenting as guiding principles in the implementation of interventions. Parents will vary in their ability to articulate their goals but some basic points which need attention are presented in Table 1 below. With psychological interventions, the primary need of the child for emotional security is paramount and it is clear that parents do not always know how to provide this for their child or how to communicate it to them in verbal and non-verbal ways. All interventions with children and young people should attend to this basic need and ensure that the proposed intervention meets this need.

Table 1. General Goals of Parenting.

(1) Providing a safe, healthy and loving environment for their child, leading to emotional security and increasing independence.
(2) Guiding the child's behavior towards socially acceptable standards
(3) Teaching the child values, especially moral values.
(4) Providing interest in and support for their child's education.
(5) Supporting the child through phases of change.

Considerations When Working with Parents of Young Children Three to Seven Years

With young children, parents are much more likely to want to be involved as they are often still very open to learning about child rearing and how to do the best for their child. There is also the advantage of explaining to them that if they learn new skills these can carry over across the years of the child's development.

Table 2 sets out these and other reasons in a manner that can help parents to understand the need to become involved and appreciate the benefits of doing so.

It is important to spell out these perspectives for parents because there is no reason to assume that a parent coming for assistance with their child, is expecting to be involved themselves, especially at a level of working on, and possibly changing their own emotional self management. Central goals of parenting young children are presented in Table 3 below. The following case history illustrates the experience of a single mother in learning to intervene with her child.

Case Illustration: Marion and her Daughter Kelly

Marion was a single mother in her twenties and Kelly was her only child aged 3 years 11 months. Kelly attended crèche three half days per week while her mother attended a university course in professional training. She had previously attended family day care at 2 years of age. Marion had stated very

Table 2. Reasons to be Involved in Your Child's Treatment.

(1) You will gain a greater understanding of your child and his/her individual needs.
(2) You will have the satisfaction of helping your child to overcome the current problem.
(3) The bonds between you and your child can be strengthened as your child will know you do not reject him/her for having a problem.
(4) The skills you learn can be applied in later years with new problems should they arise.
(5) The experience of problem solving together can help the child understand your ongoing commitment to him/her.
(6) In the process of learning how to help your child you may gain greater understanding of yourself and establish new skills for application in your own life

TABLE 3. Specific Age-Related Parenting Goals for Young Children.

(1) Placing external limits on the child's behaviour
(2) Helping the child establish the beginnings of impulse control.
(3) Helping the child distinguish between fantasy and reality.
(4) Helping the child name and acknowledge emotions.
(5) Helping the child begin to understand others and their needs

clearly in the process of making the referral that she did not want to bring Kelly in but rather she wanted to learn how to help her child.

Kelly's Problem: Marion reported that Kelly demonstrated anxiety and fears, specifically her distress at separation and obsessive questioning and checking prior to attending crèche. Her withdrawal in certain home situations also concerned her mother and we agreed to work on alleviating this behavior.

The two relevant levels of consultation were explained to Marion, namely direct consultation for herself in regard to her parenting (Consultee-Centered Consultation) and indirect consultation for Kelly's problems (Client-Centered Consultation). Marion identified her own problem as: "My parenting of Kelly at the moment". She was experiencing anxiety but wanted to give Kelly "the confidence I never had". She identified multiple problems including separation anxiety, fears, tension, sleep disturbance, toileting and tantrums. While I indicated to Marion that each of the identified areas deserved our attention, she was firm in her decision that only certain ones were to be addressed by us. For example, toileting was "off limits" as she had decided to wait to address toilet training difficulties until other problems were alleviated. Therefore, we agreed to work together to alleviate Kelly's emotions and behaviors of concern.

Consultee-Centered Consultation

Through Consultee-Centered Consultation Marion was taught emotional self-management. A functional analysis showed that Marion's behavior and expression of emotions were acting as discriminatory stimuli or "triggers" for Kelly's problem emotions and behaviors. Specifically, Marion's displays of anger in response to an accumulation of home responsibilities and restriction of her freedom appeared to lead to anxiety, fear and withdrawal in the child. She became aware that thinking about the extent of her responsibilities in parenting Kelly and evaluating them as unbearable, awful and unfair, were activating events for her angry feelings and behavior, which then in turn became activating events for Kelly's anxiety and withdrawal. The cycle continued with Kelly's reactions becoming activating events for Marion's guilt as she believed that her child "should not have" problem behavior and, as she did, it must be her fault as mother.

Marion had a hypothesis that Kelly had generalized her disturbed emotions, especially fear, to a staff member at crèche. According to Marion, fear of this person had led to an obsessive checking ritual in the evenings and mornings in which Kelly asked her mother a series of repetitious questions

which she wanted Marion to ask on her behalf at crèche and "I have to be there when you ask them." Kelly appeared to experience severe anxiety when faced with her mother's outbursts of very loud yelling. These same reactions appeared to generalize to a teacher at crèche who had raised her voice (and probably looked angry) and now elicited in Kelly withdrawal responses and obsessive questioning.

Further **Client-Centered Consultation** involved psychoeducation about:

- Kelly's emotions: Marion learned that Kelly's behavior was a direct expression of Kelly's emotions and that there was a reason for the behavior.
- The relationship between the parent's emotional states and the child's disturbance: It was explained to Marion that children react to the emotional tone of what parents say to the child as much as to what the parent says to the child. It was clearly stated that seeing a parent upset and angry can threaten a child's emotional security.
- Kelly's developmental needs/problems (history and current): Marion reported on Kelly's relationship with her father who lived separately. She was helped to understand the developmental context of Kelly and her limited ability to understand adult behavior and interactions. Kelly, at three years of age, could not understand the reasons for adult behavior and, being unable to predict when her mother or teacher would erupt in anger, experienced increased anxiety and fear.

In summary the goals of the intervention with the mother involved:

- first, new emotional self-regulation by Marion;
- second, teaching emotional management for Kelly;
- third, teach developmentally appropriate behavior management skills to Marion

Following the psychoeducation phase Marion was helped to identify and acknowledge her emotions, with a particular focus on her LFT anger and guilt. Understanding that her anger was affecting her daughter motivated her to change her patterns of behavior very quickly. Her beliefs included "It is not fair I have to work so hard, bringing up Kelly all on my own", "If I'm angry it's OK to let it out. It won't hurt anyone." She learned to challenge these evaluations and inferences, building new high frustration tolerance. She challenged the inference of "all on my own" by reminding herself of supports in her life—her sister, the child's father. She also challenged the irrational "awful" and "unbearable" nature of her situation by reasoning about what she has managed by herself so far, and about her ability to be a good parent and to manage her life overall, including studying to become a teacher.

She recognized her angry outbursts as stimulus conditions for Kelly's withdrawal at home and changed her emotional expression. She began to tune in to her frustration levels and, using new emotional resilience skills, remove herself from the situation if she was becoming angry instead of yelling very loudly. She would then calm herself with new rational thinking and return to the situation. Her new self talk included: "It's very hard to parent on one's

own, but I've been doing it up to now and I can continue. There are people I can turn to for help when I need them"; "letting my anger out can hurt my child's security, so I'll calm myself down and not yell around her". It was hoped over time she would do this while remaining in the situation but initially she needed to remove herself briefly to manage her emotions.

As the assessment of Marion also revealed that she was experiencing intense guilt, as she judged herself to blame for Kelly's problems, the intervention also included helping her to challenge her self rejection for her child's problems. She learned to evaluate her parenting but not her self in total, to accept that she, like all parents, did not know everything, and to appreciate her commitment as a loving parent seeking assistance for her daughter. A new self-acceptance emerged and her level of guilt was lowered.

Marion implemented her new emotional self-management (anger and guilt) as the first step with her child. This included monitoring her non-verbal behavior, (e.g. looking angry). She also talked with Kelly in a simple way about emotions, teaching her that she understood how Kelly was feeling, including both the thoughts that bothered Kelly and the tight sensations in her body; that everyone has strong feelings sometimes and although they can feel scary Kelly doesn't need to be very afraid of how she feels.

New emotional exchanges took place: Marion talked with Kelly more calmly about her fears at crèche and asked Kelly whether the teacher reminded Kelly of her mother. Kelly agreed that she was like her mother when she was angry and Marion needed to reassure her about the teacher's trustworthiness. Behavior management was implemented to reduce the frequency of the repetitious questioning: Marion explained to Kelly that she had a new plan to help Kelly with her worries. It was explained to Kelly that she could ask a few questions once per night but not keep repeating them. After that Marion ignored more than three questions.

Processes of Change and Outcome

As a result of change in the content and tone of communication between Marion and her daughter (empathic talks with Kelly, acknowledging her fears and worries and listening to Kelly's feelings without any "buts"), Kelly's protests at separation ceased. She no longer cried when her mother left her at crèche. Marion was firm in implementing the limits on questioning and the questioning was soon extinguished. This happened in conjunction with counter-conditioning regarding the feared teacher. Kelly was helped to observe that the teacher had never in fact expressed angry at Kelly or been threatening to her. This helped Kelly to modify the anxiety associated with attendance at crèche. An unexpected change also occurred with Kelly and her father. Marion reported that Kelly's (previously unreported) anxious protests when she left Kelly with her father every Sunday had stopped. The change in his daughter's behavior resulted in her father feeling relieved as he no longer believed that there was something wrong with him as a father.

Marion followed the consultation plan carefully and saw results for her efforts. She had been ambivalent about attending in the first place and only came because she was desperate. Three sessions were the most I could keep her coming and she cancelled the follow up session. However she said: "You have given me back my Kelly. She is playing, laughing and happy again". Marion's desire was to go it alone from there.

Considerations When Working with Parents of Children 8–12 Years

Problems of children in this age group may be occurring at home, at school or in other social situations such as sporting groups. It is helpful to parents if the practitioner demonstrates willingness to work with others involved in the care and education of the child, such as teachers or sporting coaches.

The timing of referral is often related to the parent's limits of frustration tolerance or to a particular event, sometimes at school, that prompts the recognition that professional help is needed for a child, even though the problem in one form or another may have been present previously for a long time. At other times the problem is in the nature of an adjustment difficulty which has arisen during a period of transition such as beginning school, moving from one school to another, or a significant change in home circumstances such as death, divorce or the arrival of a new baby. Therefore, assessment needs to evaluate carefully the context and duration of the problems. Listed in Table 4 are major goals of parenting for children in this age group which may help parents to understand important developmental needs of their child.

Case Illustration: Carmen and her Son Joel

Carmen and her son, Joel, aged 9, were referred by the school following episodes of Joel's verbal aggression towards peers in the playground and verbal clashes with his teachers. Both Carmen and Joel attended a university-based clinic and both recognized there were problems to address, although they understood them very differently.

Joel was impulsive in his reactions to frustration and extremely determined to have what he wanted. Once having made up his mind he wanted something, especially if it was to do with his football team, he was rigidly

TABLE 4. Specific Age-Related Parenting Goals for Children 8-12.

(1) Giving the child a simple understanding of their emotional experience and teaching simple strategies for calming themselves.
(2) Supporting the child's early logic of associative, rule governed thinking
(3) Teaching the child simple negotiation skills to manage external conflict.
(4) Teaching the child to take turns and to make efforts to acknowledge others' needs.
(5) Supporting the child's emerging individual interests and achievements

determined to obtain it at any costs. He reacted emotionally and with verbal aggression to those who frustrated him and as the school staff were not successfully managing the problems there was some risk that he would be excluded from school. Problems were also apparent at home, for example Joel would swear when frustrated and sometimes leave the situation (e.g., run out from home even though it was dark and refuse to come back in response to parental instructions).The intervention was carried out with the mother and son in separate sessions by two REBT-oriented practitioners who communicated with the school in consultation with the parent.

REBT Consultation with Carmen was at two levels:

(1) improve her mental health including emotional self-management and overall functioning/knowledge as to what it means to be a good parent and (2) assist her in developing management skills (including parent-child relationship skills) and in understanding and changing her son's ABCs.

Consultee-Centered Consultation

Goals of treatment were discussed with Carmen including the role of her emotions as contributing to Joel's problems. It was agreed that she would work on her anxiety and other relevant emotions and try to change how she reacted to Joel in problem situations as well as modifying her oftentimes overanxious communications on a broader everyday basis. She indicated she would try to bring her husband into this process as best she could.

Carmen learned about the importance of accepting Joel's emotional state even when his emotional state and behavior are problematic. She learned that she needed to and could communicate differently with him at these problematic times; for example, communicating positively with him to acknowledge what it is that he strongly wants and how frustrating it is that he is unable to have it right away. Importantly, she learned about the negative effects of global self-rating and rating of her son.

The work with Carmen focussed on her anxiety and guilt regarding Joel's problem behaviour. Using the ABC model, she identified her "As" as being Joel's misbehavior, or his teachers' or grandparents' upset and complaints about Joel. At C, she would become anxious and feel very guilty. Her beliefs at "B" included: "It is awful that my child has these problems", "I should be able to stop them", "What if he never gets over them?", "What if he never has any friends?", "What if he is expelled from school?", "That would be terrible", "My child's problems prove I'm no good".

The practitioner disputed these irrational beliefs and helped her with new self talk: "Just because I don't like Joel's problems doesn't mean they shouldn't exist", "his current problems don't mean he'll always have problems and even worse ones", "As his mother I can help him to overcome what ever problems he has", "His problems don't make me worthless".

Specific negative activating events were identified for her to practise her additional thinking skills to help her maintain emotional calmness. These occurred

when Joel was noncompliant and when he became angry. She would say to herself "This is all he has learned so far", "To learn the next steps he needs me to be calm", "I'll remember our plan to not overreact but to speak to him calmly".

Joint session time between the two therapists and Carmen and Joel enabled the boy to understand that his mother wanted to help him solve his problem. A collaborative rather than antagonistic relationship was built. In his own sessions Joel was learning:

- To be less demanding and angry by thinking more rationally.
- To clarify what he wanted (to get to the High School his big brother attended, to make friends and stay out of trouble).
- To think before he acted: alternative solution thinking skills were taught in concrete detail and practised.

His efforts were reinforced by his therapist. This was good modelling for Carmen who also needed to refocus on his good behaviour (which was most of the time) and his achievements and not on his poor behaviour.

Client-Centered Consultation

Carmen planned to begin listening to Joel with an ear for his emotions, always being able to "side with him" in these in a validating way. She helped him to name his feelings appropriately and express his desires verbally as strong wishes rather than through demands and negative behavior. She also communicated to him positive expectations through an attitude of "I know you can do it". She reinforced his good behavior and his efforts. To achieve these changes Carmen had worked hard at changing her irrational beliefs that maintained her anxiety and guilt.

Processes of Change and Outcome

Joel appreciated the new approach by his mother, feeling validated and supported by her instead of receiving frequent disapproval and criticism. Over a period of twelve weeks, the incidents at school became less frequent—about one per month instead of several per week. Carmen expressed increased confidence in herself in her parenting role and new expectations that Joel could succeed at High School.

Considerations When Working with Parents of Young People 13–17 Years

The level of maturity as well as the severity and type of presenting problem of adolescents needs to be taken into account in deciding whether to work with the parents. Several factors will influence this decision directly, including who communicates first with the psychologist and in what context. In

private practice it will certainly be the parents referring the young person. In some school settings a young person may approach the psychologist for assistance on their own initiative. There may be organisational policies in place to govern whether parents need to be brought in immediately to every case or not. This section of the chapter is relevant where parents have come for assistance either by themselves or jointly with their young person.

In my experience, difficulties coming to professional attention for the first time in adolescence are either adjustment difficulties which are generally best dealt with in direct intervention with the young person (e.g., emotional problems with transition, peer conflict, social anxieties) or symptoms of deep seated psychopathology, such as mood disorders, which require long term intervention with both parents and young person. Emerging personality disorders in young people fall into this category and may present initially in a variety of symptoms such as panic attacks, depression or eating problems. Multiple diagnoses frequently apply in these cases.

Case Illustration: Alma and Bill and their Son, Jeffrey

Alma and Bill sought assistance regarding their 15-year-old son, Jeffrey, who was refusing to go to school. Assessment of the young man led to a diagnosis of panic disorder and an emergent borderline personality disorder. There were also features of generalized anxiety and marked social immaturity. Narcissism and severe rigidity of thought were characteristic of this young man. He made incessant and unrelenting demands for consumer goods. Strengths of the family included strong friendship and support networks and a shared sense of humour.

Initial discussions required clear communication to the parents of the results of the assessment. It took time for them to realise the seriousness of the disorders their son was experiencing. Initial steps were planned to get him back to school as this was deemed a priority.

Consultee-Centered Consultation

As there was a culture of mutual blame in the family, the parents were taught the REBT model and given homework via reading and ABCD practice. Alma

TABLE 5. Specific Age Related Parenting Goals for Young People 13–17.

(1) Helping the adolescent adjust to the physiological and psychological changes of puberty.
(2) Supporting their adolescent's participation in groups outside the family.
(3) Supporting the young person in clarifying and testing values.
(4) Supporting the young person in widening their experience as a basis for vocational choice and linking them to the wider community.
(5) Allowing increasing autonomy as appropriate, while still setting limits
(6) Listening to the young person's emotional experience and guiding him/her in the management of internal conflict.
(7) Supporting the young person through mistakes.

blamed herself ("It's my fault our son has these problems. I'm no good") and Jeffrey's behavior was an activating event for Alma's self downing beliefs. Bill was unable to engage in reflection and focussed only on his demands towards Alma. The coming together and expectation for joint responsibility for their son's welfare led to increased stress in the marriage relationship. As the son resisted efforts to support his return to school, this steadily worsened and a marriage break-up ensued. Alma was keen to continue to help her son while Bill, his father, was unable to assume this responsibility. He was referred to another therapist for his own individual work.

Alma learned that her own anxiety and depression were an important part of the family dynamics but nevertheless that it was not helpful to blame herself for the problems. She learned that blaming herself would make things worse rather than better. She learned that there were strategies that both she and her son could learn in order to manage their anxiety and that these took practice to make a difference in their lives.

Part of Alma's difficulties lay in her own partial transition to adult maturity, her primary emotional ties to her mother still influencing her thinking and especially her self criticism and rejection as she continued to need her mother's affirmation to feel worthwhile. Her "need" for her mother's approval was disputed as a pre-requisite for her being able to assume a more mature adult role especially as it related to parenting and being more confident in her approach to her son. This was basic to enabling her to set limits on her son's behavior as her desire to please him and be liked by him was helping to maintain the problems at the beginning. Education about frustration tolerance (hers and his) as well as the goals of parenting for her son enabled her to adopt new attitudes and behaviors. It was agreed that the son be referred to another therapist for intensive individual work.

The intervention with Alma included personal therapy for her anxiety and depression. She worked hard in sessions on learning to dispute her irrational self downing beliefs and achieved some relief. Her anxiety levels were very high and hard for her to work on. She had aptitude for reflective thinking work and was successful in disputing her irrational beliefs; however, she had difficulty employing relaxation skills to combat her physiological arousal accompanying her anxiety. This was problematic in the intervention as physiological responding was a strong element in her anxiety.

Specific plans for minimizing her anxiety in the way she communicated with her son were put in place. She learned that her emotions and accompanying behaviors could be his triggers (As) and she worked to increase the calmness in her parenting. Her beliefs about her parenting leading to anxiety and depression included:

I should have been able to prevent my son's problems.
There must be something wrong with me.
It's terrible that he has these problems.
People (especially my family) will think I'm worthless.
I should be able to solve my son's problems.

She practised challenging her irrational beliefs and was able to lessen her distress and act more calmly in her parenting role.

Her new beliefs included:

In spite of my best efforts in the past my son does have serious problems.
My parenting in the past was the best I knew at the time.
My son's problems do not mean there is something wrong with me.
His problems are very serious and it will take a long time to help him but that's just a fact of life.
I like to have my family's approval but I don't absolutely have to have it. If they criticise me I can still think and act independently of them.
When people have major problems there are many resources in the community to assist and it is appropriate to call on them for support.

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Alma's plan for intervening with her son to support his individual therapy was to teach him to become aware of his emotions and understanding of the B-C (thinking–feeling) connection. She also learned about the principle of successive approximations and was careful to reward any improvements in his behaviors if they represented changes in the right direction. She kept as specific goals to remain calm in communicating with him and to stay firm in the face of his strong and persistent demands for purchases. She also planned to set limits on his behaviour in the home (verbal abuse).

Processes of Change and Outcome

The therapeutic work continued over a period of 5 years and Alma's tasks were extremely difficult as Jeffrey met her efforts with resistance and escalated aggression. Even with individual support and multiple attempts he would not return to school and eventually, in the face of physical abuse in the home he was excluded from the home and helped to set up independently in a small flat. His financial affairs were placed in the hands of a government body to avoid family conflict over consumer goods.

Jeffrey did not persist with his own therapy and the management of his difficulties was left to the mother, especially after the break-up of the marriage. Over a period of several years Alma persisted in her own therapeutic work, persisting in her disputation skills, and continued her regime of rewarding his approximations to appropriate social behaviour. She supported his interests and guided him to introductory courses which enabled him to "put a toe in the water" of education again.

Her major effort to develop high frustration tolerance, combined with firm limit setting, resulted in Jeffrey slowly learning where the limits of his behavior lay. He took positive steps towards his own career goals, joined a peer group in his post secondary education setting and began to learn from interpersonal relationships outside his immediate family. For Jeffrey each new step

was like a mountain to be climbed and it was three steps forward, one step back, but gradually progress was made. It was essential for Alma to be able to take the long term view and not get overly caught up in the minutiae of each of Jeffrey's mini-crises. In the longer term, Jeffrey has been able to move interstate to attend university, having organised his applications and interviews himself and is nearing the end of his degree. Alma has continued to work on her anxiety and has worked through various adult developmental tasks, especially in relation to her primary emotional ties.

This chapter turns now to three major types of disturbance and distress, namely anxiety, anger and depression and considers ways REBT is used in work with parents whose children suffer these problems.

Working With Parents to Alleviate Children's Anxiety

Anxiety has two components, the mainly cognitive one of worry and the other of physiological responding. Individuals differ in the extent of involvement of each component in their anxiety problem. Recent clinical writings and research (Cox et al., 1999; Flett et al., 2004) have identified "anxiety sensitivity" as playing a part in how individuals manage their anxiety. REBT has consistently made the distinction between ego anxiety (performance and/or social anxiety) and discomfort anxiety (Ellis, 2003) reflecting similar processes of anxiety experience and reactions to this experience.

Children are known to experience both ego and discomfort anxiety. Many cognitive interventions address only the ego anxiety and omit the sensitivity or reactivity to the physiological experience. This section will address ways in which parents both contribute to and can moderate anxiety in their children.

It is very common to find an anxious parent (or grandparent) in the family of a child suffering from anxiety. This person may not be aware that they suffer from anxiety but through the assessment of their child it can become apparent to them they demonstrate symptoms of anxiety. In these cases, the child's symptoms appear to represent either shared temperament, or emotional learning, or both.

Psychoeducation of Parents Regarding Anxiety

The process of teaching a parent about their child's anxiety generally begins with an explanation of the two components of anxiety: worry about being rejected or about their achievement and worry about the physiological responding that accompanies worry such as "butterflies in the stomach", shakiness, sweaty hands, nausea, tightness and tension. The practitioner explains to parents that children experience these symptoms just as much as adults and may be quite frightened by them. For example, some children interpret their physiological arousal to mean exaggerated or extreme danger.

The parent needs to learn that anxiety may be of different kinds: performance or social anxiety which arises from the child's extreme reactions to external situations, and discomfort anxiety which arises from the child's disturbance about their feelings.

The therapist's explanation of anxiety needs to provide a model for the parent as to how to talk to their child about anxiety. Therefore, it needs to be kept simple and clear and the therapist should check that the parent understands what is being said. Parents are provided with simple words to use with their children, for example, they could talk with their children about "thoughts that bother them and won't go away", or "thoughts that go round and round in their heads". During this phase of psychoeducation, it is important for the therapist to elicit examples from the parents of their ability to communicate to their child about anxiety using simple language. Asking the parent to give back to you verbally what you have said is a good way to give practice to the parent in putting it into words, as well as an opportunity to check for any misunderstanding and also a chance to reinforce their new behaviors. Parents whose children demonstrate discomfort anxiety should be taught that their child is "sensation-sensitive", even perhaps extra sensitive, and therefore reacts to their feelings in an anxious way. Parents learn that children with performance or social anxiety react to new or uncertain situations and people in an anxious way. The parent can help their child to overcome the anxiety, not by urging that "there is nothing to be frightened about" but by *acknowledging and accepting* the child's reactions, both emotional and behavioural, and by teaching the child emotional self-management. The parent helps the child to dispute irrational beliefs underlying ego anxiety such as "I must not let people criticise me—better to avoid the situation". "I must always do well or I will be rejected". They can also help the child dispute irrational beliefs underlying discomfort anxiety for example "I must be able to stop feeling this way—it's horrible and dangerous".

In cases where the parent also experiences high levels of anxiety, anxiety will be observed in relation to the task of helping their child. This provides the opportunity to raise the parent's consciousness of their own thinking, feelings and reactions and to begin to understand their child in a new way, by gaining insight into their own experiences. Resistance is sometimes apparent in the parent in recognising their anxiety, so observable signs can be discussed: the parent speaking very fast, looking tense, showing over-concern about doing their new task perfectly. Sometimes one parent can be drawn in to assist the other by saying what they have noticed about the other's anxiety. Talking about the parent's reactions in the here-and-now is a useful teaching strategy. It is useful to ask the parent what strategies he or she has used in life to manage anxiety as the parent may be able to identify such methods as taking a deep breath, or reminding themselves they can manage. It is necessary to point out directly to the parents that these are examples of what their child needs to learn but does not yet know.

For young children, communication about their physiological responding is primary because it often is accompanied by withdrawal and avoidance behaviors, which are then negatively reinforced as the tension is relieved. The child who experiences discomfort anxiety, the fear about his/her anxious reactions, is a problem which needs addressing before the "danger" (rejection, poor performance) external to the child can be managed. In severe cases the child feels sabotaged inside and out, as the danger seems everywhere—within as well as in the world outside. REBT has always emphasized the importance of treating any secondary emotional problem before the primary emotion can be alleviated. So, this is the case in working with parents to help their child overcome anxiety, and fear or anxiety about their anxious feelings can be the first focus.

The communication with children, however young, should always begin with a focus on their body: where in their body do they feel the anxiety? Surprising answers are given by children: "it's my heart, it's going to burst" "my brain gets bigger—too big for my head" "it's my tummy" but they always, in my experience, have a clear answer and the knowledge of this body focus then is a crucial basis for the adult to help them communicate throughout the intervention.

Initially, what the parents need to learn to do is to teach their child to "normalize" the experience of feeling anxious. The therapist needs to help the parent put into child-friendly language that many children feel anxiety and that while such feelings are unpleasant and uncomfortable, they are not dangerous. Parents need to be coached in being able to communicate to their child the idea that there is nothing terrible about feeling anxious but that anxiety is a clue that they need to solve a problem. At this point in psychoeducation, parents are taught how to communicate to their anxious child that he or she can learn new ways to calm down when they feel anxious.

Steps for Parent to Help a Child with Anxiety Cope with Their Physiological Responding:

1. Invite child to tell someone (parent) about how they feel.
2. Listen to child.
3. Explain that it is an ordinary experience and he/she is OK.
4. Explain that others feel this way often.
5. Explain it is not terrible and will not hurt them even though it feels "bad".
6. Teach them directly some new strategies to calm down, especially relaxation, finding something funny to do and finding someone to talk to.

Steps for a Parent to Help a Child with Anxiety:

1. Explain the primary sources of anxiety in their child or adolescent; namely, worry about being laughed at/rejected and worry about not doing things perfectly or making mistakes.
2. Teach the child about the thinking-feeling-behaving connection.

3. Teach the child any relevant facts to help the child restructure their anticipation that they will be rejected or make mistakes, and that if the worst came to the worst something awful would happen if they were rejected or made mistakes (e.g., when teachers frown it does not mean they do not like you).
4. Teach them directly some new thoughts that will help them stay calm, for example "I can just try my best. It's OK to make mistakes sometimes. It's only human".
5. Together make plans to overcome the anxiety provoking situation by taking new small steps, a little at a time, gaining confidence gradually. If it is a school or kindergarten problem, bring the teacher in on the plan so that she/he will support the child's efforts at new behavior.

Case Illustration: Jenny, Sam and their twins, Lily and Georgina

This case study is one limited to client-centered consultation in which helping parents to work with their children's discomfort anxiety and sensation sensitivity moderated the children's social anxiety. Jenny and Sam were referred with their 4-year-old twins who were then diagnosed with selective mutism. The twins, Lily and Georgina, spoke normally at home but at kindergarten just stayed close to each other and did not speak to any other child or any teacher. The parents recognized that their daughters were shy by nature and had observed their withdrawal and hesitation in new social situations. Urging and encouragement by adults had not alleviated this problem.

Psychoeducation

The therapist explained to the parents that their children's temperament had combined with (unintended) learning that unpleasant feelings could be minimized if they avoided certain experiences, namely talking outside the home. The parents became aware that they did not know what their children were experiencing subjectively and were assisted to communicate with them about their feelings. As REBT predicts, the children were experiencing unpleasant physiological responses and were feeling overwhelmed and anxious about these feelings. The parents learned that establishing a problem solving framework with the children (even ones so young) can enable a change of emotional management and behavior patterns in the children.

Although neither parent demonstrated high anxiety, they were high achievers and expectations were certainly high for their children's success, educationally and socially. The main belief shared by both parents was that their child's failure to speak at kinder was a terrible and awful problem for them. They quickly overcame this thinking when they understood the nature of the problem and found there was a systematic way forward to

alleviate the problem. No direct therapeutic intervention was necessary with the parents.

Client-Centered Consultation

The parents established communication with their daughters regarding their anxious feelings which were "normalized" and validated by acceptance in these discussions. They talked with their daughters about their own feelings on different occasions and told them how they managed them. They explained to the girls that there was a new plan "to help them join in at kindergarten and make more friends". The teacher was going to help with this plan too.

As functional analysis carried out during observation of the girls at kindergarten showed that they were not participating in group play activities, joining in/participation was added to the goals of the intervention, along with verbal interaction. The plan was a simple reinforcement one, with specific steps identified day by day and week by week, for example:

Say "Good Morning" to teacher at the beginning of the day, "Good-bye" at the end of the day.
Make eye contact with the teacher while giving greetings.
Pick up the paint brush and put it to the paper during painting time.

That is, behaviors were clearly identified for their children to practice and they knew that completing the behaviors on a given day would mean a gold star on their chart at home. The teacher recorded their relevant behaviors each day. At the same time, the parents would monitor the children's physiological responses before and after school and offer guidance in how to understand and manage them. They communicated positive expectations of their children but showed understanding and acceptance of their "failures" along the way. They also planned to invite the teacher to their home to bridge the two environments.

Processes of Change and Outcome

Lily and Georgina were happy with the new plan and indicated they would put it into effect. They made their first efforts at morning and afternoon greetings to their teacher and received their first gold stars and praise at home. They practised their new thinking that "It's all right to feel butterflies in my tummy. They don't mean I have to freeze and not talk" "Just because the teacher is looking straight at me doesn't mean she doesn't like me".

The kindergarten teacher's visit to their home was successful and this experience helped the girls to generalize their talking from home to kindergarten. They progressed rapidly until after a few weeks they were ahead of the plan—they had begun talking to the other children, had socialized with new children invited to their home and began to visit their school for the following

year to make contact with their new teacher. Follow up at six months revealed they were in separate grades at school and were doing well.

Working With Parents to Help their Child Overcome Anger Problems

Problems with anger management generally arise in a context of twofold aetiology, similar to anxiety: there is a contribution of child temperament as well as a contribution of environmental influence (parenting style, parental emotional make-up, and family problems). When parents fail to teach their children delay of gratification and frustration tolerance skills (impulse control) and when they model strong negative emotions that they fail to self-regulate, a child born with a feisty temperament is likely to display problems of conduct and display developmentally inappropriate levels of anger. In the initial assessment of the children with anger management problems and disorders of conduct, it is important to identify which factors are operating so that the planned intervention can be appropriate and effective.

Psychoeducation of Parents About Anger

The REBT psychoeducational approach to parents serves the purpose of acquainting parents with the distinction between their own practical problem-solving skills needed to help their children behave in less impulsive, core developmentally appropriate ways and emotional problem solving where parents learn of the role of their own emotions and emotional reactions in their ability to implement an effective child management approach and in their child's learning through modelling of inappropriate ways to express emotions. Two REBT key ideas about anger for parents to learn are the role of their own beliefs regarding frustration and frustration tolerance in anger, and the relationship between their own feelings of anger and their child's unacceptable behavior.

The REBT therapist teaches that one important aspect of socialization of their children involves helping them to increase their ability to put up with frustration—from the beginning of infancy when they have no frustration tolerance (NFT), up to late adolescence when they are expected to have high frustration tolerance (HFT), to function satisfactorily in society.

Anger problems in children may or may not be accompanied by aggressive behavior such as swearing, hitting or destroying property. Sometimes children have trouble regulating their feelings of anger (due to LFT) and, recognizing this, want help in managing better. Other children are used to self-indulgent behavior and resist efforts to change. The former group of children will be willing participants in new emotional learning, and communication and joint problem solving will be the main types of intervention. Children with accompanying behavioural problems will benefit from the emotional learning but

will need systematic consequences to be put in place as well for their undesirable behavior.

Parents are taught that their children's physiological reactivity is important to address in learning how to teach their child the regulation of anger. As in helping anxious children, parents help children to identify parts of their body where they feel the anger most. They can be helped to think about these perceived bodily experiences as cues to use their new strategies: these will most likely be a combination of cognitive and behavioral techniques.

Discussion of the parents' own anger will be a key part of psychoeducation. It is extremely common for children with anger problems to have a parental model for their anger outbursts. Often this is when parents are frustrated with their child's inappropriate behaviour and the parent is unaware that they are providing a poor model for the child. On the contrary, they think they are teaching the child good behavior. To clarify this I teach parents about the two simultaneous lessons a child is learning from them: *the behavior lesson* (what to do) and *the emotional lesson* (how to manage emotions, including anger). Often the parent's focus is on the behavior lesson, as they are telling the child what to do and not do. But, if they do this angrily, unfortunately the child also learns that when frustrated, the way to be is angry!

Parents are also provided with a list of irrational beliefs of children who get angry and are given practice in discussing with their children why the beliefs are unhelpful. Parents learn how to discuss, model and reinforce their children's rational beliefs that lead to better anger management.

Children's Irrational Beliefs Associated with Anger

Parents should always be fair.
Teachers should always be fair.
When they are unfair it is awful.
I should get what I want when I want it.
I can't stand waiting for things.
I have to win.
When others don't give me what I want they deserve what they get.

Steps for Parents to Help their Children with Anger Problems

1. Teach the child to name and recognize their frustration and anger.
2. Teach the child that anger varies in intensity and duration.
3. Teach the child that they have a choice in how angry they get.
4. Teach the child that it is OK to have feelings but acting to hurt others is not OK.
5. Teach them that the more intense their anger, the more likely that they will do something hurtful, and the more likely it will have bad consequences for them.

6. Teach the child that everyone feels angry sometimes and there are things we can do to overcome the anger.
7. Teach the child there are simple things (like counting to ten before responding, leaving the situation) that can help in the short term.
8. Teach the child that learning to think differently can be the best way to know how to put up with difficult people and things that happen in life and therefore to keep anger to a minimum.
9. Teach the child new rational beliefs about fairness, what "should" and "should not" happen.
10. Teach the child tolerance of other people's imperfections.
11. Teach the child that it is much easier to use their anger strategies if the anger is not too intense and therefore it is important to use them as soon as they notice the beginnings of angry feelings.

Case Illustration: Dora and Her Daughter, Susan

This case illustration goes beyond the scenarios painted in the psychoeducation section as it occurred in a deeply dysfunctional context. The child's anger was part of a wider set of problems and I have included the case as one that draws attention to the need to address the child's basic emotional security as well as the more obvious problems.

Dora brought her daughter, Susan, aged 13, to a university clinic for help. She reported that Susan was frequently angry and aggressive, would not do her homework and was sulky and unpleasant around the home. Her husband, Susan's father, had died unexpectedly as the result of a workplace accident a few months ago. Neither Dora nor Susan could speak about his death or their loss.

Attempts to help Susan in individual therapy were not successful as she was barely verbal with her therapist. Attempts at cognitive assessment using drawing techniques revealed that her angry episodes at home were triggered by her brother's bullying which was not being contained by the mother. The only way Susan knew how to communicate her distress to her mother was to come near to her and explode with anger. She would often do this on the kitchen floor just out of sight behind the kitchen table. Dora reacted very negatively to this behavior and these emotions, becoming punitive in her attitude to her daughter. This led to Susan feeling even more isolated and threatened—and more angry. She was unable to express her desire for protection and reassurance in an appropriate way as she was of low verbal ability and had poor emotional expression skills.

Consultee-Centered Consultation

The focus of intervention became Dora and her relationship with Susan. Dora learned that her "bottling up" of her feelings of normal grief and loss on the death of her husband was having a negative effect on herself and her

family. She was helped to express these feelings safely. She learned that things would not go well at home if any of her children were lacking in basic emotional security and that, though this was hard to provide on her own without her husband, it was necessary for her to face this challenge if her problems were to lessen and her daughter was to improve.

She learned that Susan had very little insight into her own needs or how to get what she wanted and needed, and that she often used inappropriate means to try to get relief from her own frustrations. Angry outbursts were one such way. Also, Susan was sleeping with her mother which her mother tolerated (and perhaps relied on), a pattern which was not appropriate at her age.

She was helped to reflect on her own irrational beliefs and how these were hindering her. They included: "It's not fair that I have to manage the family alone", "I can't stand it when my daughter is angry all the time—in fact I can't stand her!", "They should all just leave me alone!" "It shouldn't be this hard to bring up a family!"

Dora needed help to challenge her irrational beliefs that were underlying her rejecting attitude to Susan. Expression of her feelings of grief and understanding that Susan also was experiencing grief helped her to begin to have empathy for her daughter. Her LFT in relation to the level of difficulty in helping Susan was a major challenge in therapy. Dora needed to learn the arbitrary nature of frustration tolerance levels. A certain level of frustration is arbitrarily selected by the individual in an implicit way so that anything beyond this is deemed "unbearable". So, if a parent believes they can "stand" complaining and mild temper tantrums but not yelling and screaming, then their threshold will be crossed and their own distress come into play. Dora needed to challenge her arbitrary threshold and think differently about her ability to deal with difficult situations.

She needed time and support to find new ways in which she could provide emotional security for her daughter, for example by setting limits on the brother's threatening behavior and giving comfort and love when Susan was distressed, at the same time teaching her appropriate ways to seek this comfort instead of through expressed anger. The issue of her family culture was addressed, with tolerance of others being an important ingredient to foster for all members' well-being.

Client-Centered Consultation

Building on her own changes, Dora implemented the following steps with Susan:

1. Communicated clearly to her that she was available to comfort and reassure her when Susan felt insecure.
2. Taught Susan awareness of her emotions, helped her to name them and communicated the acceptability of emotions, though acknowledged some are distressing.

3. Taught Susan the thoughts that lead to anger and alternative thoughts she could think in her frustrating situations.
4. Taught Susan that she could learn to feel less distressed if she learned from her mother calming thoughts to help her both in a crisis and in everyday situations.
5. Taught Susan that she herself was learning and practising new ways of managing emotions.
6. Discuss with Susan her school difficulties and what kind of help Susan would like to try for her schoolwork.
7. Support new age-appropriate activities for Susan including peer group activities.

Processes and Outcome

Over a period of months Dora managed to make some changes in her own functioning which formed the basis for her intervention with her daughter. Susan began to experience acceptance and love from her mother instead of rejection. Although she was not a verbal child she was reassured by the changes and gradually learned to let her mother know what she needed in a direct and appropriate way. The anger episodes reduced and the mother's frustration experiences also lessened, easing the stress in the family.

Working with Parents to Overcome Children's Depression

Depression in children and young people, like anxiety, may be related to both constitutional predispositions and to experience. It is extremely important for a child who is experiencing depression to be assisted by adults to overcome this mood so that it does not become a destructive force in the child's life, even to the point of being life threatening.

Children and young people form simple philosophies of life and where this includes strongly held negative beliefs about themselves and those around them, they are vulnerable to depression and other disturbances. While children more often demonstrate symptoms of action rather than thought prior to adolescence, it is nevertheless possible for younger children to experience depression and even suicidal thoughts. This mood can be expressed by children through irritability, withdrawal, silence, loss of interest in activity, decrease in pleasurable activity, sleeping and eating problems. Unless parents recognize the emotional distress accompanying these behavioral signs they may react to the child in ways that increase rather than relieve the distress. It is important therefore to assess the immediate history of parental attempts to overcome the problem(s) when they come for assistance.

Psychoeducation of Parents Regarding the Treatment of Depression in Children

Events that commonly precede depression in children include family conflict, divorce, death of a family member, loss of a friend and death of a pet. The child believes that they "must have" what they have lost and that it is terrible for life to be this way. The parent will need to learn to help their child to moderate their response to loss or disappointment and to know that they can still be happy about other things in their life.

Where severe depression is apparent in a child or adolescent, individual therapy is recommended. Parents can nevertheless play a significant adjunct role in the first stages of the child receiving help and an increasingly important role in maintaining the gains of therapy over time. Where suicidal ideation or self harm is part of the child's or young person's presenting problems, individual therapy is always recommended as well as parent involvement.

Parents often need to learn that the depressed mood of their child can be expressed in a variety of ways. The particular behaviors which they may wish their child to change need to be considered in conjunction with the emotions accompanying them. Concepts of emotional expression and emotional regulation can be taught. The need for their child to receive validation, (i.e. acceptance of their emotions), is a basic concept as the foundation for teaching or learning self-regulation.

Sometimes, the precipitating events that lead to the child's depression may not be objective "events" that can be known directly by the parents. They may be "events" that occur in the mind of the child, especially for young children. Examples of this I have experienced are fantasies of a child about the implications of the death of a loved pet, and ideas a child formed about parental conflict and the child's role in and responsibility for that.

These examples underline the central role of cognitions in children's depression and the importance of correcting faulty inferences as well as modifying irrational evaluations that according to Ellis give rise to emotional distress. As with other parent interventions, as well as depression-specific learning, parents will need to learn basic knowledge regarding emotions and the importance of validating their children's emotions.

As a part of their REBT psychoeducation, parents are provided instruction regarding the process of self-downing and how to talk to their child about this negative habit. Parents learn about global self-rating, are shown how such rating often operates in a child's world and are provided with examples of how to dispute their child's self-downing and to teach, model and reinforce self-acceptance. Thoughts such as "I'm no good", "I'll never be any good", "I'm totally ugly", "I'm stupid", "I'm a failure" are all examples of such evaluative beliefs. Parents can learn ways to talk to their child about mistake making in a way that teaches the child to accept him/herself *with* mistakes and not to demand perfection of themselves. Parents are shown

ways to talk with their child about the difference between needing the approval of others and preferring positive affirmations. Additionally, in the case where a child is depressed about family break-up or being abandoned by one parent, a parent can learn about the dysfunctional nature of a depressed child's beliefs ("It's my fault. My parent doesn't love me. I'm a loser") and how the parent can help change a child's depressed pattern of thinking.

Steps for Parent to Help their Child with Depression

1. Acknowledge with the child significant changes the parent has noticed (e.g., eating, mood) and express concern about these.
2. Ask the child about his/her feelings and assist the child in naming the feelings of depression.
3. Teach the child that many people experience these unpleasant feelings but that it is possible to alleviate them (feel better).
4. Establish trust with the child to allow expression of inner thoughts that may seem weird, extreme or otherwise difficult to share.
5. Listen to the child uncritically (no "buts").
6. Teach the child that they have a choice in how depressed they get.
7. Teach the child in a simple way the connection between thoughts and feelings.
8. Ask the child about other feelings which may be present along with the depression such as anxiety and anger.
9. Help the child express their self downing and other negative thoughts.
10. Suggest new helpful thoughts to the child and encourage practice of them.
11. Remember to smile at the child when appropriate to communicate a positive mood on your part. (It is sometimes easy to "enter into" and reinforce another person's gloomy world without intending to do so).
12. Encourage age-appropriate activity for the child to counter withdrawal and disconnection.
13. Encourage positive social interaction for the child (e.g., encourage them to invite friends over).

Children's Irrational Beliefs Associated with Depression

1. When something bad happens it means I am to blame and I am no good.
2. No parents could love me.
3. If my parents are angry it means they don't love me because I am no good.
4. I should be different (a boy, a girl, more beautiful, cleverer).
5. I'll never be different.
6. There's no hope for me to be happy.
7. The world is a bad place.
8. If I have lost something or someone important to me I can never get over it.

9. I'll never.....get my parents' love.....have friends,... succeed in school.
10. No-one can help me.
11. No-one could understand how I feel.
12. I shouldn't live / have been born.

Case Illustration: Gina and Her son, Paul

Gina referred her son, Paul, aged 9 to a university clinic for depressed moods. According to his mother, he cried very easily, seemed to be "in his own world" and got into trouble at school for not attending and completing work. Paul's father had separated from his mother following a violent relationship and had left the country to return to his country of origin.

Assessment showed that Paul had an extremely vivid imagination and had not yet achieved the ability to distinguish between imagined and real occurrences. He reacted with great anxiety to his experience of imagined threats and dangers. This imaginary world was very elaborate and sustained but he had communicated it to no-one.

Consultee-Centered Consultation

Gina was helped to understand that, although her son was 9-years-old, he was still thinking like a 4 or 5-year-old in some respects and that he was also a very deeply feeling child who was not managing well the events surrounding his father's departure. Paul had irrational thoughts about his father "He comes in the night to hurt me" "I see him in the dark" "He left so I know he doesn't love me". Gina struggled to understand these matters but had an attitude of respect for the professional and an intense desire for her son to be helped. She believed she could not help him herself. She was prepared to attend sessions, in parallel to her son's individual work by another therapist and to try to implement changes.

Client-Centered Consultation

Prior to coming to the sessions she had reacted to Paul's behavior with anxiety, frustration and negativity. She fussed about his crying and distress which she perceived as dependency and which she tried to inhibit by scolding. Her homework was to firmly communicate to her son her expectations of his behavior. She was also to employ active listening when her son appeared upset "tuning in" to his feelings. At these times, she was to ask him about his bad feelings and listen if he wished to share them. She was to avoid any communications that modelled irrational thinking (e.g., any sentences such as "You are a...." or I am a....)"

As the therapist was working with Paul to empower him in the face of his depression-creating thoughts and ideas Gina was encouraged to support his self-efficacy at home and school. If small frustrations (such as falling over or

missing out on something) were experienced by Paul, she would not rush to his aid and express anxiety for him but would watch surreptitiously from afar to see if he could cope by himself in the first instance. A crucial part of the intervention was her learning to overcome her anxieties, especially in relation to her parenting.

Process and Outcome

Several months of individual weekly work was provided for Paul. His mother attended weekly for the first six weeks and then fortnightly. Her first achievement was to understand that her anxiety was getting in the way of effective parenting. Next, she tried new ways of communication with Paul based on her new understanding of his development and thinking. She had strong relationships with friends who had children and discussed her new ideas with them, so that a support group emerged and increased opportunity for Paul to develop new interests and social skills with peers.

Paul's therapist helped him to make reality checks in his thinking, by seeing how his thinking matched with hers and, in his homework, asking his mother whether she agreed with his beliefs. His need to express fantasies of exaggerated control and power lessened as his reality testing improved. He understood himself and his world in a new way, enabling him to enjoy the everyday experiences in his life.

Conclusion

REBT provides a useful framework for working with parents to help their children and it also allows integration of other techniques that may be appropriate to particular families (Ellis, 2002). This chapter has shown that developmental factors including the child's degree of maturity in relation to goals of parenting across different ages can be incorporated sensitively into treatment plans. The importance of parents understanding the child's emotions and keeping a focus on a child's underlying need for emotional security is emphasized throughout.

TABLE 6. Beliefs of parents and their emotional consequences (Bernard, 2004a) (Location in chapter 6 TBD).

Beliefs that Underlie General Parent Emotional Upset
1. My child can upset me.
2. I have little ability to control my feelings and unhappiness.
3. One has to get upset when things go wrong.
4. My children cause all my unhappiness. They must change first before I can feel better.
Rational Alternatives
1. My emotional stress is self-created.
2. I decide how upset I am about my child.

(Continued)

TABLE 6. Beliefs of parents and their emotional consequences (Bernard, 2004a) (Location in chapter 6 TBD). *(Cont'd)*

3. Getting too upset makes matters worse.
4. Before my child will change, I will have to make some changes.

Beliefs which Underlie Parental Anxiety

1. I must be a perfect parent. If I am not always calm, competent and correct in handling my children, they will turn out badly.
2. I must see to it that my child is never uncomfortable, hurt or in any danger.
3. It would be awful if my children didn't love me all the time.
4. It's awful if others disapprove of the way I parent.
5. If I'm not consistently anxious and fearful about the welfare of my children, I'm a bad parent.

Rational Alternatives

1. I will try my best in caring for my child but I know I cannot be perfect.
2. It is not the end of world when my child is angry with me.
3. While it is preferable to try my best as a parent, there is no law of the universe that says I must be.
4. There is no such thing as a perfect parent.
5. When something bad happens to my child, it is rarely awful and terrible.

Beliefs that Underlie Parental Anger

1. Children should always and unequivocally do well (e.g., be motivated, achieve) and behave correctly (e.g., be kind, considerate, interested).
2. It is *horrible*, *terrible* and *awful* when children do not do well, misbehave or question or disobey their parents.
3. My child must always behave the way I demand.
4. My child must do what I say.
5. A child and his/her behavior are the same and thus children who act badly or err are bad.
6. My child must be fair to me at all times.
7. My child shouldn't be so difficult to help.

Rational Alternatives

1. Anger can be compared to a child having a temper tantrum.
2. When parents get angry, it brings them down to the level of a 4-year-old.
3. Do not discipline with anger because anger puts your children down and, as a consequence, your child may develop a spiteful reaction.
4. Getting angry will not help parents or their children; anger is only temporary at best.
5. No law of the universe says that what parents wish to happen, must happen; children are children, ignorant, mischievous.
6. Anger frequently generates more anger and resentment in others.
7. Never hate the child, only disapprove of his/her actions.

Beliefs that Underlie Parental Low Frustration Tolerance

1. Parenting shouldn't be so hard.
2. I must have fun in my life and I cannot stand having frustrations.
3. It is far easier to give in to my child's demands and whines.
4. I cannot stand the stress of following through on everything I say I am going to do for my child.
5. Things should always go my way and people should do my bidding.
6. I shouldn't have to put up with frustration.

TABLE 6. *(Cont'd)*

Rational Alternatives

1. It is easier to face a task than to avoid it.
2. Short-term tolerance of frustration may well lead to long-term gains.
3. Parenting is often very hard.
4. In order to parent successfully, I sometimes have to do things I do not feel like doing.
5. I can tolerate high amounts of frustration associated with my child and his/her behavior.

Beliefs that Underlie Parental Depression

1. When I don't perform as I think a good parent should (e.g., worry all the time, solve all my child's problems), I am a complete failure as a person.
2. If my child misbehaves frequently, it is awful and I am a failure as a parent.
3. If my children think I'm a poor parent, I'm worthless.
4. My worth as a person depends on the performance of my child.
5. My self-worth as a person is tied up to how I do as a parent, so I had better not make mistakes.
6. I am worthless because my child has so many problems.
7. I am a terrible parent for being so annoyed with my child who cannot completely help his/her problems.

Rational Alternatives

1. Never blame yourself as a person or others for anything.
2. Parents make themselves miserable, not their children.
3. Children's hardships are never as bad as parents make them out to be; parents shouldn't blow them out of proportion.
4. A person's performance as a parent does not determine his/her self-worth.
5. The performance of a child does not determine the value of a parent as a person.

Beliefs that Underlie Parental Guilt

1. Past or present adversity is so unpleasant and awful that my child cannot be expected to live normally; restitution for this adversity needs to follow.
2. It is awful for my child to suffer and I *must* prevent it at all costs.
3. I am the sole cause of my child's problems.
4. If I make a mistake, it will always affect my child.
5. I could have and should have done something to prevent my child's disability.
6. I am totally responsible for virtually everything that happens to my child.
7. My child is being punished for my own personal inadequacy.
8. I *must* always do right by my child.

Rational Alternatives

1. Parents are not the sole cause of their child's problems.
2. Parents can never be so omnipotent to prevent bad things from happening.
3. Children can overcome many of their adversities.
4. Children can tolerate frustration.
5. If parents should have known better, they would have done better.
6. While its preferable to be a perfect parent, there is no law of the universe that says you must be. Parents are fallible and make mistakes in raising children. They do not deserve to be condemned and punished for their fallibilities.

References

Bernard, M.E., and DiGiuseppe, R. (eds.) (1994). *Rational-emotive consultation in applied settings*. Hillsdale, New Jersey: Lawrence Erlbaum.

Bernard, M.E., and Joyce, M.R., (1984). *Rational Emotive Therapy with children and adolescents: Theory, treatment strategies, preventive methods*. New York: Wiley and Sons.

Borcherdt, B. (1996). *Making families work and what to do when they don't. Thirty guides for imperfect parents of imperfect children*. New York: The Haworth Press.

Bowlby, J. (1988). *A secure base: Parent-child attachment and healthy human development*. New York: Basic Books.

Cox, B.T., Borger, S.C., Taylor, S., Fuentes, K., and Ross, L.M. (1999). Anxiety sensitivity and the five factor model of personality. *Behavior Research and Therapy, 37,* 633–641.

David, D., Montgomery, G.H., Macavei, B., Bovbjerg, D.H. (2005). An empirical investigation of Albert Ellis's binary model of distress. *Journal of Clinical Psychology, 61*(4), 499–516.

Dukes, A., Mellor, D., Flory, V., Moore, K. (2003). A preliminary investigation of the relationship between parental empathy and social anxiety and children's social anxiety. *Proceedings of the 3*rd *Australasian Psychology of Relationships Conference,* 33–39.

Eisenberg, N., Zhou, Q., Losoya, S.H., Fabes, R.A., Shepard, S.A., Murphy, B.C., Reiser, M., Guthrie, I.K., and Cumberland, A. (2002). The relationships of parenting, effortful control, and ego control to children's emotional expressivity. *Child Development, 74*(3), 875–95.

Ellis, A. (2002). *Integrating other psychotherapies with REBT*. New York: Albert Ellis Institute Newsletter.

Ellis, A. (2003). A new cognitive-behavioral construct Part II. *Journal of Rational-Emotive and Cognitive Behavior Therapy. 21*(3–4), 193–202.

Ellis, A., Wolfe, J. H., and Moseley, S. (1966). *How to raise an emotionally healthy, happy child*. New York: Crown; and Hollywood: Wilshire Books.

Flett, G.L., Greene, A., and Hewitt, P.L. (2004). Dimensions of perfectionism and anxiety sensitivity. *Journal of Rational-Emotive and Cognitive Behavior Therapy, 22*(1), 39–57.

Flory, V. (2004). A novel intervention for severe childhood depression and anxiety. *Clinical Child Psychology and Psychiatry, 9*(1), 9–23.

Flory, V. (2005). *Your child's emotional needs. What they are and how to meet them*. Sydney: Finch Publishing.

Gottman, J. and DeClaire, J. (1997). *The heart of parenting. How to raise an emotionally intelligent child*. London: Bloomsbury.

Gottman, J., Katz, L., and Hooven, C. (1996). *Meta-emotion: How families communicate emotionally, links to child peer relations and other developmental outcomes*. Mahwah, N.J.: Lawrence Erlbaum.

Hauck, P. (1967). *The rational management of children*. New York: Libra Publishers.

Hauck, P. (1983) Working with parents. In A. Ellis and M.E. Bernard (eds.), *Rational-Emotive approaches to the problems of childhood*. New York: Plenum Press, pp. 333–366.

Joyce, M.R. (1994). Rational-emotive parent consultation. In M.E. Bernard and R. DiGiuseppe (eds.), *Rational-emotive consultation in applied settings*. Hillsdale, New Jersey: Lawrence Erlbaum.

Joyce, M.R. (1990). Rational-emotive parent consultation. *School Psychology Review*, *19*(3), 304–314.

Kegan, R. (1982). *The evolving self. Problem and process in human development*. Cambridge, Mass.: Harvard University Press.

Kegan, R. (1995). *In over our heads. The mental demands of modern life*. Cambridge, Mass: Harvard University Press.

Meyers, J, Parsons, R.D. and Martin, R. (1979). *Mental health consultation in the schools*. San Francisco: Jossey Bass.

Patterson, G.R. and Dishion, T.J. (1985). Contributions of families and peers to delinquency. *Criminology, 23*, 63–79.

Serbin, L., and Karp, J. (2003). Intergenerational studies of parenting and the transfer of risk from parent to child. *Current Directions in Psychological Science, 12*(4), 138–142.

Woulff, N. (1983). Involving the family in the treatment of the child. A model for Rational-Emotive therapists. In A. Ellis and M.E. Bernard (eds.) *Rational-Emotive approaches to the problems of childhood*. New York: Plenum Press, pp. 367–385.