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# Treating Aggressive Children: A Rational-Emotive Behavior Systems Approach

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## Description of the Problem of Aggression

Aggressive behavior remains stable from early childhood through adulthood and is one of the most invariable human traits. Aggressive children are likely to be aggressive as adults and to engage in physical abuse and criminal behavior (Huesmann et al., 1984; Loeber and Dishion, 1983). Effective early interventions may be necessary to change this trajectory. This chapter addresses the treatment of aggressive children with Rational-Emotive Behavior Therapy (REBT).

Professionals often confuse anger and aggression because they often occur together (DiGiuseppe et al., 1994). Distinguishing aggression from anger is important. Anger is an emotion, whereas aggression entails engaging in a physical or verbal action (Bernard and Joyce, 1984). One can be angry without exhibiting aggression, and one can behave aggressively without feeling angry. Aggression involves an external act, whereas angry emotions are private events. The distinction between aggression and anger is relevant in the clinical differentiation between emotionally reactive aggression versus instrumental or predatory aggression. Emotionally reactive aggression occurs when strong emotions of anger are elicited by some perceived threat to self. Thus anger and aggression coexist. Unlike emotionally reactive aggression, predatory aggression need not arise from any emotion. These aggressors simply take things from others by force or coerce others to maintain their own sense of power. Individuals engaging in predatory aggression may be categorized as psychopathic or as having an antisocial personality disorder.

Often children who are aggressive are classified as having either Oppositional Defiant Disorder (ODD) or Conduct Disorder (CD)

(American Psychiatric Association [APA], 1994). Children who are verbally aggressive and exhibit a pattern of hostile behavior particularly toward authority figures may be categorized as having (ODD). It is also possible, however, for children who are not aggressive to manifest signs of ODD. CD is a more severe problem occurring when the child violates major societal norms. Most of the CD criteria involve aggressive behavior toward people, animals, or property. CD is categorized further into subtypes of either childhood or adolescent onset. Children with CD who have childhood onset-type, where one criterion of CD is present before the age of ten, are more likely to demonstrate more pronounced aggression than those who manifest signs of CD in adolescence. Further, childhood onset CD is more likely than adolescent onset CD to develop into Antisocial Personality Disorder (APA, 1994). Therefore, we presume that children with childhood-onset CD are more likely than children with adolescent-onset CD to display predatory aggression.

## Basic Approach

Rational-Emotive Behavior Therapy (REBT) provides an effective model for treating aggressive children. As its name implies, REBT is an integrative therapy that incorporates many interventions to accomplish its goals (Walen et al., 1992). Research suggests that disruptive and aggressive behaviors are often best treated behaviorally by changes in home or school contingencies. In fact, for children who display predatory aggression we recommend intervention based exclusively on concrete behavioral strategies. Based on our clinical experience, these children do not respond well to cognitive treatments. As an element of REBT, cognitive interventions may also be used and are often directed at the adults who need to implement the behavioral strategies.

REBT involves strategies for learning to control dysfunctional emotions. REBT can be used to treat aggressive children in two ways: by teaching children to control the underlying angry emotions that lead to aggression and by teaching parents to control their disruptive emotions that interfere with effective parenting skills.

The trademark of REBT is its emphasis on teaching people to learn the **"ABCs"** of emotional disturbance, identifying the **A**ctivating events, their **B**eliefs about those events, and the resulting **C**onsequences. REBT teaches that disturbed emotional and behavioral **c**onsequences result from irrational **b**eliefs individuals hold, rather than from **a**ctivating events. REBT works to alleviate emotional disturbance by helping people to identify their irrational **b**eliefs, recognize that the irrational **b**eliefs are maladaptive, and replace those dysfunctional cognitions with more adaptive, rational **b**eliefs. Rational cognitions express preferential, flexible desires, whereas irrational cognitions express absolutistic, rigid needs. Rational thinking leads to happiness and enables individuals to attain goals and strive toward their potential; irrational thinking causes

people to be extremely disturbed, and thwarts individuals' ability to attain their goals, leading to unhappiness.

REBT also distinguishes between disturbed, dysfunctional emotions and normal, motivating, albeit negative emotions. Negative emotions do not reflect psychopathology. If an activating event occurs (**A**) and one thinks irrationally (**B**), one will experience a disturbed emotion such as anger or anxiety (**C**). If one then challenges one's irrational belief and replaces it with a rational belief (a new **B**), one will still experience a negative, nondisturbed, motivating emotion. Most psychotherapists understand therapeutic improvement as a quantitative shift in the emotion. However, Ellis (1962); Ellis and DiGiuseppe (1993) proposed that when people think rational thoughts they experience a qualitatively different emotion rather than a lower intensity of the disturbed emotion. The emotions generated by rational thoughts will be in the same family of emotions as the disturbed emotion, but they differ in many aspects. Ellis posits that although irrational thinking leads to anxiety, depression, or anger, rational thinking will lead to concern, sadness, and annoyance, respectively. These emotions are not necessarily less intense but they may lead to qualitatively different phenomenological experiences and they will elicit different behavioral reactions.

## Intervention Procedures Based on Empirical Research

Several meta-analyses examining the effectiveness of psychotherapy with children and adolescents have concluded that behavioral and cognitive therapies are more effective than non-behavioral or traditional therapies (Casey and Berman, 1985; Weisz et al., 1987; 1995). However, these reviews failed to address which behavioral and cognitive treatments were most effective with which types of children. We have uncovered more than 30 cognitive and behavioral interventions used with children. Knowing that such interventions are generally more effective than non-behavioral interventions still leaves practitioners with the task of choosing from a variety of techniques. The results of two recent meta-analyses concerning cognitive and behavioral interventions with aggressive children can provide a basis for treatment planning.

Wellen (1997) conducted a meta-analysis of 20 single subject studies of cognitive and behavioral treatments with aggressive children. Studies of children presenting with aggression as the primary problem, and with no other major clinical syndromes such as psychoses or developmental disabilities, were selected from a comprehensive search of the research literature. The subjects in the studies ranged in age from 3 to 17 and exhibited verbal aggression, physical aggression, or both. Wellen coded the dependent variables as measures of prosocial behavior or antisocial behavior. The treatment variables that made the greatest impact on increasing prosocial behaviors sometimes had a small effect on reducing antisocial behaviors. Similarly, the

treatments that had the largest effect sizes for reducing antisocial behaviors sometimes had minimal effect for increasing prosocial behaviors. Overall, treatments involving rehearsal (e.g., modeling, role-play, and social skills training) were the most effective.

Kendall's (1993) cognitive distortion and cognitive deficit model can explain Wellen's results. This model suggests that the cognitive processes of aggression involve both cognitive distortions and deficiencies. Aggressive children often engage in dysfunctional thinking and lack the skills to use environmental cues and process information accurately, especially regarding others' actions. Kendall suggested that practice involving techniques such as modeling and role-play leads to the development of more appropriate coping skills and social skills that were absent from the child's repertoire. None of the studies in Wellen's meta-analysis used rehearsal alone. Researchers combined rehearsal of new skills with other techniques. The combined treatments with the highest effect sizes were those that paired rehearsal with some form of contingency management such as contingent reinforcement, reprimands, response-cost, and time-out.

The type of contingency intervention employed had differential effects on the dependent variables. Positive behavioral interventions (positive rewards and praise) increased prosocial behaviors but did not reduce antisocial behavior. Negative behavioral interventions (reprimands, response-cost, and time-out) had larger effect sizes for reducing antisocial behavior but a much lesser effect on increasing prosocial behavior. Negative contingency management procedures yielded a larger effect size than the use of positive interventions.

DiGiuseppe et al. (1996) recently performed a meta-analysis on 20 between-groups outcome studies using cognitive and behavioral treatments for children and adolescents classified primarily as aggressive[1]. The findings suggested that the treatment components of modeling and behavior rehearsal (role-play) were most effective. This supports Wellen's (1997) finding with single case studies indicating that treatments involving rehearsal were most effective. As in Wellen's (1997) meta-analysis, use of negative contingency management techniques alone was more effective than use of positive treatments alone. Despite the greater acceptability of positive reinforcement, negative consequences might be more effective in reducing aggression. Surprisingly, negative techniques alone were also superior to the combination of negative and positive treatments. Further supporting Wellen's (1997) findings, positive techniques were most effective at increasing prosocial behaviors, whereas negative techniques were most effective in reducing undesirable behaviors. This suggests that therapists should choose different treatments depending on which types of behaviors are targeted for change.

[1] This meta-analysis is part of a larger ongoing meta-analysis of over 260 outcome studies involving a broader population of children with externalizing disorders.

DiGiuseppe et al. (1996) found that the combination of cognitive and behavioral therapies worked better with children than either one alone. Cognitive components included problem-solving, coping self-statements, and anger-management training, whereas behavioral components included positive and negative reinforcement techniques, relaxation training, and rehearsal techniques. Researchers often fail to operationalize their definitions of aggression and fail to distinguish between angry aggressive and predatory aggressive behavior. We believe that this distinction between types of aggression is important and that they may be responsive to different interventions.

Cognitive interventions may be more effective with children whose aggression is of the emotional type and less effective with the predatory type. Cognitive skills may help the child learn to reduce anger and thus limit impulsive aggression. Our clinical experience suggests that children with predatory aggression may respond better to contingency management and may be more resistant to treatment overall.

Wellen's (1997) meta-analysis of cognitive interventions consisted only of problem-solving strategies. However, the cognitive components of REBT involve more complex skills that require more motivation than problem-solving techniques alone. We recommend that instead of beginning with both behavioral and cognitive techniques, treatment should focus initially on behavioral techniques and then the cognitive component should be added as needed. At times it may be necessary to first use negative strategies so that the child's behavior can become more manageable. This may help the child to become more invested and motivated in treatment. A cognitive component can then be added while continuing the behavioral treatments. Also, at this time, one might include positive behavioral techniques with rehearsal. For instance, one might introduce a prosocial behavior one would like the child to increase. Besides positively reinforcing this behavior, the research indicates that giving the child an opportunity to practice the behavior through role-play or modeling, for example, is beneficial.

Results of these meta-analytic reviews suggest that therapists need to develop interventions that model and rehearse new cognitive and behavioral responses to emotionally laden eliciting stimuli. The effectiveness of these rehearsal interventions may be augmented by changes in the contingencies for aggressive behavior. Negative contingencies, such as response-cost and time-out, may be more effective than positive reinforcement. Also the negative interventions appear to eliminate antisocial behavior and positive contingencies help build new prosocial responses. However, the elimination of antisocial responses appears to need more attention initially when treating aggressive children. Finally, adding more interventions to the treatment does not necessarily lead to more effective treatment, and in fact, may reduce effectiveness. This presents a problem for clinicians treating angry children. Treatment usually entails teaching children to evaluate anger-provoking situations differently and to respond in new ways. Parents and teachers learn to control their own anger at the child, to consequate antisocial responses

negatively without being punitive, and to reinforce new prosocial responses positively, which is a lot to cover in treatment. Developmentally appropriate treatment models need to be created that allow these new skills to be implemented effectively.

## Major Mechanisms of Change

REBT theory posits four types of irrational thinking that lead to emotional disturbance: demandingness, awfulizing, global condemnation of human worth, and frustration intolerance. Two of these, demandingness and frustration intolerance, are most likely to be core schemas of children with emotionally reactive aggression.

### *Demandingness*

Demandingness is represented in English by the words "must," "should," "ought to," and "have to." These words reflect demands on how the self, others, or the world must be. REBT makes the distinction between preferences and demands. Individuals' desires do not cause disturbance. However, when individuals demand that their preferences become reality, those individuals may become disturbed. Demandingness can be thought of as schema assimilation rather than schema accommodation. When disturbed individuals encounter a situation that is inconsistent with their desires, they assimilate and still construct the world as consistent with their desires. Failing to distinguish between the situation as it is and one's desire leads to poor coping. When adjusted people encounter a similar situation, they accommodate and restructure their schema to include the discrepancy between the way the world is and what they want. This construction of the situation as inconsistent with one's desires is more likely to lead to adaptive coping responses. For example, an adolescent might tell herself, "My parents must let me do what I want." Not only does she want her parents to allow her to do as she desires, but she believes that because she wants it, they will comply. She may be shocked when they punish her for transgressions of their rules and she may continue to behave against their rules despite their feedback indicating that they disapprove of her behavior and will initiate consequences for it. A different young woman, who recognizes that her parents will not behave as she wishes just because she wishes it, may try to win them over to her view or pursue other avenues of gratification.

### *Frustration Intolerance (FI)*

Beliefs marked by FI imply that an individual cannot stand something he or she finds frustrating or that he or she does not have the endurance to survive in its presence. For example, someone who is addicted to caffeine might tell

himself or herself, "I cannot stand feeling the slightest bit tired when I have all this work to do; I must have some coffee." Or, the adolescent mentioned above may say to herself, "I cannot stand it if my parents do not let me do what I want." These types of beliefs are illogical as well because, short of dying, one is tolerating whatever one claims one cannot stand.

## Individual Psychotherapy with Children and Adolescents

Aggressive children often experience disapproval from many sources including parents, teachers, and peers. An important facet of aggressive behavior is that, like most externalized disorders, it is viewed as a problem primarily based on when and how others view it as a problem. However, those engaging in aggression are unlikely to view their behavior as a problem. As a result, most children attend therapy against their will. Aggressive children can be particularly difficult to treat because they are often not motivated to change their behaviors. Thus, when therapists encounter aggressive children, the initial goal of therapy is to motivate them for behavior change; that is, to ensure there is agreement on the goals and tasks of therapy.

Discussing the goals and tasks of therapy may be more critical to the establishment of a therapeutic alliance with children than with adults. Prochaska and DiClemente's (1981) constructs of stages and processes of change are particularly helpful in designing interventions for those unmotivated to change. They postulate that people pass through four stages of attitudes about change. These include the pre-contemplative stage (the person does not wish to change); the contemplative stage (the person is thinking about changing); the action stage (a person tries to change); and the maintenance stage (a person consolidates his or her gains and attempts to keep the new behaviors). Prochaska and DiClemente proposed that the type of therapy needs to match the clients' stage of change. REBT is an action-oriented therapy, designed for people in the action stage of change. Since most children and adolescents arrive in the pre-contemplative stage, the therapist must establish agreement on the goals and tasks of therapy to build the therapeutic alliance before using such an active approach.

DiGiuseppe and colleagues (DiGiuseppe, 1995; DiGiuseppe and Bernard, 1983; DiGiuseppe et al., 1996; Walen et al., 1992) presented a cognitive behavioral approach to establish the therapeutic alliance in children and adolescents who begin therapy in the pre-contemplative stage. A technique called the motivational syllogism may be used to reach agreement on the goals of therapy. The elements of this motivational syllogism are as follows and are described further in Table 1:

1. My present emotion is dysfunctional (for aggressive children, the dysfunctional emotion is primarily their anger).
2. An acceptable alternative emotional script exists for this type of activating event (e.g., annoyance).

TABLE 1. Steps of the Motivational Syllogism to Establish Agreement on the Goals and Tasks of Therapy.

Prerequisite Beliefs to Disputing Irrational Beliefs

**Insight 1:** My present emotion is dysfunctional. **Technique:** Through Socratic questioning, help the client understand how the present emotional reaction is dysfunctional.

**Insight 2:** There is an alternative acceptable emotional goal. **Technique:** Through teaching and reviewing acceptable models, help the client understand that there are alternative emotional scripts that are more adaptive.

**Insight 3:** It is better for me to give up my dysfunctional emotion and replace it with the alternative emotional script. **Technique:** Through Socratic questioning, have the client imagine feeling the new emotional script and review the consequences for the new emotions. This should accomplish agreement on the goals of therapy.

**Insight 4:** My beliefs influence my emotions, therefore, it is appropriate to examine and change my beliefs. **Techniques:** Teach the beliefs-consequences connection. This should accomplish agreement on the tasks of therapy.

3. Giving up the dysfunctional emotion and working toward feeling the alternative one is better for me.
4. My beliefs cause my emotions; therefore, I will work at changing my beliefs to change my emotions.

This model proscribes that the therapist ask clients in a Socratic fashion to assess the consequences of their emotional and behavioral responses. This helps clients identify the negative consequences for their maladaptive emotions and behaviors. Next, the therapist presents alternative emotional reactions that are culturally acceptable to each client. Because people learn emotional scripts from their families and some emotional scripts are culture-specific, it is possible that the disturbed child or adolescent has not changed because he or she cannot conceptualize and experience an acceptable emotional script in place of the disturbed emotion. REBT has adopted the script theories of emotions (DiGiuseppe, 1995) which proposes that clients need to learn adaptive emotional scripts, not just change the intensity of their feelings. As a result, it is helpful for therapists to be very careful with the words they use to describe emotions and to help clients to choose which emotions they will use to replace their disturbed emotion. They help clients formulate a vocabulary to describe adaptive, albeit negative, affective states that they could experience instead of the disturbed emotions. Therapists need to explore culturally acceptable alternative emotional reactions with the client. Next, therapists help clients connect the alternative script with an advantageous outcome.

Therapists then focus on helping the clients to change their dysfunctional cognitions and emotions. As mentioned earlier, with aggressive children and adolescents, the disturbed thoughts usually are centered around the irrational beliefs of demandingness or frustration intolerance, and the disturbed emotion is that of excessive anger. Therapists explain and demonstrate how thoughts can cause feelings and that certain thoughts, namely irrational beliefs (IBs)

produce disturbed emotions, whereas other rational beliefs (RBs) lead to nondisturbed emotions. Some children may have difficulty distinguishing between disturbed and nondisturbed emotions, and therefore, the therapist may need to teach them to identify and label various emotions, and then to be able to distinguish between those that are helpful and those that are hurtful. Further, the therapist teaches that thoughts can be changed to produce nondisturbed feelings. The therapist helps the child practice how to distinguish between disturbed and nondisturbed cognitions and emotions. Additionally, the child practices disputing irrational beliefs and replacing them with more rational thoughts. Specific techniques used to help children practice these skills include modeling, role-playing, imagery, and homework involving the parents. Other REBT techniques used with children include assigning self-help books (i.e., bibliotherapy) and written homework assignments.

Children who have not yet reached the concrete operational phase (those who are younger than 8-years-old) will have difficulty with the logic of disputing and thinking about their thinking. For these children, therapists can use treatments that focus on concrete skills, such as problem-solving (Spivack and Shure, 1974; Spivack et al., 1976) and rehearsing rational coping statements (DiGiuseppe, 1977; Meichenbaum, 1971).

Adolescents are concerned with forming their own identities. They are often oppositional and refuse to heed the advice of people from a different generation. Therefore, with adolescents it is particularly important to ensure that the therapist and adolescent agree on the goals and tasks of therapy, and to explain how the tasks will improve his or her current situation. We recommend therapists go through the steps of the motivational syllogism before the discussion of each new problem and before the use of any intervention. Establishing these four beliefs will help motivate a child or adolescent to engage in the REBT process. This model facilitates agreement on the goals of therapy and moves clients to the action stage of change. Therapists need to assess each child's and adolescent's stage of change and agreement on the goals of therapy before proceeding with any interventions. If the child or adolescent has not reached the action stage and does not want to change, techniques outlined by DiGiuseppe et al. (1996) or other similar techniques like motivational interviewing (Miller and Rollnick, 2002) could be used to bring about a desire to change.

## Parental Involvement in Treatment

Despite the context in which children are being treated, having parents involved in the treatment is crucial so that behavioral changes can generalize to the home setting. The problem is that although parents desperately want to see their child's behavior change, they often have difficulty carrying out behavioral interventions. Research has shown that the presence of parents' maladaptive emotions is the primary reason adults fail to engage in correct

parenting practices (Dix, 1991) and fail to benefit from behavioral parent training programs (Dadds and McHugh, 1992). Although behavioral parent training may be the most successful intervention for children with externalized disorders (Kazdin, 1994), parents are unlikely to follow a therapist's recommendations if their emotional disturbance about their child's behavior interferes. The failure to address parents' emotional reactions to parenting may be the largest void in the extensive parent behavior training literature (Petersen et al., 1997). In fact, the failure to find combined interventions as more effective than singular interventions in our meta-analytic review may occur because parents are too upset while interacting with their children to follow the behavioral interventions taught to them.

DiGiuseppe (1988) devised a sequential family therapy model for the treatment of families of children with externalized disorders. In this model, changing the parents' irrational cognitions and emotional disturbance is the goal in order to get the parents to adopt more effective parenting skills. This is necessary to accomplish the primary goal of changing the child's symptomatic behavior. The parents' disturbance is a crucial target of the interventions; both the parents' and the child's disturbances are treated with REBT. It is also helpful to have the parents involved in treatment from the outset so that the therapy does not reinforce what the child is likely to feel at home—that he or she is the problem child and the cause of the family's problems. This REBT family therapy model focuses on the following steps: (1) Conduct a thorough assessment of the child's difficulties, including a behavioral analysis of the eliciting stimuli, consequences, reinforcers, and family functioning; (2) Form a therapeutic alliance with the parents; (3) Choose a target behavior and appropriate consequences collaboratively with the parents; (4) Assess parents' ability to carry out the interventions, including their emotional reactions and irrational beliefs; (5) Change parents' irrational beliefs and emotions that may interfere with performing the new parenting strategies; (6) Have parents predict what resistance they expect to occur to their new parenting strategies from the identified patient or other family members and generate solutions to confront these attempts at resistance; (7) Assess the parents' ability to follow the strategies they choose to handle the resistance, again focusing on their emotions and irrational beliefs; (8) Intervene with parents again to change irrational beliefs and schema that may prevent them from handling the resistance; (9) Continue to assess the child's progress and the parents' compliance with the behavioral skills and modify the behavior treatment plan as needed; (10) Begin individual therapy with the child to internalize gains made by the behavioral intervention. These steps are presented in Table 2.

Even when the child is treated individually, parents can still play a role in treatment. When individual therapy is employed, parents are often unaware of the issues discussed by the therapist and child. Parents often want to be involved in their child's therapy because of their natural concern for their child's well-being. If the child agrees, if the problem does not involve a family matter the child would be unable discuss in front of his or her parents, and if the parents

TABLE 2. Sequence of family therapy for treatment of externalized disorders.

| Stages of Therapy |
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| **Stage 1: Conduct assessment:** Assess (1) the nature of the psychopathology (2) the developmental level of functioning and the discriminative stimulus that elicit the problems and its reinforcers (3) the structure of the family (4) the roles of the individual members (5) who will resist? (6) the emotions, cognitions, and skills of each member. |
| **Stage 2: Engage parents in the therapeutic alliance:** If one parent is resistant to change, use motivational interviewing or problem-solving with the motivated parent to engage the resistant parent. |
| **Stage 3: Plan behavioral intervention**: Choose a target behavior and consequences. Depending on the needs of the child and the family, the intervention can aim to increase a positive behavior or to decrease a maladaptive behavior. |
| **Stage 4: Assess parents' ability to carry out the agreed intervention:** Assess the parents' emotions and the cognitions which will stop them from carrying out the agreed upon intervention. Some possible parental interfering emotions: guilt, anger, anxiety, and discomfort anxiety. Assess the parents' irrational beliefs. Some possible irrational beliefs: (1) demandingness (2) catastrophizing (3) frustration intolerance (4) projected frustration intolerance (5) condemnation of the child. |
| **Stage 5: Conduct therapy with the parents:** Cognitive restructuring of the parents' irrational beliefs. Use all of the appropriate techniques of adult REBT to focus on the emotions and the cognitions identified in the previous stage. |
| **Stage 6: Predict resistance:** What do the parents believe the child or others will do to sabotage their efforts? Problem-solve how they can respond to those attempts at sabotage. This will help them continue to deal with sabotage on their own after termination. |
| **Stage 7: Assess the parents' ability to implement the intervention:** Ask the parents to imagine themselves following through. What emotions and beliefs will they have about this new action? What do they believe their emotional reactions will be? Assess the emotions and the cognitions that will get in their way of following through on the intervention chosen to counteract the sabotage. |
| **Stage 8: Conduct intervention with parents:** Dispute the irrational beliefs that they will experience that may lead to resistance. |
| **Stage 9: Assess how the child responds to the plan:** (1) repeat the assessment (2) redesign the interventions through collaborative problem-solving, if necessary (3) continue to assess the parents' ability to carry out the new interventions (4) continue to use cognitive restructuring to help them follow through on the planned interventions. |
| **Stage 10: Conduct individual therapy with the child or adolescent:** At the beginning of each session, assess the progress the child and the parents have made. If parents have followed their interventions, remain in this stage. If they have not, return to stage 8. Use motivational syllogism to help the child internalize the desirability of change and cooperation with the therapists. Use all REBT and CBT methods to reduce the undesirable target behaviors and support the desired positive changes. |

are willing, they can play a helpful role in the child's individual therapy. Bernard and DiGiuseppe (1990) recommend four different ways that parents can become involved to improve the effectiveness of individual therapy. First, children can be assigned the homework of describing important points of a session to their parents, such as the beliefs-consequences connection, disputes to irrational beliefs, or the rational coping statements they will use when they become upset.

This technique gives children opportunities to rehearse the principles therapists want to teach and allows the parents to feel involved in their child's treatment.

Second, parents can join the therapy session. When problematic activating events or emotional upset occurs between sessions, parents usually attempt to help their child and give advice. Sometimes parents' comments are inconsistent with the therapists' goals; they reinforce their child's irrational thinking, or they are just not helpful. If parents have been present during the sessions, they can remind their child of the rational coping statements provided in the session or they can use the principles of REBT that they learned in session to guide their responses to their child when the child experiences problems. Again, parents who participate in this way feel good about being part of the solution and learn how to talk to their child in ways that are helpful. Some parents even report that it has helped them with their own emotional problems.

Third, parents can provide information that children often forget. Weekly therapy sessions were designed for adults. Children often fail to remember significant events that happen between sessions, thus denying therapists important information about problems they have had since the last session. When parents are present, they often remind the children of their successful coping experiences which therapists can reinforce. The parents also report important activating events that children do not handle well which can be the focus of the session.

Fourth, therapists can often design homework assignments that include the parents. For example, children who react angrily when they are teased need to learn new rational coping statements in response to verbal attacks by peers. Often therapists can role-play the verbal attacks in the session and the children learn to rehearse their disputes and coping statements. Therapists can enlist the parents to role-play their children's tormentors between sessions. The parent can call out a barb to the child and the child will rehearse his or her new cognitions and new social skills. Here the parent prompts the rehearsal of a new response and can coach the child because of what the parent has learned in the session. Whenever and however possible, REBT involves parents in the child's treatment.

## *Case Study*

Jamie, a 9-year-old girl, was referred for therapy by her mother, because her parents could not control her behavior and were concerned that soon her behavior would be entirely out of their control. Her parents' primary complaint was that Jamie did not follow their directions. When she did not get what she wanted, she became verbally and physically aggressive. Her parents explained that when they ask Jamie to do something (such as helping them set the table for dinner, or letting her father watch sports events on TV), she often ignores them. At first she pretends she does not hear them and when they persist, she says that she does not want to do whatever it is they have

asked of her and that she should not have to do it. Further, often when Jamie asks something of her parents (such as if she can have a friend over) and they say, "No" to her, she whines and then becomes verbally aggressive, saying things such as "I hate you," or "You do not love me." If she still does not get what she wants she will, at times, begin to push and hit her parents. Jamie's parents reported that nothing they do helps. Socially, Jamie has few same-aged peers. Her friends are primarily younger children who let her control them. When they do not do what Jamie wants, she uses various verbal threats to scare them and when that does not work she will occasionally hit them. Academically, Jamie gets average grades and can be managed fairly easily in her classroom.

We can conceptualize this case from REBT, behavioral, and systemic perspectives. Because Jamie's parents had never established a pattern of firm limit setting with her, she learned that she could control the interactions with her parents and became used to getting her way. Her parents' attempts to enforce limits elicited IBs in Jamie that she *must* have her way and that she *cannot stand* failing to get what she wants. Feelings of extreme frustration and anger accompanied these IBs, which led Jamie to try even harder to get what she wanted, often by acting aggressively. Her parents' tendency to react to her by eventually giving in only served to reinforce the oppositional and aggressive behavior they wished to extinguish.

The first step in dealing with this case was to teach Jamie's parents to use more effective behavior management techniques. Before this could be accomplished, however, it was necessary to identify the core beliefs that were interfering with Jamie's parents' attempts at managing or disciplining their daughter. In working with her parents it was discovered that they felt guilty about punishing Jamie because they thought "It is awful if we cannot give her what she wants because then she might not love us. It must mean that we are not good parents if we make her upset." For Jamie's parents to be able to use behavioral techniques effectively, they first needed to work on challenging their IBs and replacing them with more rational beliefs. This helped them to change their dysfunctional feelings of guilt to more helpful feelings of concern.

Jamie's parents were then ready to choose a target behavior for Jamie. They wanted her to stop hitting her peers or parents. The therapist started with teaching her parents behavioral strategies of employing negative techniques through rehearsal, using strategies of time-out and punishment where natural consequences were established. In the therapy room, they role-played scenarios where Jamie pretended to hit her parents and her parents set consequences for her. Practice was accompanied by therapist feedback about how they could better carry out the techniques.

Once the initial negative behavioral strategies were in place, the next step was to begin having individual sessions with Jamie. Working on motivating her to want to change was crucial, making sure she agreed on the goals and tasks of therapy. This was accomplished through Socratic dialogue and the motivational syllogism. Jamie realized that becoming angry when things do

not go her way is not helpful for various reasons. She said she did not like feeling upset and seeing her parents get upset. She recognized that sometimes her anger caused her to say or do things to others that she would rather not do. Further, Jamie began to realize that her anger and the aggressive behaviors she exhibited made it difficult for her to form and maintain friendships. Jamie was taught that she could feel other ways that would be more helpful to her. She worked on learning this new emotional script. Next, she was taught how her beliefs influence her behavior. At this point she was more motivated to change her behavior and specifically to think about what kind of beliefs she has that influence her behavior. As she approached the action stage of change she was willing to use rational self-statements and start challenging her own IBs saying things to herself such as, "I guess I do not have to have my parents do what I ask . . . though I prefer they do what I want. This way I won't feel so angry when they do not do what I want. Instead, I would feel a little mad and not really angry." At this point Jamie's parents were encouraged to begin using positive techniques with rehearsal in the therapy setting and at home. For example, one of Jamie's target behaviors was setting the table. The family, with the therapist, devised a reward system contingent upon Jamie's behavior. Jamie's parents continued to use negative strategies once they had successfully implemented the positive techniques.

## Research Support of REBT

DiGiuseppe and Nevas (1997) discovered fourteen reviews of REBT (DiGiuseppe et al., 1977; Engels et al., 1993; Gossette and O'Brien, 1992; 1993; Haaga and Davison, 1989; Hajzler and Bernard, 1991; Jorm, 1989; Lyons and Woods, 1991; Mahoney, 1974; McGovern and Silverman, 1984; Oei et al., 1993; Polder, 1986; Silverman et al., 1992; Zettle, and Hayes, 1980). Most of these are narrative reviews. Three have been meta-analyses (i.e., Engels et al., 1993; Lyons and Woods, 1991; Polder, 1986). Most have included studies of adults and children. Others have focused only on adults (i.e., Gossette and O'Brien, 1992; Zettle and Hayes, 1980) and two have focused only on research with children and adolescents (i.e., Gossette and O'Brien, 1993; Hajzler and Bernard, 1991). Most reviews have been favorable, although some others have been critical. Table 3 lists the reviews alphabetically by author and includes the year published, the range of years included in the studies, the populations reviewed, and their general conclusions.

Each review employed a different selection criterion. More than 280 outcome studies are mentioned in these fourteen reviews. However, the reviews rarely included the same studies. Only 13 studies appeared in five reviews, and only 3 studies were included in six reviews. No study appeared in seven or more of the reviews. One hundred and twenty-four studies were mentioned in only one review. DiGiuseppe and Nevas (1997) point out that the reviews had

TABLE 3. Meta-analytic reviews of the REBT outcome literature.

| Author(s) | Year Published | Range of Years Studied | Number of Studies | Population Reviewed | Conclusions |
|---|---|---|---|---|---|
| DiGiuseppe, Miller, and Trexler | 1977 | 1970–1977 | 26 | Published and unpublished studies of children and adults. | RET “. . . appear(s) generally positive and promising, but far from conclusive.” p. 70 |
| Engels, Garnefski, and Diekstra | 1993 | 1970–1988 | 32 | Published and unpublished studies of children and adults. | “RET on the whole was effective, compared with placebo and no treatment. Its effects were maintained over time, and it produced a delayed treatment effect with regard to behavioral outcome criteria.” p. 1088 |
| Gonzalez, Nelson, Gutkin, Saunders, Galloway, and Shwery | 2004 | 1972–2002 | 19 | Published studies of children and adolescents. | “The overall mean weighted effect of REBT was positive and significant...the longer the duration of REBT sessions, the greater the impact...children benefited more from REBT than adolescents” p. 222 |
| Gossette and O’Brien | 1992 | 1970–1990 | 85 | Published and unpublished studis of adults. | “RET was effective in 25% of comparisons.” p. 9 RET results in, “...a decreased score on scales of irrationality... a parallel decrease in self reported emotional distress. Other measures, noticeably behavior, were insensitive to RET...RET has little or no practical benefit “ p. 20 |
| Gossette and O’Brien | 1993 | 1974–1992 | 36 | Published and unpublished studies of children and adolescents. | RET has little or no practical benefit. “The most distinctive outcome of RET is a decrease in the endorsement of irrational beliefs.” p. 21 “We can conclude that continued use of RET in the classroom is unjustified, in fact, contraindicated.” p. 23 |

*(Continued)*

TABLE 3. Meta-analytic reviews of the REBT outcome literature. (*Cont'd*)

| Author(s) | Year Published | Range of Years Studied | Number of Studies | Population Reviewed | Conclusions |
|---|---|---|---|---|---|
| Haaga and Davison | 1989 | 1970–1987 | 69 | Published and unpublished studies of children and adults. | Supported the effectiveness of REBT but pointed out limitations to the research designs used. |
| Hajzler and Bernard | 1989 | 1970–1982 | 45 | Published and unpublished studies of children and adolescents. | "...support for the notion of changes in irrationality and changes in other dimension of psychological functioning." ".....changes have been maintained at follow up periods." p. 31 |
| Jorm | 1989 | 1971–1986 | 16 | Studies of any type of theory that included a measure of trait anxiety or neuroticism. | "While RET and related therapies proved superior in the present meta-analysis (to other therapies), this conclusion is limited by the breath of studies available." p. 25 |
| Lyons and Woods | 1991 | 1970–1988 | 70 | Published and unpublished studies of children and adults. | "The results demonstrated that RET is an effective form of therapy. The efficacy was most clearly demonstrated when RET was compared to baseline or other forms of controls. Effect sizes were largest for dependent measures low in reactivity (i.e., low reactivity = behavioral or physiological measures; high reactivity = measures of irrational thinking)." p. 368 |
| Mahoney | 1974 | 1963–1974 | 10 | Published and unpublished studies of cognitive restructuring and RET. | RET "... has yet to be adequately demonstrated" and "... may be viewed as tentatively promising." p. 182 |

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|---|---|---|---|---|---|
| McGovern and Silverman | 1984 | 1977–1982 | 47 | Published and unpublished studies of children and adults. | "...there were 31 studies favoring RET. In the remaining studies, the RET treatment groups all showed improvement and in no study was another treatment method significantly better than RET." p. 16 |
| Oei, Hansen, and Miller | 1993 | 1982–1988 | 9 | Studies designed to assess whether irrational beliefs mediate change in other psychological constructs. | "This review demonstrates that while RET has been demonstrated to be an effective therapeutic intervention for a variety of target problems, there is no evidence to show that improvement in RET is due to changing irrational beliefs to rational beliefs." p. 199 |
| Polder | 1986 | MI | 53 | Controlled studies of adults. | REBT yielded higher effect sizes than other forms of CBT. |
| Silverman, McCarthy, and McGovern | 1992 | 1982–1989 | 89 | Published and unpublished studies with children, adolescents, and adults. | "...49 studies resulted in positive findings for RET." When compared to other treatments, "...no other treatments were found to be significantly better than RET." p. 166 |
| Zettle and Hayes | 1980 | 1957–1979 | 20 | Published and unpublished studies with college students and adults. | "... the clinical efficacy has yet to be adequately demonstrated." p. 161 |

*MI=Missing Information

very low agreement on which studies to include. Each of the fourteen reviews ignored, excluded, or failed to uncover many studies from the period from which the articles were selected. The most comprehensive reviews were the two by Silverman and colleagues (McGovern and Silverman, 1984; Silverman et al., 1992). More recently, Gonzalez et al. (2004) provided a meta-analysis in support of REBT for children and adolescents.

DiGiuseppe and Nevas (1997) found more than 70 REBT outcome studies not included in the reviews. More than 350 REBT outcome studies have been found. Many studies exist that compare REBT to no treatment, wait-list controls, or placebo controls, and support the efficacy of REBT across a wide range of problems including: social, testing, math, performance and public speaking anxiety, agoraphobia, neuroticism, stress, depression, anger, teacher burnout, personality disorder, obsessive compulsive disorder, marriage and relationship problems, alcohol abuse, poor dating skills, overweight/obesity, school discipline problems, unassertiveness, type A behavior, parenting problems, emotional reactions to learning disabilities, school underachievement, sexual fears and dysfunction, bulimia and anger. Few studies have specifically focused on the treatment of aggression but the outcome studies conducted on REBT with children who exhibited aggressive behavior displayed successful results (e.g., Block, 1978; Morris, 1993). A series of studies, not mentioned by any of the reviews, suggests that REBT can be useful for practitioners working in clinics or school settings. Sapp used an REBT program with African-American children to improve their academic performance (Sapp, 1994; 1996; Sapp and Farrell, 1994; Sapp et al., 1995).

Despite the large number of investigations of REBT, research has failed to advance our knowledge. The overwhelming majority of studies compared REBT with a no contact, wait-list, or placebo condition. Few studies compare REBT with a viable, alternative treatment. REBT is better than no treatment or placebo treatments for a wide variety of problems. However, no evidence exists that it is more efficacious than alternative treatments or that there is one condition for which it is the treatment of choice.

Also, the research has done little to advance our knowledge concerning the best way to practice REBT. For example, does the inclusion of imagery, written homework forms, bibliotherapy, or the style of disputation make a difference in the outcome? Or how many sessions of REBT are necessary for clinical improvement? Researchers have failed to examine the critical components of REBT. No studies have addressed the issue of whether the positive effects of REBT are obtained by changing clients' irrational beliefs before change occurs in other dependent measures (Oei et al., 1993). Lyons and Woods' (1991) meta-analysis suggested that more therapy sessions produced greater effect sizes and that more experienced therapists produced larger effect sizes than less experienced therapists. They concluded that dependent measures low in reactivity produced higher effect sizes than measures high in reactivity. These findings are the opposite of those reported by Gossette and O'Brien (1992, 1993).

Generally, psychotherapy research with children and adolescents has lagged behind research with adults (Kazdin, 1994). This has also been true of research in REBT. Sixty-nine studies mentioned in the 14 reviews of REBT treated children or adolescents. However, most of these studies could be considered analogue studies or tests of REBT as a preventive intervention because they focused on using REBT with normal children in groups or in classrooms. Studies of clinically diagnosed children and adolescents are lacking and fewer studies exist for externalizing disorders in children. No outcome study yet exists to test the Sequential REBT approach to family therapy advocated here. Research on modifying parents' irrational beliefs has found REBT to be successful in improving parents' emotional reactions to their children (Joyce, 1995). Greaves (1997) expanded on Joyce's program and showed that the program could reduce stress and improve parenting skills in parents of Downs Syndrome children. Although more research is needed, these studies suggest that psychologists may find REBT useful with children and parents.

Meta-analytic reviews of psychotherapy with children and adolescents have demonstrated that behavioral and cognitive therapies produce more change than non-behavioral, traditional non-directive, or play therapies (Weisz et al., 1987; see Kazdin, 1994 for a review). Since REBT shares many similarities with other behavioral and cognitive therapies, research on REBT with children and adolescents will continue to support its effectiveness.

## Future Research

Researchers have failed to distinguish between predatory aggression and anger provoked aggression. We believe that such a distinction may be helpful in designing effective treatments. The relationship between anger and aggression is unclear for adults and unstudied with children (DiGiuseppe et al., 1994). Anger provoked, or emotionally reactive aggression may respond more to REBT or other individual cognitive interventions as compared to instrumental or predatory aggression. Children with predatory aggression may also need more time spent on interventions that reflect strategies such as the motivational syllogism so that they are invested in treatment. However, most of the efforts of this intervention would be focused on the negative consequences of their aggressive behavior. Children with angry aggression require a focus on alternative emotional reactions.

Further, many questions remain unanswered concerning the effectiveness of REBT with aggressive children and their parents. This is especially important in light of managed care demands. Is REBT more efficacious than other CBT or behavioral interventions? Addressing the effectiveness of specific techniques in REBT with children and adolescents is important for research. Do all children benefit from logical disputing, or would rehearsing rational coping skills without disputing be as effective? Although some evidence indicates that children can benefit from REBT written homework forms

(Miller and Kassinove, 1978), do all children benefit from the bibliotherapy and written homework sheets frequently used in REBT?

More research is also needed to examine the effects of modifying parents' irrational beliefs. Specifically, will this help to increase the parents' ability to benefit from parent training and will this directly be related to a decrease in their children's aggressive behavior? Further, research is needed to test the Sequential REBT approach to family therapy. These are only a few of the many research questions that need to be addressed in order to develop effective treatments for aggressive children.

## Summary

In children with reactive aggression, feelings of anger drive their aggressive behavior. To treat these children most effectively, utilizing both behavioral and cognitive techniques is necessary. REBT is particularly well-suited for this purpose. The use of negative strategies and positive strategies combined with rehearsal are critical in decreasing inappropriate behaviors and increasing prosocial behaviors, respectively. One of the most important and challenging aspects of treating aggressive children is stimulating them to become motivated for treatment and helping them progress from the precontemplative to the action stage of change. The use of the motivational syllogism and obtaining agreement on the goals and tasks of therapy are critical to achieving this end. Further, helping children dispute and replace their IBs with RBs enables them to substitute feelings of anger with less disturbing feeling of annoyance. Besides working directly with the children, involving the parents in the treatment as much as possible is crucial. It is often necessary to work with the parents in disputing and replacing their IBs before they can manage their child's behavior effectively.

REBT focuses on the role of irrational, dogmatic, and rigid thinking in causing psychopathology. Irrational beliefs are tacit, pervasive, rigid schematic representations of the way the world is and ought to be. These beliefs are both factual and evaluative in nature. Beliefs are irrational when they are rigidly held in the face of evidence that they are logically inconsistent, anti-empirical, and self-defeating. The theory further discriminates between adaptive and maladaptive emotions. Its goal is not to eliminate negative emotions, but to replace maladaptive negative emotions with more adaptive negative emotions and to help individuals improve their lives and be free of emotional disturbance.

The primary techniques of REBT involve challenging and replacing dysfunctional irrational beliefs. Many logical, empirical, and functional strategies to challenge beliefs are recommended. In addition, REBT employs a wide range of behavioral, imaginal, and emotive exercises to cause change. The theory stresses the importance of rehearsing new ways of thinking and a variety of appropriate techniques that accomplish this.

Although REBT was originally designed for adults, it has been used with children and adolescents for more than 25 years. It follows a psychoeducational model that allows it to be used in groups, workshops, and classrooms as a preventative procedure. Because of its psychoeducational format, REBT can easily be integrated into educational settings. It can be used in an educational format to teach students, parents, and teachers how to reduce their emotional disturbance and improve their productivity. REBT provides a model for school mental health services including direct service and consultation.

REBT can be integrated with family systems theory to work with parents. The theory helps identify the clients' thinking that reinforces family dysfunction. The use of REBT techniques can eliminate parents' emotional disturbance so they are free to explore and follow more productive models of relating and parenting. Since REBT shares many similarities with other behavioral and cognitive therapies, there is reason to suspect that research in REBT with children and adolescents will continue to support its effectiveness.

There is a substantial body of research supporting the efficacy of REBT. However, this research has employed too few designs and has not compared REBT to alternate active treatments. Future research could focus on identifying the crucial techniques of REBT, the problems and populations for which it is best suited, and more efficient ways of achieving change in clients.

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