REBT with Children and Adolescents

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From its inception, Albert Ellis pioneered the application of REBT with children and adolescents, stressing, in particular, the importance of teaching young clients positive mental health concepts that would promote their social, emotional, behavioral, and cognitive development. Although REBT has been practiced very successfully with young clients, one of the misconceptions is that it is simply a "downward extension of REBT adult methods" (Ellis & Bernard, 2006, p. xi). In fact, there are numerous specific techniques that have been adapted to complement the developmental levels of children and adolescents, helping them learn REBT concepts in their "own language" through unique approaches that enable them to apply the basic theoretical principles to address typical developmental challenges as well as more serious problems.

There are compelling reasons why REBT is especially appropriate for this population. First, it is generally a briefer form of counseling, which is very effective with young clients whose sense of time is more immediate. Consequently, the problems they present with today might not be problematic next week, which is why it is so important to help them in the "here and now." Second, this theory takes into account the developmental level of the client. DiGiuseppe and Bernard (2006), as well as Vernon (2009a), all stressed the importance of using concrete examples which are more developmentally appropriate, involving young clients in "doing" and "seeing" as much as "hearing" (DiGiuseppe & Bernard, 2006, p. 88). Third, children and many adolescents are still very concrete thinkers, which can become problematic in that their capacity for logical problem solving is limited. REBT promotes the use of specific techniques that help young clients distinguish between facts and assumptions, identify irrational beliefs, and learn perspective-taking in order to facilitate more effective problem solving. In addition, this theory and its therapy teaches young people what they realistically can and cannot change in their lives. Given the high

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preponderance of dysfunctional families, abuse, violence, bullying, and the increasing challenges in this contemporary society that negatively affect youth, learning how to control their thoughts, feelings, and behaviors can empower young clients to deal more effectively with problematic events and issues.

REBT has been shown to be highly effective with youth for a variety of presenting problems such as: anxiety and phobia (Silverman, Pine, & Viswesvaran, 2008), obsessive-compulsive disorder (Barrett, Farrell, Pina, Perls, & Piacentini, 2008), trauma (Cohen, Mannarino, & Murray, 2011), social phobia (Crawley, Beidas, Benjamin, Martin, & Kendall, 2008), depression (Vernon, 2006c), aggression (DiGiuseppe & Kelter, 2006), eating disorders (Phillips & Rogers, 2011) and ADHD (Doyle & Terjesen, 2006). For all of these more serious psychological problems, REBT has proven to be "best practice," and in addition, it is also widely regarded as a highly effective preventive approach in schools (Bernard, Ellis, & Terjesen, 2006; Vernon, 2009b).

Several scholars and practitioners have contributed to the REBT literature as it applies specifically to children and adolescents. Knaus (1974) developed a curriculum that teaches children the ABC's of REBT. Bedford (1974) wrote a short story emphasizing the connection between thinking, feeling, and behaving, and Waters (1979) created a coloring book that incorporates rational principles. Bernard and Joyce published a book in 1984 on REBT treatment strategies and preventative methods with children and adolescents, and in 2006 Ellis and Bernard and contributing authors wrote a comprehensive text on REBT approaches to childhood disorders. In addition, other curricula (Bernard, 2001, 2005; Vernon, 2006a, 2006b) have been written that teach children to develop critical thinking skills, differentiate between facts and assumptions, identify irrational beliefs and distorted cognitions, distinguish between healthy and unhealthy emotions, identify what causes emotional upset, and develop various ways to challenge irrational beliefs.

The purpose of this chapter is to describe specific applications of REBT with children and adolescents, including core theoretical concepts, assessment and treatment strategies, and treatment guidelines. A case example will illustrate the process of this theory, which has been proven to be highly effective with this population because it has a preventative emphasis and promotes skill acquisition. Not only does REBT teach young clients how to *think* better, which helps them *feel* better and also *get* better, but it can be readily adapted to children of most ages, cultural backgrounds, and intelligence levels.

Key REBT Theoretical Concepts When Working with Children and Adolescents

One of the distinguishing features of REBT as it applies to children and adolescents is the emphasis on teaching and prevention. Knaus (1974) described REBT as a therapeutic approach "by which children can be taught sane mental health concepts and

the skills to use these concepts" (p. 1), and Wilde (1992) emphasized the importance of "arming" young clients with knowledge and skills to use in the present as well as in the future. The basic core concepts that characterize REBT can be readily adapted so that young clients can comprehend the essence of the theory. Specifically, it is critical to orient children and adolescents to the following.

Emotional and Behavioral Problems Result from Irrational Beliefs

It is important to teach young clients that emotional and behavioral problems result from irrational beliefs about the event, not the event itself. This concept can be difficult for adults to grasp, which makes it imperative that it be presented to children and adolescents in a very concrete manner, personalizing it so it will be clear and relevant. For example, if I were working with a 9-year-old who had a sibling, I would ask him if he and his sister always feel *exactly* the same way when their parents won't let them do something that they really want to do. If he says yes, then I might ask: "So suppose you both want to watch a special TV show…what do you *do* when you dad says no?" "And does your sister act *exactly* the same as you do?" Depending on the developmental capability of the young client, it might be necessary to "come in the back door," so to speak, by asking about the behavior, which he or she can often relate to more readily than the emotion, and then have a discussion about how the behavior relates to the feeling. In other words, if the client threw a fit and his sister just shut herself in her room, he was probably angry and she might have just been annoyed or disappointed, which can be explained to the client, asking him if he indeed felt angry, or was there a different emotion? This concept could also be conveyed by using a brief example: "Suppose there are two cousins who are going to an amusement park. Their parents buy them tickets for the roller coaster. One of the cousins is jumping up and down because she is so excited. The other throws up because he is so scared. It is the very same situation—a roller coaster ride, but why are these two cousins feeling differently about it?" Generally with young clients this concept needs to be explained in multiple ways over time in order for them to clearly understand the connection between what they think, feel, and behave.

When Thoughts Change, Feelings Change

The notion that feelings can change when thoughts change is especially significant for young clients who in reality have little control over some of the events in their lives. As previously noted, they have no control over their parents who may decide to get a divorce, and they don't get to choose a stepparent or decide if the family is moving to another city or country. Therefore, helping them understand that while

they might not be able to change the event, they can change how they feel about it can have an important impact. This concept can be illustrated to an adolescent by an example such as the following: "Suppose you are at the shopping mall and your best friend suddenly grabs your arm and pulls you out of the main walkway into a narrow corridor. You get angry and tell her to stop pushing you around and are just about ready to push her back when she whispers that she saw a person with a gun coming out of the food court. Once you have that information, would you still feel angry or would you feel something different?" Reinforce this concept with other examples so that they clearly understand the concept.

Two Kinds of Beliefs

As Ellis (1962, 1994) has proposed, there are two kinds of beliefs: rational and irrational. This terminology can be confusing for younger clients, so terms such as "sensible and insensible" or "hot thoughts and cool thoughts" are more effective. The distinction between these two types of beliefs can be taught to young clients in several developmentally-appropriate ways such as through games, music, or stories. For example, in working with an 8-year-old, I would read a story entitled *I Have to Have My Way* (Vernon, 2006a, pp. 47–48) about a boy who was so demanding during a ball game that his friends didn't want to play with him. After discussing the concept of demandingness as reflected in the story, I would contrast demands with preferences by asking if it makes sense to *demand* that his friends always play exactly what he wants and if they don't he gets mad and refuses to play with them, or if it makes more sense to *prefer* that they play a game the way he wants it to be played but understands that he can't have his way all the time and keep his friends. To reinforce these new learnings I would then engage him in a bean bag toss, reading a statement that is either a sensible or an insensible belief. If sensible, he tosses the beanbag into a small box labeled "sensible" and if not, he tosses it into a similar box labeled "insensible" and then we would discuss why it is insensible and how he could change it to make it sensible. These same methods can be used to explain demands against self (the need to be perfect, to be liked by everyone), awfulizing, global evaluation of human worth, and frustration intolerance. Using the story of *The Little Engine that Could* (Piper, 1986) about persistence and frustration tolerance, coupled with the following song (Vernon, 2009a, p. 177) illustrate other concrete ways of conveying key REBT concepts to a 10-year-old who was easily frustrated by tasks that she didn't like to do.

(Sung to the tune of *Are You Sleeping*)
I can't stand it, I can't stand it, no I can't, no I can't
This is just too boring, I just feel like snoring,
I can't stand it, I can't stand it
The second verse portrays the rational belief:
I can stand it, I can stand it, yes I can, yes I can!

I don't have to like it, I just have to do it,
I can stand it, I can stand it.

Disputation

Although this can be a challenging concept to explain to young clients, there are many different interventions that concretely convey the essence very well. For example, use the metaphor "erase" the irrational with an adolescent who is struggling with self-demands. In one column have her write each of her irrational beliefs on individual lines, and in the next column, have her pretend to "erase" the irrational beliefs and replace them more helpful ways of thinking, such as: rather than thinking "I MUST always be perfect," the rational response could be: "I WANT to do well and I will try my best, but if it's not perfect, it doesn't mean I'm stupid". With younger children, play a game such as *Race to be Rational*, where the client draws a card and reads it, and decides it if is a rational (sensible) belief or an irrational (insensible) belief. An example might be an *awfulizing* belief: it is awful if I don't get my way. If the client is correct and says it is irrational, he must identify a rational alternative. If he is able to do this he then gets to move his toy matchbox car ahead on a race track (drawn on a large sheet of poster board) the number of spaces specified on the back of the card. If his answer is incorrect or he is not able to identify a rational belief, he stays where he is and draws another card when it is his turn. By playing with the client, I can serve as a role model by identifying rational/sensible beliefs when I draw an irrational/insensible belief card.

The A-B-C Model

Albert Ellis developed the A-B-C model as a way of conceptualizing the major constructs of REBT and the process of change. This model can also be explained to children and adolescents using creative approaches. With younger children, movement generally works well since many "learn by doing." An effective strategy is to write the letters A-B-C-D-E on large sheets of poster paper and place them on the floor. Ask the young client to stand on the "A" and explain that it stands for something that happened or might happen or what the client thinks happened. Then generate a recent example based on the client's experience. Next, have her hop over to the "C" and explain that it stands for the emotional and behavioral consequences, or how the client feels about the "A" and how she behaves in relation to it. Help her generate responses to the "C" based on the identified A. Then ask the client to hop to the B, explain what it is, and help her identify the beliefs associated with the A and the C. If the A that was identified was positive, the model can still be explained up to the point of irrational beliefs, but then it would be necessary to say something like,

"Let's pretend that instead of getting a good grade that you felt excited about and thought that you were pretty smart for getting it, let's pretend that the grade wasn't good. Then how would you feel, behave, and think?" In this way the D, disputation, can be hopped to and worked through even though the client didn't actually identify a negative situation. This is a helpful psychoeducational technique to use because as is often the case with younger clients, they may not want to admit that something is wrong, but by having them *pretend* that the situation was negative and not positive, it is possible to teach them the disputation process anyway. In my experience, clients sometimes "bend the truth" a bit and later admit that the event was actually negative. So referring again to the notion of pretending that the grade was bad, the counselor might say to the client, "how do you think you would feel if you had gotten a bad grade instead of a good one, and if you felt that way, how do you suppose you might react? After the client responds, the counselor would say, "Now, what might have been going through your mind when you got the paper back with a bad grade instead of a good one?" After eliciting the beliefs, the counselor would ask the client to hop to the D, disputation, and explain what this means, asking the client questions that challenge the irrational beliefs she identified in the hypothetical "bad grade" scenario. For example, the counselor could ask the client how one bad grade proves that she is stupid, how helpful is it to think she will never get good grades again, or if she can really prove that she is totally worthless because she got this bad grade. Finally, have the client hop to the E and ask how she feels and thinks after the D, explaining that this is the goal…to feel better, think more reasonably, and behave more appropriately. The A-B-C model can also be taught using stories such those found in *Rational Stories for Children* (Waters, 1980) or by having adolescents participate in the ABC activity (Vernon, 2006b, p. 37) which helps them understand more about core REBT concepts as exemplified in the ABC model.

Key Best-Practice REBT-Based Assessment and Treatment Strategies and Techniques in Working with Children and Adolescents

Although there has been considerable research focused on the effectiveness of REBT with adults, these findings cannot be generalized to children and adolescents because there are important differences between these two populations. To learn more about the impact of REBT on children and adolescents, Gonzalez et al. (2004) conducted a meta-analysis. They found that REBT had the most impact on disruptive behaviors and that REBT was equally effective for children and adolescents whether they had an identified problem or not, which suggests that this therapy is effective for prevention as well as intervention. Furthermore, they found that after REBT treatment, "the average child or adolescent scored better on outcome measures than approximately 69% of the untreated control group" (p. 232). While these findings are good, the

authors emphasized that there is a "paucity of and greater need for empirical studies using REBT with children and adolescents" (p. 233).

When working with children and adolescents, the assessment and treatment process is essentially the same as it is with adults except for the fact that developmentally-appropriate methods must be used because there are significant differences between the way adults and children present and process information. In the following paragraphs, examples of specific ways to assess the activating event, the emotional and behavioral consequences, and beliefs will be described, followed by examples of developmentally-appropriate treatment techniques.

The Therapeutic Alliance

As REBT therapists, we typically believe that we strengthen the therapeutic alliance by *working* on the problem. However, with most young clients it is important to spend time at the beginning of therapy doing some specific rapport building activities, for several reasons. First, they are usually referred by someone else and may not think they have a problem or even know what it is, so they may be more reluctant to engage. Second, attending therapy is most likely a new experience for them and they may feel quite anxious. In addition, therapists can learn a lot about the client by engaging in various get-acquainted activities and use this information in later sessions as metaphors or analogies or examples. I recall working with an 8-year-old who was very perfectionistic. During our first session we had played a game called *Who Are You* (Vernon, 2009a, pp. 26–27), in which we took turns asking: who are you and responding with something about ourselves that we were willing to share. In one of the examples she said that she loved to ride her bike and skate. So when it came up in one of the sessions that she thought she had to do everything perfectly the first time, I asked if she remembered the first time she rode her bike or tried to skate…did she do these things perfectly right away or did she learn to do them better with practice? Personalized examples such as this are very helpful because they convey the concepts in a more concrete manner which facilitates understanding. Using rapport-building activities such as games, movement activities, art or music also helps put younger clients more at ease and paves the way for a more productive therapeutic experience. Games and movement activities may not be appropriate for adolescents, but there are other ways to break the ice, such as inviting them to share a series of songs that are meaningful to them or to bring in their high school yearbooks and share pictures of their best friends, activities they are involved with, and so forth.

Assessment Strategies

In assessing the activating event, I might ask children to draw a picture of the problem, act it out, or pretend like they are telling me a story about the problem. Oftentimes

children and adolescents may be reluctant to share what the problem is because they may feel embarrassed or think that there is something really "wrong" with them, so it is important to explain that everyone has problems from time to time and the smart thing is to get some help so the problem doesn't get worse.

Once you have a sense of the problem, then ask how the child feels about the problem. This may be more challenging for younger children who may not have a well-developed feeling vocabulary, so it is often necessary to have the client select a feeling from a short list of feeling words, act out or pantomime the feeling, or draw a picture that portrays it. Psychoeducation may also be important—I might read a book about feelings or play a feelings game with younger children to help them understand more about feelings so that they can better identify their own emotions relative to an activating event. Although adolescents generally have a broader feeling vocabulary, they may be reluctant to admit to having certain emotions. In this case, I would use bibliotherapy, having them read about how other adolescents felt when experiencing a similar activating event. Similarly, cinematherapy is also an effective way to promote identification of feelings.

With young clients, it is especially important to assess the behavioral consequence as well as the emotional consequence because children often express how they feel through their behavior. Therefore, if they are unclear about the emotional "C," asking for the behavioral "C" is an effective way to assess it as well. If they have given you an emotion, then simply ask them how they behaved when they felt angry. If they weren't clear about the emotion, ask what they did in relation to the activating event and then infer the feeling, saying something like: "Since you said you hit your brother when he didn't let you play with his soccer ball, it sounds like you might have been angry?"

The next step is to assess beliefs, which can be challenging with both children and adolescents, so it is important to use very concrete strategies such as thought bubbles, sentence completions (when I felt anxious, I thought_____), or have puppets dialogue about the activating event. Inference chaining and the "think aloud" technique (Vernon, 2009a) are also helpful. *Supplying the inference as a hunch* ("Some kids might think they are total losers if they miss something on a test. Is that what you think?") or playing a game such as *Rational or Irrational* (Vernon, 2002, pp. 48–49), where young adolescents learn to distinguish between rational and irrational beliefs so that they can classify their own beliefs are age-appropriate assessment techniques. *Rational emotive imagery* may also be helpful in assessing beliefs.

Treatment Techniques

Given that disputation is the "heart and soul" of the REBT model, it is imperative to use techniques that are concrete and oftentimes psychoeducational, introducing young clients to the process through creative methods. As with adults, functional, empirical, and logical disputes are effective, but it is not good to rely solely on verbal

methods with this population. For example, a reverse role play is a very concrete way of helping young clients generate their own disputes. I used this with an 8-year-old who was quite perfectionistic and became very frustrated and upset when he performed less-than-perfectly on an assignment. I pretended to be him and he assumed the role of the teacher. When he handed me back my paper I got frustrated and threw it on the floor, verbalizing how horrible it was that I missed several and that I was stupid. His reply as the teacher was, "That's ok; you just made a few mistakes and it isn't worth getting upset about. You can try harder next time." In my role as the student, I said, "But I always have to get everything right because if I don't, it proves I am stupid." His reply was, "No, you are not stupid and you don't always have to get everything right." After several rounds of this type of practice he was able to generate quite a few rational beliefs to counteract his irrational thoughts.

Other age-appropriate techniques include the Best Friend technique ("If your best friend told you that you were a complete loser because her boyfriend broke up with her, would you agree with her or tell her something different?") and the Survey technique (Vernon, original). I used this with an adolescent who insisted that her parents were the worst in the world because they never let her do anything. Asking her for "evidence" that they were so horrible was not effective because she stubbornly insisted that they were, so I asked her to survey others her age, asking them questions about what their parents did or didn't allow them to do. We developed the survey in the session and she actually used it with ten of her friends, concluding that everyone else's parents were just like hers! With this understanding, it was easier to work with her to dispute her demand that her parents should always let her do exactly what she wanted to do.

Other effective disputing techniques include having young children pretend that they are "fact detectives," hunting for facts (versus assumptions) that are hidden throughout the room. After they have learned the difference between these concepts they can more accurately analyze their own problem to see if they are making assumptions and misconstruing the situation. *Stay Cool is the Rule* is a good strategy to help children replace their "hot thoughts" with "cool thoughts." They write their "hot thoughts" on tongue depressors that have red lines at the ends to resemble fire and for each one, they take a square of paper resembling an ice cube and write a "cool thought" replacement (Vernon, 2002, pp. 159–162). Having them perform rational puppet plays is another way of identifying disputes, as well as writing rational limericks, poems, and songs.

When working with this age group, it is especially important to reinforce rational thinking in many different ways. Having clients monitor movies or television shows for irrational beliefs and then writing rational replacements can be helpful, as well as writing rational endings to their own problems, making rational posters or banners, or using concrete analogies such as "changing the channel" when they are thinking irrationally and then identify rational replacements. Another strategy that helps adolescents understand the connection between how they think, feel, and behave is the *Chain Reaction* activity (Vernon, 2006b, p. 35). I used this with a client who didn't want to study for an exam. I took a strip of paper and labeled it "activating event—have an exam to study for. Then I took another strip and had the

client identify how he felt about studying for the exam (angry), wrote his beliefs on additional strips (I shouldn't have to waste my time, I should be able to go out and have fun and not study for some stupid test), and on another strip, what he did as a result of thinking this way (did not study and failed the test). Then I asked him to identify the consequences of not studying and failing the exam, using separate strips of paper for each one (had to stay after school, parents were upset and grounded me, I missed a party, etc.). Next, I stapled these together to form a chain and held it up so he could see how long it was. I then asked what the chain might look like had he thought differently about the same event; in other words, instead of thinking he shouldn't have to study and consequently didn't, he realized that even if he didn't want to study, the benefits might outweigh the costs. Concrete methods such as this one help make the point.

Rational coping self-statements are also very effective with this population. I used this technique with a young adolescent who was socially anxious, thinking that others did not like her or wouldn't work with her if she asked them to team up to complete a project. She identified several coping self-statements that she typed into her cell phone and referred to them prior to asking several peers if they could work together on the science experiment.

To summarize, the assessment and treatment phase of this approach can readily be adapted so that children and adolescents are going through the same process but in a slightly different way. Through stories, games, music, concrete analogies, and other creative interventions, young clients can learn to the REBT process.

Treatment Guidelines from the Empirically-Supported Therapy Literature that Inform Best Practice in REBT with Children and Adolescents

According to Fonagy et al. (2015), "somewhere between 10 and 50% of youth are likely to meet diagnostic criteria for a mental health disorder at any one time" (p. 1). This is especially concerning since adult mental health is clearly linked to childhood disorders, so identifying the most effective "best practices" for children and adolescents will also have a positive impact on adults if problems can be effectively dealt with in childhood through both prevention and intervention. Fonagy and colleagues stressed the importance of taking the following into consideration in implementing evidence-based practices with children and adolescents: brain development, the child as part of a system (family, school, friends), the need to network with systems that define the child's context, the importance of school as best place to introduce prevention, and the strong correlation between medical consultations and behavioral issues, making it imperative that medical practitioners know how to diagnose behavioral problems and not simply prescribe medication. Similarly, substance abuse service providers need to understand the link between mental health disorders and substance abuse problems in order to implement effective treatment.

Based on the above-mentioned suggestions concerning the child as part of the system, Cartwright-Hatton et al. (2011, as cited in Fonagy et al. 2015) discussed the effectiveness of working with parents on a CBT-based parenting intervention for helping children manage their children's anxiety, with impressive posttreatment results. Likewise, with respect to conduct disorders, the most common reason for referral in this population, parent training as a treatment was more effective than CBT for children, although another intervention that combined problem-solving skills training with parent management training showed promise in that the child's behavior improved and there was less family stress (Fonagy et al., 2015). Fonagy and colleagues also noted the effectiveness of a multimodal approach when working with adolescents with conduct disorders, focusing on the family and involving other parts of the system that influence the adolescent's behavior.

Fonagy et al. (2015) also stressed that brain development must be taken into consideration with regard to evidence-based practice, and REBT practitioners should strive to stay current with the developmental literature, taking into account the critical developmental tasks and characteristics particular to the young client's presenting problem. Specifically, cognitive development has a major impact on how young clients respond to events because formal operational thinking does not begin to develop until early adolescence, which has specific implications for how children process information. That is to say, their capacity for logical thinking and problem-solving is limited, they have a tendency to think dichotomously, and they do not consider a wide range of alternatives. They frequently take things out of context and are slowly developing the ability to see things from other perspectives (Glowiak & Mayfield, 2016). During early adolescence, ages 11–14, the rapid physical changes impact young teens in multiple ways, resulting in emotional volatility characterized by moodiness and strong negative emotions such as anger, depression, anxiety, and guilt. They also may feel embarrassed and confused about their physical and hormonal changes. Although they are gradually moving into formal operational thinking and can think more abstractly, hypothesize, and reason more logically, they often have difficulty with cause and effect. Consequently, it is important not to assume that they are capable of more mature cognition when the degree of abstract thinking is erratic (Scott & Saginak, 2016). It is not until mid-adolescence (ages 15–18) that they begin to think more abstractly and there is more emotional stability. At this stage they are better able to see things from other perspectives, and are able to think more abstractly, hypothesize, and consider alternatives and consequences. They also tend to be less impulsive and can manage their emotions more effectively (Scott & Saginak, 2016).

Taking into account developmental limitations, Bernard et al. (2006) noted that "REBT does little disputing of irrational beliefs in children younger than age 6 and reserves more sophisticated disputing of general beliefs until after the age of 11 or 12" (p. 7) because developmentally, most are not capable of comprehending the concept of disputing before formal abstract thinking has begun to develop. With this guideline in mind, I have spent years developing age-appropriate methods to help young clients understand fundamental principles that help them think more logically prior to when it is possible to actually use disputing techniques with them. For example, I was working with a 6-year-old who was very upset because she had

a new sibling and felt like her parents didn't love her anymore because they were paying more attention to the baby sister than they were to her. I read her a rational story with a similar theme, and then adapted the use of an empty chair technique in which she was first herself and "talked" to the empty chair about her problems, and then she switched chairs and pretended that she was giving herself some advice about this problem. So although she was not doing "disputing" as we typically think of it, when she was talking to herself she was able to say, based on what she had learned in the story, that just because her parents weren't paying as much attention to her presently, this just meant that her sister needed more care and that did not mean they did not love her. As this vignette illustrates, young children can learn rational concepts if they are modified to be developmentally-appropriate.

The REBT literature also guides best practice regarding the reciprocal relationship between mental and emotional development. Specifically, when children are very young, the way they experience emotions is limited by their ability to think clearly and understand the meaning of what they experience (Bernard et al., 2006). Consequently, it is very easy for children to acquire beliefs that are untrue and irrational and if these beliefs aren't addressed, they can have a major negative impact. Their incapacity for rational thinking manifests in thinking that is characteristic of preoperational and concrete operational thought, including dichotomous thinking, overgeneralization, magnification/minimization, arbitrary inference, and selective abstraction. These maladaptive thinking patterns were very characteristic of young clients I worked with in therapy and I developed many different techniques to help them correct them (Vernon, 2002, 2009a). One strategy in particular that has proven very helpful to children and also young adolescents is to use a continuum as I did with a 9-year-old who was convinced that her mother would get into a car accident and die, which was resulting in a great deal of anxiety. I drew a continuum on a sheet of paper and helped her see that the car accident resulting in death was one option, as well as there being no accident and no death, there were also many other possibilities in between on the continuum: being in a bad accident and getting hurt but not dying, being in an accident and getting some cuts and bruises but not being seriously injured, and so forth. Broadening her perspective and reducing her dichotomous thinking and magnification was an effective way to reduce her anxiety.

Another critical aspect of development relates to self, and REBT is well known for its emphasis on self-acceptance, which is a critical aspect of child and adolescent development (Vernon, 2009a). From an REBT perspective, helping young clients accept themselves with their strengths as well as their weaknesses and dealing with their irrational beliefs related to perfectionism is key. In addition, peers are extremely important to children and adolescents and are associated not only with pleasure but also with pain, as lack of other-acceptance and demandingness negatively impact peer relationships. Demandingness and the concept of other-acceptance are also central aspects of the theory which can be employed in developmentally-appropriate ways to help youth deal with these issues. In addition, it is a well-established fact that cognitive-behavioral approaches are considered "best practice" when it comes to dealing with strong negative emotions such as depression, anger, anxiety, and guilt,

all of which are very common among adolescents (Curry & Hersh, 2014; Seager, Rowley, & Ehrenreich-May, 2014).

REBT incorporates many techniques and concepts that help children and adolescents move beyond their concrete thinking tendencies that can become problematic throughout their development (Vernon, 2009a). In addition, REBT promotes skill acquisition and practical problem-solving techniques, which is so important for young clients who need to find ways to "grow up without giving up" when they are faced with challenging circumstances. Because they are prone to thinking illogically according to REBT theory (Ellis & Bernard, 2006), young clients are especially vulnerable because they can easily become overwhelmed and fail to put problems in perspective. The REBT literature (DiGiuseppe & Bernard, 2006; Vernon, 2002, 2009a, 2009b) identifies many developmentally-appropriate strategies which can be employed to teach children and adolescents how to think, feel, and behave in ways that enhance their development. The educative and preventative nature of the theory fits very well with the developmental theory which suggests that children and adolescents are not able to generate alternative ways of thinking or behaving without guidance, which can be provided under the REBT umbrella that adheres strongly to the notion that teaching skills is an integral part of this theory.

Brief Case Example

Marcy, age 17, had been a very good student who was planning to graduate from high school at the end of the year and attend a nearby university starting in the fall. Midway through her senior year she suddenly lost interest in school, stopped studying, and started skipping classes in order to hang out with her new boyfriend, a high school dropout who had a bad reputation in the community for using drugs and alcohol and getting into trouble with the law. Despite her parents' insistence that she stop seeing him, she didn't, and after the school called and expressed concern that she might not graduate, her parents referred her to therapy. Needless to say, Marcy didn't think she had a problem and was very resistant during the first session. It was quite evident that she would not identify a problem she wanted to work on, so I identified the "A" as her parents forcing her to attend therapy and trying to change her behavior. She readily agreed that this was a problem and that she was very angry at them for trying to get her to stop seeing her boyfriend and start going to school and studying, which she considered to be unimportant.

When asked how she was behaving in relation to her anger, she said that she was doing what she wanted to do and discounting her parents' concerns because she was 17 and old enough to make her own decisions. When asked about her thoughts when she felt angry, she identified a number of demands related to her parents' behavior. Although she admitted that there was no law that said her parents had to treat her exactly as she wanted them to, she still held onto the beliefs that at age 17, she should get to make her own decisions and that they shouldn't interfere with her life. Realizing that it might be difficult for her to give up these demands, I tried a

different tactic. I told her I understood that at her age she wanted to make her own decisions—this was normal. But I asked her to think about her choices, and if she was convinced that they were in her best interests, maybe we could figure out a more helpful way of discussing this with her parents rather than just defying them, which she admitted wasn't really helping because they were always "on her case." When she agreed, I said, "Suppose you decide not to change…that what you are doing right now is working for you and it is how you want to live your life. Imagine that it is 3 months from now (high school graduation) and take some pictures of what your life might be like if you decide not to change." At the next session she showed me pictures depicting a pyramid of beer cans, a wrecked car, a traffic ticket, a torn in half high school diploma, and other pictures that represented negative consequences of her current choices. When asked how she felt about this "picture" of her life, she still said she it was fine. I then casually asked her to suppose that she did decide to change, which was entirely up to her, and take pictures of what her life would be like in 3 months. This time her pictures depicted a diploma, a college campus, and a new car that her parents had promised her if she graduated. When asked which "picture" of her life she preferred, she referred to the latter and we began to discuss behavioral changes.

As this case exemplifies, adolescents are often resistant to therapy and need to come to their own conclusions about their choices. Initially disputing her demands against her parents was not very successful, but after helping her see the consequences of her behavior and letting her decide for herself if her current choices were helping her or hurting her, we were able to come back to the disputation and she was able to see that she couldn't change her parents and her demands getting her anyplace, but by changing her beliefs and recognizing that the choices she was making were not in her best interests she was able to focus on herself and make better choices, which in turn got her parents to back off.

What I Have Learned About Using REBT with Children and Adolescents

Having worked with children and adolescents for many years, I have learned that there are many different ways to help them learn REBT concepts and how important it is to take into consideration their developmental level as well as individual differences. Furthermore, I have learned from my young clients the importance of being flexible and creative.

Accommodating Individual Differences

One of the best ways to accommodate for individual differences is to use the creative or expressive arts. Because of the universal nature of the creative arts, they can be used with any client, "regardless of gender, ethnicity, ability, age, language, cultural identity, or physical functioning" (Degges-White & Davis, 2011, p. 5). These approaches attempt to facilitate change and they can expedite diagnosis, prevention, and intervention. When used in conjunction with REBT, there is a greater probability that the counselor and client will connect in a more meaningful way, which results in more effective outcomes (Vernon & Barry, 2013).

Although it is easier to teach the concepts to clients whose intelligence is average and above, with adequate modification, the concepts can be simplified so that they can at least learn basic elements of the model. This same principle applies to very young children. As an example, my 3 year-old granddaughter was taking a bath and said she needed more bath bubbles. I said, "Elia, you don't *need* them, you just *want* them. We went back and forth for a minute about whether she needed them or wanted them, and the subject was dropped. Several days later I was visiting her and told her that I had ordered a magazine for her with lots of games and stories. I told her that the mail carrier would bring it and I asked if she had gotten it yet. Her reply was, "No, Nanna, but I don't need it. I have lots of magazines." She seemed to get the concept, even at that young age. Two years later her brother told her that he needed something and she told him that he didn't really need it, he just wanted it! I think that is a good example of how rational concepts can be explained to young children, but if they aren't as quick to grasp the idea or aren't as verbal, it may be necessary to focus more on behavioral changes. While this approach may not be considered "elegant," it is nevertheless helpful.

As has been demonstrated with adults, REBT is very appropriate with clients from different cultural and socio-economic backgrounds, although it is necessary to modify the content at times to address contextual realities (Friedberg et al., 2014). Furthermore, the therapist needs to be sensitive to the fact that issues and beliefs that clients present will reflect their cultural norms and values. For example, when working with adolescents in the United States or other Western cultures, independence is valued much more than it is in Latin American countries, for example, where families are more close-knit and there is more of a dependent relationship within the family. For this reason, adolescents who are seeking independence in the U.S. are more likely to rebel against what they perceive as their parents' demands, while in Latin American countries, adolescents are more likely to feel guilty if they go against parental norms (personal communication, M. T. Parades, June 17, 2017). Consequently, REBT therapists working with youth from different cultures need to be aware of how cultural norms impact treatment.

The "Do's" in Working with Children and Adolescents

There are several factors that I consider to be important in working with children and adolescents, as highlighted in the following paragraphs.

Building rapport. This was discussed previously in the chapter, but the importance of building rapport cannot be underestimated. Because they are generally not self-referred, it is essential for young clients to sense that the therapist genuinely cares about them and takes their concerns seriously. Adolescents in particular are suspicious about whether they can trust the counselor to understand them. I recall asking a 16-year-old for feedback at the end of the first session. His response was, "For someone who's not a teenager, you seem to understand what it's like to be one!" Stepping into the shoes of the younger clients is an important aspect of rapport building.

Repeating concepts in multiple ways. Another important thing I have learned in working with younger clients is that it is critical to repeat concepts in multiple ways using a variety of different strategies in order for them to understand REBT. For example, in working with an adolescent whose boyfriend had broken up with her, I would address her self-downing: he wouldn't have broken up with me if I were smarter, prettier, more popular, and so forth, as well as the overgeneralization that she would never feel better or have another boyfriend. Although disputation was successful to a degree and she was able to see that life could go on and that she wasn't a loser, I wanted to reinforce this in different ways, so I asked her to write about her problem as if she was seeking advice from an advice columnist and to write a response to her problem as if she were the advice column expert. As a homework assignment, I asked her to interview her older sister and her cousins to see if they had ever experienced a break-up and if so, did they consider themselves losers, are they happy now, and have they had other boyfriends? Given that adolescents are egocentric and think nobody experiences things like they do, this was a helpful assignment. In a subsequent session I asked her to do a reverse role play, in which I played the role of the "worthless" girlfriend who would never be happy again and she played the therapist role. By incorporating these techniques into therapy sequence, the client ultimately was much more rational about this break up.

Using the creative arts. As mentioned previously regarding how to accommodate for individual differences, I consider it very important to employ the creative arts when working with clients of all ages, but children and adolescents in particular. Creative arts interventions are engaging and very appropriate for this age group who may not be able to verbally express what they are thinking or feeling or how they behave. Furthermore, these approaches put young clients at ease, reducing their anxiety about the therapy experience. And because children's attention spans are limited, it is much more effective to use interventions that are motivating and engaging. In addition, because their ability to remember concepts between sessions may be limited, it is important to use interventions such as the creative arts which are more concrete. Music, games, art, or metaphors help anchor the concepts in their heads more effectively than just relying on verbal methods.

I recall working with an adolescent male who was very angry at his girlfriend who hadn't called him at 10:00 pm the previous evening as she had promised. He assumed it was because she no longer liked him and wanted to break up with him because she was seeing someone else. Of course he hadn't checked out his assumptions, but rather, firmly held to the belief that the only reason she hadn't called him was because she no longer liked him. As he was talking about this situation, he was looking out the window where I had an electric machine that zapped bugs. I asked him what the zapper did and he said that it killed the bugs. I suggested that he think of his head as a giant bug zapper and that every time he started assuming things, he should "zap" those thoughts and check out the facts first in order to have a better handle on this. The concrete metaphor made sense to him and he used the zapper metaphor throughout high school and even as a young adult in college!

The "Don'ts" in Working with Children and Adolescents

What we don't want to do in REBT therapy with children and adolescents is assume that they will readily understand the concepts, which is why it is so important to repeat them in numerous ways using concrete examples as discussed more thoroughly in previous sections of this chapter. Another "don't" relates to disputing.

Don't assume that disputing is always feasible. Another thing that we don't want to do is to assume that disputing is always feasible with young children. As Bernard et al. (2006) noted, disputing of any kind is generally not possible with children younger than age 6, and more sophisticated disputing occurs after they have begun to think more abstractly, which usually occurs between the ages of 11-14 or later. But because abstract thinking develops gradually, it is a mistake to assume that preferential REBT is feasible with all adolescents. According to Bernard et al. (2006), it is typically suitable for many bright teens, but not for many average adolescents, and certainly not young children. In that case, non-preferential RET is employed and can be very effective. For instance, consider how important it is to simply teach young clients the difference between a fact and an assumption, as illustrated in the previous example about the "zapper" metaphor. Had this client stopped to consider the facts before making assumptions he could have avoided a lot of anguish. Additionally, teaching clients how to identify alternatives and evaluate consequences is extremely helpful as they make decisions about whether to cheat on a test, drink alcohol or use drugs, engage in unprotected sex, and so forth, especially because the consequences can have serious ramifications. Helping them learn how to reframe, which opens their minds to other possibilities, can be very useful.

While disputing is obviously a core REBT concept, we have to work harder to employ functional, logical, and empirical disputes with this population. As just noted, philosophical disputing may not be feasible for those who are not abstract thinkers. Consider the example of a 7-year-old whose parents got a divorce and his mother moved across the country. He thinks that she doesn't love him and that's why she moved, and while it could be true that she doesn't love him, this could

be a very difficult concept for a child this age to understand. As DiGiuseppe and Bernard (2006) noted, it is preferable to help the child deal with this reality rather than challenge his perceptions, but the therapist must be very cautious in doing so because the child may not have the ability to understand that even if his mother doesn't love him, he is still loveable. In these cases, it may be more appropriate to challenge inferences and automatic thoughts.

Don't just work with the child. **A**nother "don't" is to work exclusively with the young client and not include parents, who are a major influence in a young child's life and may be contributing to the child's irrationality. Thus, an important consideration is that the identified client (child) may not be the problem; the child may be reacting to the parenting style which may be inappropriate and detrimental. For this reason as well, parents must be an important part of the therapeutic process.

REBT Aspects that Affect Change

As has been discussed thus far in this chapter, the REBT model can readily be adapted to children and adolescents, but there needs to be a strong emphasis on "thinking outside the box" so that the strategies employed are best suited for this population. There are several key aspects of REBT that affect change with this age group.

What they can control. In my experience, perhaps the aspect that effects the most change is the notion that while they cannot control other people, they can control how they choose to think, feel, and behave. I often start with the behavior because it is something that is observable and more understandable to children than how they think of feel. I use the robot analogy with younger children who say that they can't help it…that's just the way they have to behave. I ask the client to stand up and I turn him around and pretend to wind him up, explaining that he is to pretend that he is a robot who is now programmed to do whatever I say. I then have him perform a series of tasks which he does, and then I ask him if he actually is a robot who has to do everything that others ask him to do. When he says no, I explain that if he isn't a robot, he has choices about how to behave. I follow up with specific examples applicable to his life: if he gets a paper back with a bad grade on it, does he *have* to throw a fit, or could he just accept the paper without such a strong reaction? Or if his mother asks him to clean his room, does he have to scream *I don't want to* or does he have other choices? This is a very important concept for children who need to learn that not only do they have choices, but that their choices have consequences.

How they behave is based on what they think. Once clients understand that they can control their behavior, another aspect that affects change is to help them see that how they behave is based on what they feel, which is related to what they think. I might illustrate this with the following example:

Suppose your parents inform you that they are going to move to a different city. At first you are really angry, thinking that this isn't fair, that it will be awful, that you can't stand to leave your friends and you probably won't make new ones. You yell and scream at them because you are so upset. But then you talk to your brother

about it and he is excited because he says it is a big city, there will be lots of cool things to do, and it will be an adventure! So after thinking about it, you decide that maybe he is right…it could be fun, it would be a new adventure, and you might make even better friends in a new school. Discuss with the client that when she changed the way she thought, she felt differently and probably didn't yell and scream at her parents because she wasn't angry anymore.

Self-help approach. The fact that REBT is designed as a self-help educative approach is also what delivers the most benefit for change. I use the analogy of a trampoline, explaining to clients that when they are on a trampoline and they jump up, they may also bounce pretty far down, but they never quite touch the ground. This is similar to what happens when they learn how to think rationally—they may experience a problem and it might get them down temporarily, but when they apply the rational thinking skills they have learned, they have "tools" that help them bounce back faster. I sometimes share the experience my son had as a young adult when his girlfriend broke up with him. At first he was really upset, blaming himself for doing things wrong and not being the kind of guy she said she wanted. But before long he realized that he was really personalizing things, allowing himself to think negative things about himself that his girlfriend had accused him of being, but in reality, he wasn't what she said he was. Because he was able to apply skills that he had learned over the years to help him deal with this problem, he began to feel better after a short while and got on with his life.

In summary, REBT can be very effectively employed with children and adolescents in meaningful ways that help them learn and apply the concepts. Parents and teachers play a key role in modeling rational beliefs and behaviors and keying in on the "teachable moment." For instance, when my son was 7 and hated to practice the piano, one day he said, "All I ever do is practice the piano." I replied by asking in an exaggerated fashion, "*All* you *ever* do is practice the piano? You don't eat, sleep, go to school, play, study, or watch movies?" After thinking about it, he admitted that he had been exaggerating. Learning this concept at an early age was something he continued to use as he was growing up.

As the old saying goes, "An ounce of prevention is worth a pound of cure"—and as emphasized throughout this chapter, REBT is a prevention model.

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