Chapter 5
Rational Emotive and Cognitive Behavioral Group Therapy with Children and Adolescents

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Childhood consists of a number of official (academic, club membership, sports team) and unofficial groups (peer play-groups) and we begin functioning as members of groups the moment we are born. The natural experience of existing in groups has logically led to group therapy being a popular treatment for over half a century. There are a number of notable considerations and challenges that warrant attention in setting up and running group therapy when providing clinical work with children and adolescents. This chapter will focus on the application of Rational Emotive and Cognitive Behavioral change methods in a group setting.

Approximately one in every five children will exhibit a mental, emotional, or behavioral health problem that will have a functional impact on them socially, academically, and in the home (Merikangas et al., 2010; National Council for Community Behavioral Healthcare, 2009; National Federation of Families for Children's Mental Health, 2008). Addressing these needs can occur through a number of different clinical approaches (Esposito, 2009). Group therapy with children and adolescents is a frequently utilized approach in both clinical and school-based settings (Terjesen & Esposito, 2006). Conducting therapy in groups allows for the direct impact of group members on one another and as Yalom and Leszcz (2005) posited "it is the group that is the agent of change" (p. 120). Groups may provide a meaningful way to address some of these clinical concerns, and schools may be a key setting in which to address these mental health problems

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given that most children and adolescents spend a significant portion of their day in this setting (Matta, 2014; The President's New Freedom Commission on Mental Health, 2003). Economical factors combined with the current health care system have placed a greater emphasis on both clinical efficiency and cost-effectiveness (Matta, 2014). Group therapy is considered to be a viable and cost-effective intervention (Burlingame, Strauss, & Joyce, 2013). As such, implementing interventions in a group format seems to be a desirable alternative to individual treatment approaches (Hales, 2008).

Rational Emotive and Cognitive Behavioral Therapy

Rational Emotive Behavior Therapy (REBT) is considered to be the original form of cognitive behavioral therapy and was developed by Albert Ellis in the 1950s (David, Cotet, Matu, Mogoase, & Stefan, 2018). The theory and practice of REBT is based on the premise that when people engage in faulty, illogical, irrational, and unhealthy ways of thinking, they may experience unhealthy negative affective states and as such engage in unhealthy behaviors. The clinical approach entails having clients become aware of these unhealthy thoughts and then challenge them behaviorally, cognitively, and affectively to develop newer ways of thinking and experience healthier emotions and behaviors (DiGiuseppe, Doyle, Dryden, & Backx, 2013).

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

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

Ellis reported that he had been successfully using REBT in groups since 1959 (Ellis, 2002), sometimes with more effectiveness than individual REBT, yet the use of REBT in groups with youth has not often been systematically evaluated. Description of REBT in child and adolescent groups is found in the literature (e.g., Elkin, 1983). Esposito (2009), in her meta-analytic review of REBT, found that group treatment is just as effective as individual treatment.

Building off of an earlier version of this chapter (Terjesen & Esposito, 2006) we will present an overview of group therapy development and application among youth, discuss the integration of RE-CBT in group work with children and adolescents, summarize the research regarding the effectiveness of group therapy, and offer future considerations in RE-CBT group therapy.

General Considerations in Group Therapy with Children and Adolescents

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

Advantages

Group therapy is a common method used with children and adolescents due to its numerous advantages over individual therapy. Corey and Corey (2013) outline a number of distinct advantages seen during group therapy that may be considered to be advantages in group work with youth: increase in self-awareness, provide an awareness of and changes in beliefs about themselves and others, examine how they relate to others, and offer a structured, guided context to learn new skills.

In their earlier work, Corey and Corey (1997) refer to these factors as "the special forces within groups that produce constructive changes" (p. 239). The concept of "Universality" is a powerful factor that cannot occur during individual therapy. Here, students relate to and recognize that other members of the group share in some of the same challenges that they are experiencing and as a result it may lead them to feel less isolated in their struggle. The support that they may receive can be both direct and indirect in this regard. That is, students in group therapy may receive verbal support but also may perceive support by the Universality of what others in the group are experiencing. Further, when other group members have demonstrated progress toward overcoming challenges (e.g., divorce of parents or death of a loved one) this may also provide hope and inspiration for those who are still struggling.

Students participating in a group receive direct feedback from both the group leader and the other group members, which may be an additional advantage of group therapy for children and adolescents. First, they may get multiple perspectives and solutions to a particular challenge. Second, if the problem they are experiencing relates to dealing with peers, feedback from fellow group members may be more valued. Group members may be direct and also may be more adept at "calling out their friends" when they believe that they are not being forthright, a skill that group leaders may not always have. In addition, offering and receiving feedback may assist group members to understand "the impact they have on others and decide what, if anything, they want to change about their interpersonal style" (Corey & Corey, 1997, p. 243).

This type of feedback may be seen in an RE-CBT based group, where in-between group meetings "homework" is assigned. Group leaders will check in as to completion of homework as well as any beliefs (e.g., "It was TOO difficult to do!") that may have interfered with completion. Feedback from other members of the group as to their homework completion as well as having group members actively participate in reviewing the work of others, can facilitate increased awareness and improved

critical thinking. Further, in group treatment there is the possibility of a "mild competition" developing among group members which may be beneficial, especially in its ability to motivate members to work harder toward their goals.

Therapy skill acquisition may also be enhanced in a group setting as some group members may tend to learn therapeutic techniques better than those in individual therapy. We believe that this may be particularly true for children and adolescents especially as it relates to problem-solving techniques and treatment components of RE-CBT. To begin, students may learn some of these techniques vicariously through group work with a peer. As an example, in discussing specific beliefs that a student may hold and how these beliefs are linked to unhealthy affective states and behaviors, a student during individual therapy may experience discomfort as they are in "the hot seat" and not wish to discuss this issue. Further, they may worry about being wrong in answering the clinicians' questions. Alternatively, in group therapy, they may learn the RE-CBT model better by watching the group leader and other group members help tease out the beliefs, emotions, and behaviors of another group member. In addition, RE-CBT techniques are modeled by the therapist as well as by other group members. Modeling provided by other members of the group can be particularly advantageous as children and adolescents may be more likely to identify with their peers than with the group leader. Modeling of other group members may also promote overcoming any discomfort in sharing and disclosure. Oftentimes, when one group member opens up to the group, other members open up as well. Modeling within RE-CBT groups may be an effective approach to teaching group members how to challenge unhealthy thinking and develop logical, rational thoughts.

Members of a group may also benefit in a manner that is beyond the structured intent of the group. For example, in a task-oriented group (i.e., RE-CBT group for overcoming test anxiety) having a mixed-gender group may allow students an opportunity to interact with members of the opposite gender, and develop more effective social skills. In addition, groups may also be a source of school environmental knowledge, where group members learn about various aspects of the school (classroom, teachers, etc.) that other group members have experienced. While not the intention of the group, group members may benefit from this social component of the group.

Perhaps most importantly, groups provide a safe environment for members to share and grow. The group context offers an opportunity for group members to practice and receive constructive feedback from the group leader and their peers as they try to alter some aspects of their behavior or way of thinking. For the group leader, it also provides an opportunity to observe the group members in action interacting with one another and perhaps examine if the presenting issue is a skill deficit or a performance deficit. That is, do they lack the skills to demonstrate a behavior (e.g., social skills) or do they have the skills but something (e.g., anxiety) interferes with the skill performance. The group context provides the group leader with important information on members' interpersonal skills and styles, which may be more accurate and helpful than self-reports of behavior offered during in individual therapy.

Disadvantages

While there are a number of benefits for group therapy and it may be considered to be a time and cost-effective approach, group therapy is not for everyone, and it certainly has its limitations in clinical work with youth. Given that treatment is occurring through a group modality, logically it reduces the amount of time spent addressing the needs of each group member, as compared to individual work. As such, some may consider group therapy to be an inefficient method for the individual. As will be addressed later on in the chapter, it is important for the group leader to consider whether the degree of impairment that the client is experiencing would warrant more intensive, individual work. In some cases, this may be true. However, it is important to recognize that many, if not most, groups are comprised of clients with similar needs or complaints. As a result, while only one group member's specific needs are addressed at a time, other group members may benefit from the general information offered.

A valid concern about group therapy is that just the idea of therapy in a group format may intimidate a student who could benefit from the approach. This may be true for students who are socially anxious but also concerned about airing personal issues to their peers. The challenges of confidentiality cannot be guaranteed, and as such some children may be wary of the group setting for therapy. During individual therapy, students are reassured that for the most part everything they reveal (excepting child abuse and the intention to harm oneself or others) will remain confidential by the fact that the therapist is bound to legal and ethical codes and could face severe consequences for breaking confidentiality. These assurances become more complicated when therapy is conducted in a group with children and adolescents. One way to address the issue of confidentiality in groups is to create written contracts that all members must sign at the start of the group (see Appendix A). While these contracts are not legally or ethically binding, their existence may help ease the minds of those who may be hesitant to enter the group due to fears about confidentiality.

The structure of the group is important and providing the opportunity for all group members to be heard and valued is essential to group engagement and participation. This can be challenged by compulsive talkers or interrupters as group members. Group leaders can reduce the risk of constant interruption by certain group members by setting up specific "ground rules" for the group during the initial session. We encourage the group leader to facilitate the development of group rules. Rules that stress the importance of being respectful when each member is speaking and recognition of specific times when it is appropriate and inappropriate for members to make comments should be offered. In our experience, group members may police one another and offer feedback when they think that other members may be monopolizing the group. This may be particularly true for adolescents and this feedback may be used as part of the therapy process ("Robyn, how did you feel when Sean told you he thought you cut him off and would not let him finish his story?"). We also suggest that to avoid embarrassment, group leaders may wish to pull a

student aside at a later time and offer feedback that they may be monopolizing the group process and encourage them to self-monitor their behavior.

Another important factor for group leaders to consider is that there may be a high level of suggestibility of some members in that they readily agree to the suggestions of other group members even if it is not in their best interest. It is important for group leaders to recognize the specific needs and persona of individual group members and consider how they may be affected by group participation. For example, some students may only do their group assignment because they think "It would be AWFUL to disappoint the group leader and/or group members." While this does lead to the group assignment being completed, it would be important to address the motive, or potential irrationality, behind their behavior. In addition, group leaders would benefit from considering and correcting members when they give bad advice or provide the wrong solution. This can be detrimental to highly suggestible members.

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

RE and Cognitive Behavioral Approaches Applied to Child and Adolescent Groups

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

REBT in Child and Adolescent Groups

The broad umbrella of Cognitive Behavioral Therapy includes a number of clinical approaches among which is REBT. REBT operates under the premise that individuals possess disruptive, dysfunctional/irrational cognitions about events, which negatively impact their behavior and affect (DiGiuseppe et al., 2013). The cognitive *dysfunction* model differs from a cognitive *defici*t model, which implies that normal development involves the acquisition of certain cognitive processes. Some students may have failed to develop these skills or experience difficulty in applying them proficiently. This distinction between dysfunction and deficit is important to consider in determining what type of group to assign a student. To clarify the distinction, we will consider the case of a child who is socially anxious from

that of a child who has social deficits as a function of their being diagnosed with autism spectrum disorder (ASD).

In order to meet the diagnostic criteria for autism spectrum disorder (ASD), a child must have "persistent deficits in social communication and social interaction" (American Psychiatric Association, 2013, p. 50). The difficulty in engaging in appropriate social interaction with others is a skill that failed to develop in the student with autism spectrum disorder. Alternatively, students who are socially anxious may in fact have acquired the appropriate social behaviors and know what the correct behavior to engage in is, but fail to do so. This may be due to any number of dysfunctional cognitions that the student may endorse: "If I say something and mess up and others think poorly of me …it would be terrible" or "I have to/must have approval of others, because not to would be intolerable." These dysfunctional cognitions are irrational in nature and would interfere with the students' ability to execute a socially appropriate behavior. That is, their performance of the behavior is impeded by these not-helpful styles of thinking.

This distinction is important to consider in that the type of therapy group a student may be assigned to may vary depending upon whether they (a) never acquired/learned the appropriate cognitive, social, and behavioral processes (deficit) or (b) they engage in distorted interpretations and perceptions of reality (dysfunction). If the presenting difficulties are a function of cognitive deficits, the best type of therapy group may be one that is more skills focused; that is, teaching students what they failed to develop. These groups may be staggered in terms of skill acquisition level, to allow other students who have demonstrated some level of competency in skill acquisition to provide a model for their peers. In our experience, these deficit-driven groups appear to be more often focused on behaviors that are externalizing in nature as here students can receive direct feedback from others about the performance of their behavior. The dysfunction-driven groups may focus more on internal cognitions/beliefs that may interfere with the performance of adaptive behaviors. Here the groups may take more of an RE-CBT approach and teach strategies to challenge unhealthy cognitions and develop and apply healthier alternatives. During these groups, the group leaders are able to see the interaction of the students' cognitions, their behaviors, and the environment (their peers) in which these behaviors occur. This allows for a greater understanding for the group leader and group members of the dynamic interaction of these variables and for an opportunity to practice/rehearse effective cognitions and behaviors in more natural contexts than may be present during individualized therapy.

Some Distinctive Features of RE-CBT Groups

RE-CBT group therapy with children and adolescents, much like individual therapy, is more psycho-educational than motivational. That is, the group leader's role is not to just inspire the group members but rather to provide them with knowledge and information within the Re-CBT framework to help them in achieving goals. Group leaders inform and educate members of the group on the dysfunctionality of their

present cognitive schemas, teach them strategies to actively challenge these beliefs, and work with them on developing healthier and more realistic ways of thinking which will lead to more appropriate affective and behavioral responses.

RE-CBT proposes that the clinical approach of the group begins with a focus on the irrational beliefs and cognitive processing underlying emotions. Through a group format, peers may help group members readily identify the cognitive schemas/irrational beliefs that may be maintaining their affective and behavioral disturbance. This is a unique benefit of the group format, as compared to the group leader, peers may be better able to relate to understanding some of the underlying cognitions that lead to the unhealthy emotions experienced. In RE-CBT groups, there typically are a number of exercises, which will be detailed later, that assist to directly challenge unhealthy cognitions that will help facilitate emotional and behavioral change.

Early on in groups with children we focus on the RE-CBT theory of emotions, and assist students in understanding the differences between functional (healthy) and dysfunctional (unhealthy) emotions. Here it is important that clinicians consider the developmental level of functioning of the group members and cater their language in therapy to a level that the student will understand. While the more traditional RE-CBT language consisting of words like "functional", "dispute", "automatic thoughts", and "irrational" may be appropriate for older students, their use may serve to hinder the understanding of some of the core principals of RE-CBT with younger children. We suggest more "user-friendly" terms that share the same content/message. As such, we use "helpful", "challenge", and "healthy thinking" in place of the terms above. For a greater review of developmental consideration in the application of RE-CBT among youth the reader is referred to Grave and Blissett (2004) and Garber, Frankel, and Herrington (2016).

Developing an emotional vocabulary is an important aspect of RE-CBT psychoeducation in both individual and group treatment. The group leader may wish to determine members' emotional vocabulary, especially with younger children. We have found many students, when asked what they feel, will offer "bad" as a response or may in fact offer what they are thinking (i.e., "I feel like she doesn't like me"). The group leader, through didactic instruction as well as experiential exercises, will help students see a range of feelings (anger, sadness, frustration, anxiety) across an emotional continuum. At the same time, the group leader and group members may assist students in understanding the four aspects of every emotion:

Phenomenological—how the emotion feels.

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

Consistent with the models of RE-CBT, group leaders work on teaching students that irrational beliefs/automatic thoughts are what lead to these dysfunctional, disturbed emotions. Using the Happening-Thinking-Feeling-Reaction/Behavior

framework, students are taught the connection between thoughts and responses (i.e., behaviors and emotions) and learn the differences between irrational beliefs and the more rational, healthy cognitions that can lead to healthier, more functional negative emotions. However, before one begins an RE-CBT group, or any group for that matter, there are a few things that we believe warrant consideration.

General Guidelines for Forming RE-CBT Groups

The screening and selection of individuals to participate in the group is a very important aspect of group therapy, especially in RE-CBT, which follows a specific model with very specific goals. We have found that one of the earlier guidelines for group formation offered by Elkin (1983) still warrant consideration today. We discuss and expand on these guidelines in consideration of the development of RE-CBT groups.

To begin, we suggest that group leaders conduct a preliminary session with potential members either prior to the start of the group (in the case of a closed group) or before a new person joins the group (in the case of an open group). This preliminary session is basically a "goodness of therapeutic fit" to determine whether the goals of the potential member are consistent with the goals of the group. It also provides an opportunity for the potential group member to learn more about the group and interview the group leader, which may assist them in deciding whether or not to join the group. Group screenings of youth may also wish to involve the parents/caregivers in the initial meeting. During this meeting group goals are discussed, as well as group expectations and confidentiality. Group leaders may also wish to consider a screening instrument like the Group Selection Questionnaire (GSQ; Burlingame, Cox, Davies, Layne, & Gleave, 2011).

In consideration of admitting a student to a counseling group, group leaders may want to develop inclusionary and exclusionary criteria of the group. The exclusionary criteria of any group are entirely dependent upon the group, its leaders, and its goals. RE-CBT groups often have exclusionary criteria that may be more stringent than other groups. This may include ruling out potential members with severe pathology (i.e., psychotic, suicidal, brain damaged, or sociopathic) as well as those who may be uncommunicative or silent, as neither they nor other students will benefit from their participation (or the lack thereof). At the same time, leaders may wish to exclude students with some of the more extreme external disorders (conduct disorder, oppositional defiant disorder). Given the importance of in-between session work in RE-CBT groups, group leaders may exclude members who appear unwilling to do group assignments or therapy homework.

Inclusionary criteria, much like the exclusionary criteria, are dependent on the specific goals of the group. In order to be included in an RE-CBT group, potential members are provided information about the general structure and model of RE-CBT to ensure that this is something in which they wish to participate. As group activities are focused around this model, potential members agree to work on

assignments and actively participate in all aspects of the group, especially disputing their own and other members' irrational beliefs. Given the goal-directed nature of RE-CBT, potential group members are to have very specific goals they want to work on during the group. We find that the ability to set therapy goals is more likely to be better developed in adolescents than in younger children. Younger children are often told by their parents or teachers what their goals are to be and leaders may expect that to continue to be the case for some in group therapy.

During the initial meeting of an RE-CBT group, group leaders may wish to provide a brief history of RE-CBT and review a number of the different techniques that will be used in the group. This helps prepare students for what is to be expected and may make them informed and ready to work. As discussed earlier, setting ground rules is quite important in group therapy. Group leaders may have specific rules about attendance, socializing outside the group, etc., and it is expected that all potential members agree to abide by these rules prior to joining the group. Providing students with a written list of the rules, or even having them sign a contract in which they agree to abide by the rules may also be helpful.

Finally, the preliminary meeting also provides the group leader with the opportunity to discuss and reinforce the important issue of confidentiality. Group members are informed of both their rights and limitations regarding confidentiality, including the circumstances in which group leaders are mandated to break confidentiality. Emphasizing the responsibility of all group members for assuring that all information revealed by fellow group members remains confidential is also promoted and reinforced. Group leaders would benefit from recognizing that given the social nature of a school, unfortunately confidential issues are not always kept secure. When this occurs, we recommend that the group leader addresses this individually with the student and in the group as well to review the rules of confidentiality. It is also at this time that the decision to allow a student to remain in the group following this breach of confidentiality is discussed.

Additional practical issues that must be decided before beginning a group include the time, dates, and location of group meetings as well as the group size. While these decisions will vary dependent upon setting, typically we have found that groups of younger students (up to age 7) should have no more than 4–5 members, while groups of older students (ages 8+) should have a 7–8 member maximum. Further, groups held in school should not be during major academic areas nor should they compete with other school-related activities that students find desirable (i.e., gym class). Marketing a group may also be an important variable to consider. As an example, Flanagan, Povall, Dellino, and Byrne (1998) held their group during a lunch period, provided popcorn, and called it a "popcorn club". If the group is going to set and evaluate specific goals, group leaders will want to determine in advance what methods/measures will be used for data collection to evaluate change and what the process will be for measure administration.

Another practical and clinical decision the group leader has to make is to determine the group type: open or closed. In an open group, students can join the group at any point provided that there is space in the group. As a result, there will be students in the group with different levels of skills. An advantage of this type of

group is that it allows students to remain in the group until they have attained their goals. A potential disadvantage of this method is what Corey and Corey, Corey, Callanan, and Russell (1992) refer to as the "cozy-nest syndrome," in which group members are, "always 'working' and perhaps never changing" (p. 35). Alternatively, closed groups have a pre-determined number of sessions and all members begin and finish the group together. The disadvantage of a closed group format is that the group may conclude whether or not the student has reached his or her goals. However, having an end date can also act as an advantage and serve as a source of motivation to begin actively making changes (Corey et al., 1992). Another advantage of closed groups is that they are more cost-effective than groups lasting for over a year.

Types of RE-CBT Groups for Children and Adolescents

While RE-CBT groups are based on an evidence-based approach to psychotherapy, considering the content and factors that best lend themselves to a group format to lead to positive clinical outcomes is important. Yalom (1995) had originally proposed 11 therapeutic factors that were considered to be essential for treatment outcome via a group therapy approach. From these 11 factors, Fuhriman, Burlingame, Seaman, and Barlow (1999) reported that group cohesiveness, catharsis, and interpersonal learning were considered to be the most helpful by clients. While these factors have been debated (see Shechtman & Gluk, 2005), we think the proposed cluster by Lieberman and Golant (2002): affective insight, affective supportive, cognitive supportive, and cognitive insight (Shechtman & Gluk, 2005) may be among the most helpful in consideration of an RE-CBT group with youth.

Where RE-CBT groups with children and adolescents may differ from RE-CBT groups with adults is the fact that with adult RE-CBT groups, the goal may be to provide individual therapy within a group setting. While this can and does occur in child and adolescent therapy groups, in our experience these groups appear to involve more group tasks with less boundaries/structure than those that exist in the adult groups. That is, RE-CBT groups with youth may involve more group experiential exercises focusing on interaction and development of healthy thinking and appropriate behaviors as compared to adult groups.

RE-CBT groups for children and adolescents involve both content and process focus. That is, teaching RE-CBT content is important to facilitate change but RE-CBT groups are also process-oriented in that many of the in-group exercises will ask students to address how they are feeling and thinking at that moment. By identifying in session thoughts this may also assist in generating alternative healthy ways of thinking and the accompanying adaptive emotions and behaviors.

Smead (1995) discussed three different types of groups for children and adolescents that we believe are applicable to RE-CBT. We briefly discuss these types of groups and the role that RE-CBT can potentially play in facilitating emotional and behavioral change.

Counseling/Therapy Groups

In these groups, the focus is on behavioral and emotional change and they may be groups that are more general with a wide range of problems or they may be geared toward specific issues, such as dealing with a divorce, relationship issues, or grief. These groups are most closely aligned with the RE-CBT model and may assist students in developing better coping strategies. Groups that are more general may be for the students who regularly experience difficulty, while in the issue-driven groups, students are aware of the content focus of the groups (e.g., stress management). Vicarious learning may have a delayed effect in general groups as students get to hear peers work through an area of difficulty (e.g., college selection) that may not be an issue for them at present, but may become one in the future. Hopefully, at that point they will be able to recall the effective solutions of their peers. With content-specific groups, students listen and learn to help others who are at varying stages of distress when they are exposed to similar environmental stressors. As mentioned earlier, the universality aspect of these groups is at play here as students see that they are not alone and they are not the only ones experiencing difficulty. Participation may help normalize their affective experiences and may provide a resource for support outside the structure of the group.

Task-Oriented Groups

Task work group members strive toward a specific goal that is not necessarily emotional in nature, but may be more of the academic/achievement sort. These may be specific group tasks (e.g., create a school-wide bullying program), or one task that all members of the group may be working toward (e.g., SAT preparation). While this type of group is seen to be more practical in nature, we also focus on the emotional components that may interfere with students' ability to work toward the task. RE-CBT may assist in helping clarify which goal(s) to work on (e.g., college applications) and identifying potential practical and cognitive/emotive blocks ("it's too difficult") to goal attainment. Establishing a clear objective and a limited time frame in which to achieve that objective is helpful. Group leaders may help facilitate goal identification, explore the irrational beliefs that may impede goal achievement through extreme negative emotions and behaviors, restructure irrational to rational beliefs, and brainstorm effective strategies to meet this goal. When students may wish to select strategies that are impractical in nature, the RE-CBT group leader may engage in brainstorming and help them examine all potential solutions and evaluate which ones have the highest degree of success, are practical, and are acceptable. Additionally, the RE-CBT group leader will work to make sure the tasks chosen have a high degree of acceptability on the part of the group members, as low acceptability will lead to poorer effort toward goal attainment.

In task-oriented groups, group leaders may encourage students to go "out of their comfort zone." Students are encouraged to select a task they are not necessarily comfortable with, which helps promote risk-taking. At the same time, we want group members' efforts to be reinforced so we do not have group members select tasks that have a low probability for success.

If groups, either as a whole or individually, fail to achieve the selected goal(s), the RE-CBT group leader will use this as an opportunity to discuss feelings and cognitions related to the lack of task achievement, differentiating between healthy and unhealthy responses. That is, working toward more self-acceptance and avoiding self-defeating beliefs.

Psycho-Education/Guidance Groups

These groups generally constitute clinical work with "at-risk" populations. This may involve students who are at risk for a number of potential problems/disorders and may take on less of an academic focus than the task groups. Group members could be students who are at risk for eating disorders or drug and alcohol abuse. These may be students who are sub-clinical and have shown some of the early warning signs of developing a disorder but may not be eligible for formal services at this point. Here, RE-CBT group leaders assist students in overcoming faulty thinking that may put these students at risk. Promoting frustration tolerance and increasing their ability to engage in consequential thinking can be quite helpful in these groups. Education is a major part of these groups and the group leader can better serve these groups if they have a good balance of knowledge of the theory of RE-CBT along with knowledge about the specific area that students are determined to be at-risk for. Additional work with family members may be beneficial and help reduce the exposure to factors that may elicit risk-taking behavior. As an example, RE-CBT groups for students who are at risk for drug and alcohol abuse may focus on helping students express their feelings, develop effective coping skills to resist peer pressure and learn strategies on how to interact more effectively with others. At the same time, children and families will also receive comprehensive information on drugs and alcohol and learn about the dangers associated with them. In family-based sessions, these programs may involve parent training, family skills training, and family self-help groups to learn how to reinforce the lessons at home.

Engaging Children and Adolescents in Groups

Among the larger challenges facing group leaders working with children and adolescents in groups is to establish a therapeutic alliance. Despite the importance paid to the topic of the therapeutic alliance (also referred to as the working relationship) with children, very few empirical studies on the topic exist as it relates to

group work. DiGiuseppe, Linscott, and Jilton (1996) proposed two main barriers to forming the therapeutic alliance with children and adolescents: (1) most children and adolescents are mandated to therapy; and (2) children and adolescents usually enter therapy in a pre-contemplative stage. That is, they are not even thinking about changing their behavior.

The level of motivation for change of children and adolescent in RE-CBT group therapy may be an important moderator of treatment effectiveness. With most children and adolescents entering therapy against their will, they generally do not believe they have a problem, do not wish to change, and may be completely unmotivated for treatment. This presents a major obstacle to the process of establishing therapeutic goals with children and adolescents, which is the first aspect of developing the therapeutic alliance (DiGiuseppe et al., 1996).

DiGiuseppe et al. (1996) have developed a cognitive behavioral approach toward motivating children/adolescents to change based on Prochaska and DiClemente's Stages of Change Model (1988; as cited in DiGiuseppe et al., 1996). We believe that this approach has important implications when working with children and adolescents in group therapy as well. The Stages of Change Model lists the five stages of change a person goes through as (1) pre-contemplative; (2) contemplative; (3) preparation; (4) action; and (5) maintenance. Students in the pre-contemplative stage have no intention of changing and usually do not recognize the issue at hand as problematic. This may be an accurate stage to consider most group members to be at. Once the student reaches the contemplative stage, he or she is beginning to perceive a problem and may be seeking help.

Entering a group at the pre-contemplative stage, when they do not perceive any problems, may be especially problematic in a group setting, as groups rely on the active participation of members. While we recognize the importance of the development of the relationship bond between the group leader and client, we think that in RE-CBT we can motivate students to change and build an alliance discussing goals with group members in a direct and open manner. Examining how the group members feel about these goals and target behaviors is a crucial step, especially considering that these goals are almost always set by others and are likely to be different from, or even completely contradictory to, the child or adolescent's own internal goals.

By having students explore the consequences of their behavior, this can be an important step toward bringing children and adolescents from the pre-contemplative stage into the contemplative stage. In a group setting, this provides a unique interactive opportunity for other group members, as they may be able to point out consequences that the child or the therapist may not have been able to identify.

Assessment in RE-CBT Child and Adolescent Groups

We propose that assessment should be an on-going part of the group therapy experience for youth both from a diagnostic as well as a progress-monitoring perspective. Involvement of data collection at multiple data points increases the responsiveness

of the intervention to meet the needs of the students, assesses the effectiveness of intervention, and examines the stability over time and situations. We will briefly discuss some recommendations for standardized mental health batteries that we have found useful in working with children and adolescents, followed by more specific recommendations for RE-CBT groups.

Standardized Batteries for Assessment

A review of all evaluation measures that may be beneficial for children and adolescents in group therapy is beyond the scope of this chapter. However, we would suggest that for general problem groups, the group leader considers a broad-based measure, like the Behavioral and Emotional Screening System (BESS; Kamphaus & Reynolds, 2007). The BESS screens for externalizing, internalizing, school problem behaviors, and adaptive skills in children and adolescents (ages 3–18 years). More problem-specific measures that address the content of that group (e.g., the CDI-2 [Kovacs, 2011]) for Depression or the MASC-2 for childhood anxiety (March, Parker, Sullivan, Stallings, & Conners, 1997). For screening and regular progress monitoring we recommend measures like the Behavior Intervention Monitoring Assessment System (BIMAS; McDougal, Bardos, & Meier, 2011) or the Youth Outcomes Questionnaire (Dunn, Burlingame, Walbridge, Smith, & Crum, 2005).

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

Finally, given that the focus of RE-CBT groups is on changing student thinking, we believe it is important to assess students' irrational thinking or automatic thoughts. In doing so, group leaders may be better served to examine how effective the RE-CBT component is within-group treatment as it relates to changing unhelpful thinking. With regard to irrational thinking in children and adolescents, we recommend the revised version of the Child and Adolescent Scale of Irrationality (CASI; Terjesen, Kassay, & Anderson, 2017). The CASI is a self-report measure of irrational beliefs of children and adolescents, which yields scores on six scales, including self-downing, dependence, conformity, demandingness, low frustration tolerance, and discomfort anxiety, in addition to a total irrationality score. Additionally, group leaders may also wish to consider using the Children's Automatic Thoughts Scale (CATS; Schniering & Rapee, 2002) which is a self-report of negative beliefs commonly seen to both internalizing and externalizing problems.

General Cognitive Behavioral Assessment Guidelines

As developmentally younger children may have difficulty in problem identification, emotional labeling, and introspection they may require a slower pace within the group and more experiential exercises and games to enhance assessment as well as treatment engagement. Further, asking students to recall prior events may be challenging as well. A relatively simple approach to collecting data about events occurred that has a greater likelihood of being accurate is to have students complete an "emotion and thought log" (see Appendix B). Conducting a functional analysis of behavior may be another important factor to consider in the assessment. This may help determine if the student engages in this behavior to change something in their environment (parent/teacher behavior), gain attention, avoid discomfort, or for sensory reasons. These logs (and the consequences received for behavior) may help in understanding this.

While not specific to RE-CBT, assessing for and then remediating problem-solving skill deficiencies is important given that the solutions often selected by children and adolescents are poor. The RE-CBT group therapist may want to determine whether the student knows effective ways of behaving but as a result of their style of thinking they do not behave appropriately, or have they not learned alternative problem-solving options. The direction you take clinically may vary depending upon whether or not you need to teach emotional along with practical problem skills.

As the RE-CBT group progresses, the group leader may utilize a number of group exercises (discussed below) to determine whether or not a group member has learned how to challenge unhealthy thoughts and develop more effective, healthy ways of thinking and behaving. This assessment can be through observation and may be accomplished through a rational role play exercise to assess both the students' overt behavior as well as to determine whether they are able to think and therefore behave more rationally in this role play.

Core Content in RE-CBT Groups with Children and Adolescents

While the focus of the RE-CBT group may vary as a function of the presenting problem and the developmental level of the group members there are some general areas that we have found are helpful for a group leader to consider when running groups as well as some group exercises and strategies that the group leader may wish to incorporate.

To begin, while the RE-CBT model is fairly straightforward conceptually, we believe that the group leader would benefit from having a strong conceptual understanding of RE-CBT and its techniques utilized as a mechanism of change. Having a group leader who is able to communicate differences between irrational evaluations and appraisals of misinterpretations (inferences, absolutes, evaluations) is

helpful. Which thoughts (inferences or evaluations) group leaders target for change may vary depending upon the developmental level of the child. RE-CBT group leaders may work on challenging distorted interpretations of reality ("He doesn't like me"), the absolute ("I NEED him to like me all the time") or evaluative beliefs ("It's AWFUL that he doesn't like me"). Conceptually, these three cognitions are very different and the group process allows for the leader and the group members to target one or all types of belief systems but what to focus on may vary by group members age with more inference challenging occurring with younger group members.

These distorted interpretations of reality (incorrect conclusions/predictions) are an example of where group therapy may be more effective in treating these beliefs than individual treatment. Peers are often a great source of data collection and feedback and may help provide evidence that contradicts the belief. As an example, if a student says "Teacher X doesn't like me!" another group member may point out that she disagrees with that inference and offer evidence to the contrary. With regards to the challenging of absolutes and derivative evaluative assumptions (e.g., "It is awful that she doesn't like me!), group therapy can be very helpful in that group members who share common absolutes and irrational evaluations can be helped by their peers to see that they are not alone in this experience. Through hearing their peers discuss similar evaluative beliefs, group members may come to realize how faulty/unhelpful that way of thinking truly is. Further, the RE-CBT group therapy approach may offer models of peers who have successfully changed different types of cognitions and as such they may be able to apply them on their own or with the support of the group.

As part of emotive education, we encourage RE-CBT group leaders to present the idea that extreme negative emotions (such as high degrees of anger, anxiety, depression) interfere with overall healthy functioning. This can even lead the most reasonable students into saying or doing something that they wish they had not, that may cause problems at school, at home, or with friends. This may be facilitated by the group leader having group members recall the last time they made a bad decision. We then will ask them what they were thinking and feeling when they made that decision and whether they ever let what they felt, emotionally, make the decision for them. Students are often fairly good at recalling bad decisions and once one student is able to identify the role their affect played in this decision it may open the door for their peers to do so as well. Group leaders may wish to use video examples to help show how people may make bad decisions when they are extremely upset. We believe emphasizing that unhealthy emotions like stress, anxiety, anger, and depression interfere with their ability to make smart choices is key to promoting motivation for change.

Another part of emotive-education that we believe benefits from early and repeated exposure in RE-CBT groups is the distinction between non-hurtful and hurtful emotions. Non-hurtful emotions occur when students are dealing with difficult situations and they experience being annoyed, irritated, or aggravated. These non-hurtful emotions allow students to problem solve and manage things effectively in difficult situations. Hurtful emotions lead to escalating conflict, name calling, and

a number of emotional (anger, depression, anxiety) and behavioral (avoidance, aggression) manifestations. We make sure to highlight that students will "feel" something when adversity occurs, and RE-CBT work focuses on helping them experience more of the healthy, appropriate negative emotions.

K. Doyle (personal communication, February 14, 2005, 2003) offers some suggested exercises for group settings that we think are excellent in general and that have specific applications to the REBT group therapy process with children and adolescents. We have highlighted a few below.

- Introduction Exercises: Have students finish the sentence, "One thing I'm hoping to gain from this group is …". We have found that this is helpful in terms of goal setting and it allows children and adolescents to hear what their peers are looking to work toward and may serve to further allow other group members to help them in the group process.
- Comprehensive Self-Inventory: Have each student use paper and pencil to assess their strengths and weaknesses; have them start on the weaknesses that they think might be remediable. With younger students you may have them draw pictures. This approach again helps with increasing insight into their problem as well as helping with goal selection.
- Expectations/Fears: Each student is asked to report his/her expectations and fears about participating in the group. We find this to be particularly helpful when working with children and adolescents, as it helps normalize cognitions they may be experiencing and may also allow for clarification of misconceptions of the group process that they may have. We also see this as a way of further clarifying specific rules of the group therapy process that are often concerns of students (e.g., confidentiality).
- Best and Worst Day: Here, group members are asked to draw a composite of their best and worst day in the past month or so and share these with the group. The group leader facilitates a conversation about what kinds of experiences make a "good" day and what are the common ingredients in a "bad" day. The group leader may help in looking for patterns of thinking that may differentiate between the two.
- Learning from Mistakes: Students are asked to think of a situation that they believe they did not handle particularly well. More specifically they are asked to close their eyes and try and recall the feelings and thoughts that they had at the time. They are then asked to write them down and share them with the group and allow the group to help them identify any thought distortions. The group leader may have them discuss what they would have liked to have happen and have the group develop a list of rational beliefs and coping statements that might have been helpful.
- Strongest Hour: This we usually try to do right after the Learning from Mistakes exercise. In this exercise, students are asked to recall a time when they relied primarily on themselves to deal with a difficult situation. We ask them to bring the situation clearly to mind by recalling the details (the setting, the people involved, the time and place, the things said, etc.). We help them experience

both satisfaction and pride about their successful handling of themselves in the situation. This may work particularly well for students with Low Frustration Tolerance, as they may see that they can handle adversity and things are not too difficult. We ask them to recall what they told themselves during that situation and discuss how they can increase the likelihood of thinking and behaving that way again in the future. This is a very powerful exercise for child and adolescent groups as peers hear of the success of their colleagues, which may serve to motivate them.

- Dear Dr. Rational: Each student writes a brief letter or email about one of their problems, as though they were writing to Oprah or Dr. Phil (the Dear Abby reference gets lost on the youth of today). These letters are then passed around the room and each person answers someone else's letter in writing. We encourage that they help each other come up with a practical solution as well as a solution that utilizes the rational thinking they have been developing.
- Evidence Against IBs: In this exercise for older students, on one side of an index card we have students write down their irrational beliefs, while on the other side, they write five negative things that have happened to them because they think this way. Students are then encouraged to read the card several times a week to remind them of how that belief is not working for them.
- Anonymous Disputing: This exercise occurs with students who possess a good understanding of the REBT framework, and most specifically of disputation. Students are asked to write down their irrational beliefs and pass them forward on a piece of paper to the group leader. The group leader reads them aloud and the group as a whole provides challenges or disputes for them. We have modified this at points to use a small ball as a "hot potato" exercise, in which group members throw the ball to their peers to try and involve all in the art of disputation.
- Shame-Attacking: This is one of the more well-known of the REBT techniques and involves having individuals do something or tell the group to do something which they would normally never do (typically for fear of others' negative reactions). We have found the group format to be an excellent forum for this in that peers support one another and also do not let each other "off the hook" for non-completion of the exercise.
- Round of Applause: Have students applaud something or someone they are grateful for. We have used this exercise at the beginning and the end of the group, around holidays (Thanksgiving or New Year's resolution) and have found this to be a very fun and enjoyable exercise. The group leader leads standing ovations, whistles, cheering for positive things/people, and helps refocus the group members on positive things in their lives, which is contrary to what the focus is of many therapy groups. We actively reinforce group participants.
- Positive Talk: Usually done in conjunction with the round of applause and it often serves the same purpose. Each student is asked to talk positively about themselves for a full 2 min. (If they qualify or modify what they say, they get a penalty of an additional 30 s.)

- Role-Play: Group members are asked to think of upcoming situations that they are apprehensive about (e.g., exam, social event) and act them out with other group members. Students can use this opportunity to provide feedback on the behavior of their peers as well as offer hypotheses as to what they are experiencing cognitively.
- Reverse Role-Play: This exercise is usually done after group members are familiar with one another. In this exercise, one group member takes another's irrational beliefs and holds onto them rigidly and forcefully. The student who presented the irrational belief has to try and talk the role-player out of the firmly held belief. This reinforces vigorous disputing for the individual and may further provide a model for their peers.
- Hotseat: One at a time, group members take the "seat" and as many participants as want to give feedback (both positive and negative), while the student remains silent. This helps students to learn to accept feedback from others and then as a group we process how the student felt and the validity of some of this feedback.

RE-CBT Group Research with Children and Adolescents

A complete review of all the research of Rational Emotive and Cognitive Behavioral group treatment approaches is beyond the scope of this chapter; however, we would like to highlight some recent findings. In her meta-analytic review, Esposito (2009) examined the effectiveness of both individual and group-based Rational Emotive Behavior Therapy (REBT) with children and adolescents. Of the studies reviewed, a significant majority (87.5%) were conducted within the school environment and delivered in a group-based format (77.8%). The effect size of 0.87 for those treatments done in a group-based format was equivalent to treatment provided on an individual basis (Esposito, 2009).

In addition, it has been demonstrated that REBT and CBT approaches are effective methods when used in non-clinical groups of children and adolescents. For example, Trip, Vernon, and McMahon (2007) conducted a meta-analytic review of Rational Emotive Education (REE) and reported that REE had a powerful effect on lessening irrational beliefs and dysfunctional behaviors.

Finally, Matta (2014) in her meta-analytic review of 98 articles on group-based psychotherapy in the school environment, found a medium to large overall within-group treatment effect size (M = 0.67, SD = 0.65), suggesting that school-based group therapy is effective in meeting the mental health needs of children and adolescents. She also reported that group treatment conditions showed significantly greater improvement than did individual treatment conditions. Finally, she reported that the modality of cognitive behavioral therapy produced one of the highest effect sizes, but it was not found to be significantly higher than other modalities.

Together these results provide significant evidence in support of the use of RE-CBT in group treatment of children and adolescents across multiple disorders and presenting problems. Further research is needed to allow group leaders to understand specifically what it is about the RE-CBT group therapy process that

leads to change in working with children and adolescents. Clearly, written treatment manuals that lend themselves to research replicability and that have high practical utility with group leaders are further warranted. As a whole, RE-CBT as a therapeutic approach works well with children and adolescents, and it is hopeful that we will continue to see further applications of RE-CBT group therapy techniques with varied populations of children and adolescents.

Test Yourself Questions

1 What factors are important to consider when determining if a student would benefit from individual or group RE-CBT?
2 What challenges may exist in group therapy that may not exist during individual treatment and what are the best practices to address them?
3 Consider what the advantages are to having an open-ended group as opposed to a close-ended group and how do we best continue to promote efforts to change?

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

Group Contract

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

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

_____ _____

Signature Date

Appendix B: Emotion Log

Student Name: _____ Date: _____

Date	Time	Activating Event	Beliefs	Emotion	Intensity (1-10)	Duration	Action
10/10/20	11:00:00 AM	Parents said "no" to movie with friends	"It's Not fair"; "I should be allowed to go"	Angry	8	45 Min	After yelling, I watched TV, checked social media, and played with my little brother

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