

Chapter 1

Rational Emotive, Cognitive Behavioral Approaches to the Challenge of Child and Adolescent Mental Health



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The history of cognitive restructuring with children and youth doubtless goes back many centuries and may be traced to early philosophers and religious preachers (Robertson, 2010; Robertson & Codd, 2019). Socrates, let us remember, was persecuted by the Athenians for supposedly corrupting the youth of that ancient city. And the Greek-Roman Stoic Epictetus, who is often acknowledged as one of the main philosophical fathers of Rational Emotive Behavior Therapy (REBT) and Cognitive Behavioral Therapy (CBT), pioneered in conveying significant cognitive teachings to the young people as well as the adults of his time. Because of his influence, some 2000 years ago, the Roman Emperor Marcus Aurelius was raised from childhood in the Stoic tradition and consequently was later led to write his famous *Meditations*, one of the most influential books of all time, outlining the principles and practice of cognitive restructuring. One of the major proponents of Stoicism in the context of mental health was the Swiss psychiatrist Paul Dubois, who in his clinical work taught patients a Stoic philosophy of life (Robertson & Codd, 2019).

In modern times, methods of teaching children and adolescents to talk more sensibly to themselves, and thereby to make themselves individually and socially more effective, were pioneered by Alfred Adler. Not only was Adler (1927) probably one of the first cognitive therapists to specialize in direct psychological approaches to youngsters, but he and his associates, starting in the 1920s, saw the importance of using cognitive approaches in the school system and of teaching these skills to parents to employ in the rearing of children. Today, the field of psychotherapy has seen a decided shift to a more cognitive behavioral orientation

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(Norcross & Karpiak, 2012; Norcross, Sayette, & Pomerantz, 2018) including child and adolescent therapy. This is further affirmed by the adoption of the definition of psychotherapy by the American Psychological Association (APA) (emphasis added):

Psychotherapy is the informed and intentional application of clinical methods and interpersonal stances derived from established psychological principles for the purpose of assisting people to *modify their behaviors, cognitions, emotions*, and/or other personal characteristics in directions that the participants deem desirable. (Campbell, Norcross, Vasquez, & Kaslow, 2013)

History of Rational Emotive and Cognitive Behavioral Therapy with Children and Adolescents

Since the late 1950s there has been considerable conceptual and empirical theories as to the nature of emotional and behavioral disturbance from a cognitive/thinking perspective (Ellis, 1957, 1962). Among the original approaches is Rational Emotive Behavior Therapy (REBT) originally referred to as Rational Therapy and Rational Emotive Therapy (Ellis, 1995). Soon after he started to use REBT with adults, at the beginning of 1955, he saw that it could also be employed with children either directly by a therapist or indirectly by an REBT practitioner working with the children's parents. This was reflected in his first book on REBT, *How to Live with a "Neurotic"* (Ellis, 1957), where he offered some cognitive parenting techniques. When he began making tape recordings of REBT sessions, he recorded a series of sessions with an 8-year-old female bed-wetter (Ellis, 1959), which were widely circulated and encouraged many other therapists to use RET methods with children. In the 1960s, cognitive restructuring with youngsters was promoted by a number of REBT-oriented writers who showed how it could be effectively employed by therapists, parents, and school personnel (Doress, 1967; Ellis, 1967; Ellis, Wolfe, & Moseley, 1966; Glick, 1967, 1968; Hauck, 1967; Lafferty, Dennell, & Rettich, 1964; McGory, 1967; Wagner, 1966).

By and large, the only cognitive restructuring approach being employed with school-age children through the late 1960s was REBT. A shift was seen in the late 1960s, where behavior therapists began to open their minds to cognition, and as a consequence, widely practiced and researched behavioral methods of helping youngsters overcome their emotional and behavioral problems began to be combined with REBT and other cognitive methods like Beck's cognitive therapy. During the 1970s, a large number of articles, chapters, and manuals appeared that explained the use of REBT with children and adolescents (e.g., Knaus, 1974). A review of these early pioneers of clinical models and outcome studies may be found in Bernard, Ellis, and Terjesen (2005). At the same time, cognitive behavioral therapy techniques were being implemented among youth; however, some early concerns were noted in the methodology of these studies (Hobbs, Moguin, Tyroler, & Lahey, 1980).

Indeed, because of the observed success of REBT that was found in early clinical and experimental investigations, the Institute for Rational-Emotive Therapy in New York started the Living School in 1970, a small private grade school where all the children were taught REBT along with the usual elementary-school curriculum. The school flourished for 5 years, in the course of which it was found that teachers (not therapists) could teach young children REBT in the regular classroom situation and thereby help them (and their parents) to improve their emotional health and to live more happily and efficiently. Publications on the use of REBT in this school setting were published by DiNubile and Wessler (1974), Ellis (1971a, 1971b, 1972, 1973, 1975), Gerald and Eyman (1981), Knaus (1974), Sachs (1971), and Wolfe and staff (1970). In order to have a greater impact in classrooms both in the community and across the country, the Living School was transformed in 1975 into the Rational-Emotive Education Consultation Service, which provided: (1) in-service workshops for teachers and counselors; (2) consultations to schools, classes, and teachers wishing to implement a program of RET; and (3) materials and techniques for use in classrooms and/or school counseling settings (Waters, 1981).

From the early 1980s with the publication of the first edition of this book, *Rational Emotive Approaches to the Problems of Childhood* (Ellis & Bernard, 1983) and Bernard and Joyce's (1984) "Rational Emotive Therapy with Children and Adolescents," through the 1990s and early part of the twenty-first century, clinical and educational applications of REBT have been written about extensively. A special issue of the *School Psychology Review* was devoted to the implications of REBT and REE for the role of school psychologists (Bernard & DiGiuseppe, 1990). Bernard and DiGiuseppe's book (1993) "Rational Emotive Consultation in Applied Settings" contained a variety of chapters detailing ways in which REBT could be used by practitioners to address the mental health needs of primary caregivers of young people (parents, teachers) with emotional and behavioral disorders as well as provided ways in which the ABCs and rational beliefs could be introduced by primary caregivers to young people. Similar to REBT, but perhaps somewhat later, the extension to the application of CBT in working with youth was seen both empirically as well as conceptually through the first major publications in the area (Craighead, Meyers, & Craighead, 1985; Meyers & Craighead, 1984). There were a number of early research reviews that supported the efficacy of REBT (Hajzler & Bernard, 1991) and CBT among youth (Weisz, Weiss, Alicke, & Klotz, 1987). A more current summary of the efficacy of the extant literature for REBT, CBT, and REE is offered in Chap. 2 of this edited volume.

Today, it is abundantly clear that within the fields of clinical psychology (child), school psychology, school counseling and guidance, REBT and CBT are preferred methodologies incorporated within the tool boxes of counselors and psychologists who work with children and adolescents. Further, in the field of school-wide prevention and promotion programming, REBT- and CBT-based applications are often seen in social-emotional learning curricula (Dayan, 2016). REBT-based programs such as the You Can Do It! Education (YCDI!) (e.g., Bernard, 2008, 2013, 2017, 2018a, 2018b; Bernard, Elias, Bell, Ferrito, & Langione, 2017; Bernard & Walton, 2011) (see Chap. 20 of this book). Over 100,000 3–6-year old children are learning

rational, positive beliefs as a result of participating in the REBT-based YCDI early childhood program (Ashdown & Bernard, 2012; Bernard, 2018a). Over the past several decades, the Albert Ellis Institute in New York and affiliated training REBT centers throughout the world have offered the Child and Adolescent Certificate in Rational Emotive Behavior Therapy to large numbers of practitioners. Further, the Beck Institute offers a 3-day CBT with a Youth training program to teach clinicians developmentally appropriate and practical CBT skills in clinical work with caregivers, children, and adolescents.

Interestingly, despite REBT being considered to be the first formal system under the Cognitive Behavioral Therapy (CBT) spectrum (Hollon & DiGiuseppe, 2010; MacLaren, Doyle, & DiGiuseppe, 2015), in the field of cognitive behavioral child treatment, clinical psychologists have not embraced REBT as extensively as in other mental health professions. This may be due in part to a perception that REBT has no research base to speak of and, as a consequence, REBT has been ignored by CBTers (M. A. Reinecke, personal communication, 2005). Hopefully, the material presented in the subsequent chapters will dispel this notion.

Theoretical Considerations in Applications of RE-CBT to Childhood Disorders

In this section, we examine important theoretical foundations that underpin the practice of RE-CBT with younger populations.

REBT and CBT Developmental Model of Childhood Disorders

Grave and Blissett (2004) and Garber and colleagues (Garber, Frankel, & Herrington, 2016) offer some important developmental consideration in the application of RE-CBT among youth. The integration of the developmental level of the child with cognitive behavioral approaches is one that has been met with challenges (Ollendick, Grills, & King, 2001) that may preclude their participation in some of the more complex aspects of REBT and CBT (Grave & Blissett, 2004). In looking at both the theory and the science, there is little question that REBT and CBT are developmentally oriented and meets existing criteria for establishing a therapy's developmental credentials (e.g., Holmbeck, Greenley, & Franks, 2003; Shirk, 2001; Weisz & Hawley, 2002). It is important that REBT and CBT clinicians who work with children and adolescents take into account the critical developmental tasks and milestones relevant to a particular child's or adolescent's presenting problem (e.g., Bernard, 2004) and have the flexibility to be able to choose which presenting symptoms to prioritize, depending on the degree to which each of the symptoms is developmentally atypical. Further, being developmentally sensitive with assessment and treatment methods where clinicians to take into account the developmental levels of

the child or adolescent has been a long-standing practice within REBT (e.g., Bernard & Joyce, 1984). Whereas most treatment models focus on the assessment of symptoms and diagnosis (Garber et al., 2016), we have found that REBT- and CBT-driven assessments have consideration of the strengths and weaknesses of the student and their developmental ability to benefit from specific cognitively oriented interventions. For example, REBT does little disputing of irrational beliefs in children younger than six and reserves more sophisticated disputing of general beliefs until after the age of 11 or 12. Table 1.1 developed by Ann Vernon, an innovator in the production of age-appropriate creative activities that teach children and adolescents the basics of REBT, has specified developmental issues to take into account when practicing REBT with younger populations.

As can be seen in the chapters of this book, REBT and CBT have always thought *multi-systemically* and always consider the need to involve peers, teachers, parents, and the whole family while treating the child. As reflected in this volume, REBT and CBT practitioners believe that emotional disorders and abnormal behavior in childhood can be best understood in terms of an interaction between “person” and environmental (e.g., parenting, peer) variables. Bernard and Joyce (1984) characterized this perspective as follows:

Children demonstrate characteristic ways of thinking about and relating to their environment which exert an influence on their environment. Similarly, situations themselves modify the behavior and attitudes of people by providing (or not providing) appropriate learning experiences and enrichment opportunities as well as rewarding and punishing consequences for behavior within certain contexts. We believe that there is an almost inexorable reciprocal relationship between abnormal behavior and a deviant environment such that abnormalities in either the person or the environment of the person tend to bring out abnormalities in the other. It would seem, therefore, necessary to determine how persons and environments interact and covary together in analyzing childhood psychopathology.

This was further reflected in similar sentiments expressed by Bernard (2004):

The extent to which children’s thinking and associated beliefs are dominated by irrationality rather than rationality depends upon their age, their biological temperament (e.g., feisty, fearful, flexible), their home environment including their parent’s style of parenting (e.g., firm/not firm, kind/unkind), the extent to which their parents model and communicate irrational or rational beliefs and whether there are negative events present in their lives (e.g., divorce, persecution). Children who manifest social-emotional- behavioral and achievement problems often present with developmental delays in their capacity to think rationally and logically concerning affective-interpersonal issues (e.g., have difficulty keeping things in perspective, personalize negative experiences) as well as in the development of other emotional self-management skills (e.g., relaxation, finding someone to talk with). They also are dominated by a range of irrational beliefs including self-downing, low frustration tolerance, and the lack of acceptance of others.

Child Factors

The ability to engage in the process of REBT and CBT is impacted by a number of factors, chief among them may be the child’s cognitive developmental level (Garber et al., 2016; Shirk, 1999) engaging in cognitive therapy. According to REBT theory, children are born with an innate capacity to think irrationally and illogically. What moderates the influence of irrationality is the development of rationality and logical

Table 1.1 Developmental milestones (Vernon, 2004)

<i>Early childhood (4–5 years) (pre-concrete operational thinking; the world of pre-school, play/fantasy)</i>	
<p>Difficult in distinguishing real from make believe Egocentric Perspective-taking impossible Self-esteem quite high Overestimate ability to do things Beginning to develop impulse control High self-efficacy Pre-concrete operational thinking Through play, children learn how to be cooperative and take turns Solve problems using information from what they see or hear rather than using logical reasoning Difficulty with abstract concepts like death and divorce</p>	<p>Aspect of their cognitive style is centration – inability to view a situation/person from multiple perspectives Because of difficulty in understanding intentionality, they are likely to misinterpret other’s behavior and respond inappropriately Cannot understand it is possible to experience multiple emotions at the same time Toward the end of the stage, children begin to develop a sense of empathy acquiring a better understanding of other people’s feelings</p>
<i>Typical problems:</i> difficulties in cooperative play and fears due to tendency to take things literally and failure to distinguish reality from fantasy. Situational problems.	
<i>Middle childhood (6–10 years) (developing a sense of belongingness with friends – socialization – and teachers)</i>	
<p>Prone to misinterpretations of reality. Prone to make faulty inferences concerning the motives of others (if their best friend does not sit next to them, likely to assume friend is angry with them rather than consider other alternative explanations) Lack of ability to generate problem-solving alternatives (alternative solution generation, consequential thinking, cause-effect) when faced with adversity Development of impulse control necessary to cope with the structure of schooling Adult and peer approval important At age 8, children enter the concrete operational stage that aids problem-solving; they are able to think more logically but cannot reason abstractly (use concrete logical disputes) Problem-solving is limited by the inability to consider alternative courses of action before approaching a situation Self-understanding improves Developmental trend toward internal locus of control</p>	<p>Become more self-critical comparing self with others and may tend to experience low self-esteem in comparison to children in early childhood period Children evaluate their degree of success in making friends and or at risk for rejection, peer pressure, and conformity as socialization becomes central developmental task Children begin to develop perspective-taking skills and, as a consequence, are better able to resolve interpersonal conflict Cannot understand possible to experience multiple emotions at the same time Adept at hiding emotions More able to recognize and communicate feelings to others than before Aware that they are not the sole cause of another’s feelings They are also better able to recognize feelings more effectively that contributes to improved problem-solving skills</p>
<i>Typical problems:</i> anxiety associated with issues surrounding peer approval (being chosen for a team, anxiety about not being liked or ridiculed by classmates); anxiety associated with school performance (grades, being liked by teacher; being disciplined by teacher). Situational problems.	

(continued)

Table 1.1 (continued)

<i>Early adolescence (11–14 years) (middle school, grades 6–8) (emotional roller coaster)</i>	
Heightened anxiety due to a variety of factors (self-consciousness of differences with others brought about by puberty/physical development, shift focus to peer group and adolescents want to be like everyone else, accepted); imaginary audience (increase in anxiety) Mood fluctuations Overly sensitive to performance and appearance (increase in low self-esteem) Push for independence leads to changes in parent-child relationship (increase in home problems including anger and rebelliousness) Formal operational thinking Imaginary audience – assume everyone is looking at them – on display Personal fable – mistaken beliefs that because they are unique and invulnerable, bad things happen to others but not to them (unprotected sex) – leads to high incidence of risk-taking behavior (increase in risk-taking behaviors)	Peers play a more important role (increase in peer conforming behavior; increase in down feelings due to peer rejection) Young people feel increasingly vulnerable due to push for independence but lack of experiences and reliance on parents (tension) Rapid physical changes; physical/hormonal changes lead to discomfort, confusion as sexual thoughts arouse accompanied by guilt and embarrassment Shift from concrete to formal operational thinking begins at 12, complete by 15 Think more abstractly, can hypothesize, predict consequences (not in emotional domain); difficulty making logical cause-effect connection when applied to self (failing a test results from not having studied) Do not assume these children are capable of mature cognition Unable to generate alternatives for dealing with emotions
<i>Typical problems:</i> easily overwhelmed by feelings, problems arise when feeling overwhelmed; anger, depression, and mood swings are common. Oversensitivity in relationships with friends/family. Excessive worry about how they look, act, and belong. And their sexuality. Anger with family due to striving for independence. Emotional reactions to adults’ over-reactions; anger may cover up feelings of inadequacy, depression; increased intensity of emotions.	
<i>Mid-adolescence (high school, 15–18 years.) (independence/emotional maturity-stepping stone to world of young adult) (Vernon, 1993)</i>	
Formal operational thinking continues to evolve – new cognitive abilities Lack of experience to make appropriate choices Interests are in exploring different roles and achieving independence Friendships continue to be important but change; may not be as dependent on friends as more emotionally mature; intimate relationships bring with them challenges of dating/sexual experimentation	Experimentation increases More able to deal with emotional issues although wide individual differences Self-confidence increases
<i>Typical problems:</i> problems arise (anxiety) due to issues inherent in more intimate relationships and uncertainties about the future including transition to post-secondary education and work. Push for more independence from parents (anger) and anxiety about being too independent. Experience more loneliness than before as their needs/interests and friends change. Self-doubt concerning themselves grows if they perceive shortcoming in skills/knowledge to get into university or job of their choice.	

reasoning abilities which emerge around the age of six (Piaget's concrete operational stage of development) with abstract reasoning abilities developing more fully around the age of 11 or 12 (Piaget's formal operational stage of development). Clinical approaches seek to consider a child's level of cognitive development as defined by Piaget's stages and therapeutic methods offered by REBT and CBT. The prerequisite skill of connecting thoughts and emotions requires both meta-cognition and causal reasoning (Garber et al., 2016) and clinicians would be wise to consider the developmental stage of the child before engaging in RE-CBT. As an example, whereas we employ rational self-statements with children of all ages, we generally do not dispute irrational beliefs with children who are less than 7 years old, and we do not often logically dispute irrational beliefs in the abstract with children much below the age of 11 or 12.

There are a number of interesting overlaps between the theories of Ellis and those of Piaget. Both share the assumption of constructivism. They also place great "faith" in the scientific reasoning method of investigation and the power of formal logical reasoning.

Sandberg and McCullough (2010) describe the systematic approach toward gathering evidence against a testable hypothesis during scientific reasoning. This is quite analogous to REBT and CBT clinicians working with students to "test" their irrational beliefs or automatic thoughts that are impacting their affective and behavioral states. Both appear to be in agreement concerning the importance of cognition in the experience and expression of emotions. Piaget (1952) wrote that "it is, in fact, only a romantic prejudice that makes us suppose that affective phenomena constitute immediate givens or innate and ready-made feelings similar to Rousseau's 'conscience'" (p. 12).

In his writings, Ellis (e.g., 1994) discusses the idea that the strength of one's propensity for irrational thought and the strength of conviction one has in one's irrational beliefs is heavily influenced by genetics (MacLaren et al., 2015). Podina and colleagues (Podina, Popp, Pop, & David, 2015) offer some preliminary evidence as to a genetic marker for predicting irrationality when stressed. Ellis recognized that while parenting practices, peers, and one's culture may condition the beliefs of young people through modeling and direct communication, the tendency for beliefs to be fully integrated within a young person's view of the world and the extent to which a young person's cognitive processing is characterized by absolutism is not learned but is biologically determined (Bernard et al., 2005). The evidence provided by Ellis to substantiate nature over nurture when it comes to the origins of an individual's irrational thinking is partly found in the many instances of families seen by Ellis where only one child presented with an internalizing or externalizing problem but their sibling did not, despite the parenting styles having remained constant. Some children who experience distress and demonstrate maladaptive behaviors have parents who appear to be reasonably well adjusted, who have positive attitudes toward their child, and whose child-rearing practices appear to be sound.

As already indicated, REBT and CBT have historically recognized the importance of the young person's cognitive developmental level of maturity in treatment. On the assessment side, a recognition of child development enables the practitioner to judge whether a presenting problem is a transient and/or a normal developmental phenomenon (i.e., fear of the dark) or whether it represents something more serious. The level at which the cognitively-based intervention is used (rational self-statements, disputing of inferences, or abstract disputing of irrational beliefs) depends on the linguistic and cognitive maturity of the young client.

REBT and CBT recognize, as do the proponents of many different approaches to childhood psychopathology, that there is a reciprocal relationship between mental and emotional development. When children are very young, the quality of their subjective emotional experience is very much limited by their capacity to think about and understand the meaning of their experience. The cognitive limitations of the early childhood period can often result in children's acquiring beliefs about themselves and their surrounding world that are untrue and irrational and that if not corrected can have an extremely deleterious effect on their future wellbeing. That is, children construct their own theories and arrive at their own conclusions based on inferences from what they have observed. The child's conception of the world is idiosyncratically organized and derives from the child's limited capacity to make observations and draw logical conclusions.

In working with children, we are struck by the pervasive influence that their ideas and beliefs have on their emotions and behavior. These beliefs are often implicit and frequently result from the child's having formed a conclusion based on limited evidence and having used the conclusion as an "unquestioned" rule for guiding subsequent behavior. The beliefs, be they rational, or irrational, that are formed early in life may become firmly fixed, and they represent part of the phenomenological framework of children that provides the basis for self-evaluation, for the demands they place on others, and for the interpretation they make of the behavior of others. Young children's incapacity for rational and logical thought limits the types of ideas that they acquire and frequently reinforces a variety of irrational beliefs which take many years to overcome.

A cognitive analysis of maladjustment in children and adolescents frequently reveals beliefs about themselves, others, and the world, as well as logical reasoning processes that appear to be either a holdover from or a regression to pre-concrete operational levels of thinking and primitive belief systems. Characteristics of pre-concrete operational thought include:

1. Drawing arbitrary inferences – conclusions not based on evidence or when evidence contradicts conclusion
2. Selective abstraction – focusing on a detail taken out of context, ignoring salient features of the situation
3. Magnification/minimization – errors in evaluating the significance of an event
4. Personalization – tendency to relate external events to themselves when no basis for making connection

5. Overgeneralization – drawing a conclusion based on limited and isolated events
6. Dichotomous thinking – tendency to place events into opposite categories (e.g., good-bad)

The advent of formal operational thought capacities in adolescents also brings with it its own problems. Adolescents in their early teens begin to experience a form of egocentrism (Rommel & Flavell, 2004), a “naive, idealism” (not dissimilar in effect from the egocentrism of the early childhood period), that frequently leads to a variety of emotional and behavioral problems. The struggle for a personal identity and for new definitions of social relationships that accompanies the increased capacity for reflective and abstract thought often results in adolescents’ acquiring sets of beliefs concerning themselves (self-rating) and others (demandingness) that accompany some people throughout life.

Parental Factors Parents may serve as role models and reinforcing-punishing agents and can play a major part in preventing, minimizing, or exacerbating emotional and behavioral problems in their children. The role of parenting cognitions, affect, and behavior as they relate to child adjustment are elaborated on in Chaps. 6 and 22 of this volume. In considering the role of parenting in adjustment, we agree with Bard’s (1980) comments:

Some children seem especially prone to make themselves miserable about their parent’s relatively minor imperfections. I emphasize this point at the onset to attack the myth that parents are always to blame and to alert practitioners to the fact that parent-child problems may be extremely complex. (p. 93)

Ellis (1973) posited that the worst thing that parents can do to their children is to blame them for their mistake making and wrongdoing. Such blaming encourages children to continue to blame themselves and inevitably leads to chronic feelings of anxiety, guilt, and low self-esteem for some children and hostility and bigotry in others.

Irrational beliefs of parents can influence their parenting behavior in two basic ways. One is through their emotions.

Parents frequently get very upset when their child breaks a rule because they believe that: (a) “My child must be good all the time”; (b) “I find it awful or horrible when my child is not-I can’t stand it,” and (c) “My child deserves punishment because he has made me so angry and for being such a bad child.” The belief that children must never break a rule leads to extreme anger which produces intense and non-constructive disciplinary action. (Bernard & Joyce, 1984)

Alternatively, parents may employ inappropriate and counterproductive methods of child management because of ignorance. That is, they believe that what they are doing is the correct thing to do, and often, it is the only way that they can conceptualize relating to their children. Their maladaptive behavior is not associated with extreme emotional arousal but motivated directly by their “unjustified” and “outdated” assumptions.

Conceptualization of an Emotional Episode

Incidents of emotional upset are complicated psychological phenomena. The theoretical approaches of REBT, CT, and CBT are grounded in the role of cognitions, beliefs, evaluations, and perceptions in contributing to unhealthy negative affective states and behaviors (Beck & Dozois, 2011; DiGiuseppe, Doyle, Dryden, & Backx, 2014). The CBT umbrella attempts to group a number of therapies together that share common elements and clinical applications. While approaches such as Cognitive Therapy, Dialectical Behavior Therapy, and Problem-Solving Therapy share similarities, there are some unique aspects to each of them. As an example, the Beck Cognitive Therapy model proposes that faulty information processing and biased perceptions lead to the development of ineffective cognitive schemas (Beck & Haigh, 2014; Buschmann, Horn, Blankenship, Garcia, & Bohan, 2018). Similarly, REBT has very unique distinctive features. In this section, we will discuss the theory of REBT in explaining an emotional episode among youth and where appropriate highlight the distinctive components of other models. For a thorough review of the distinctiveness of these models, refer to Dryden (2015).

Ellis (1994) has provided his now famous ABC model (outlined below) to help clients grasp the role of their thoughts in causing emotional disturbance. Wessler and Wessler (1980) expanded the ABC model to help therapists to a fuller understanding of these complex psychological events. At the start of every emotional event, a stimulus is presented to the child:

Step 1: Stimuli are then sensed by the person's eyes, ears, sense of smell, touch, etc.

Step 2: Sensory neurons process the stimuli and transmit them to the CNS.

Step 3: Not all sensations enter consciousness. Some are filtered out and others are perceived. Perception is Step 3. Perception, however, is not an exact replication of reality. Perceptions consist of equal parts of information provided by the senses and information provided by the brain. At this point, all information is organized, categorized, and defined. Perception is as much a peripheral as a CNS function.

Step 4: People usually do not stop thinking after they have perceived information. In most cases, they attempt to extract more information than is present in the perception, so some interpretations or inferences are likely to follow perceptions.

Step 5: Humans are not just passive processors of information. Inferences and conclusions usually have some further meaning associated with them. Conclusions and inferences may vary in their importance to an individual. Almost all inferences are appraised by the person either positively or negatively in relation to the person's life. Irrational appraisals consist of *absolutes* (shoulds, oughts, musts, needs) and *evaluations* (awfulizing, I can't stand it-it-is, global rating of self, others, the world).

Step 6: According to rational emotive behavior therapy, affect or emotion accompanies appraisal. We feel happy or sad or mad at Step 6, after we have appraised something as being beneficial, threatening, etc.

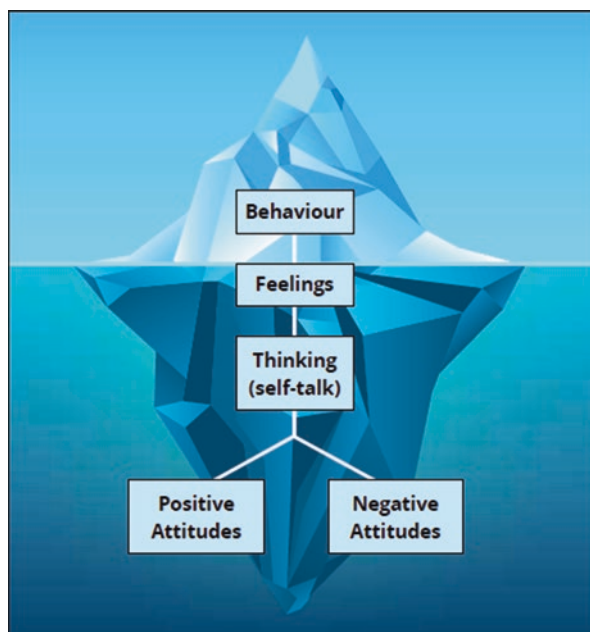
Step 7: Emotional states are not separate psychological phenomena. Emotions have evolved as part of the flight-fight mechanism and exist primarily to motivate adaptive behavior. Therefore, emotions usually include not only the reactions of the autonomic nervous system and the phenomenological sensations, but action tendencies or behavioral response sets that are learned.

Step 8: Responses, once they are made, usually have some impact on the external world. This effect can be desirable or undesirable, and feedback of our action tendencies serves as a reward to strengthen or extinguish a response set.

Given this model, emotional disturbance develops because of one or two types of cognitive errors: empirical distortions of reality that occur at Step 4 (inferences) and irrational, exaggerated, and distorted appraisals of inferences at Step 5. According to REBT, it is primarily the appraisal that is necessary for emotional disturbance. This is the B in Ellis's ABC. Ellis has noted, however, that, many times, the appraisals are about distortions of reality. Faulty inferences usually do accompany exaggerated appraisal, but the appraisal alone is sufficient to arouse disturbed affect.

We have found that visuals can assist in clinical work in communicating the relationship among beliefs/thoughts and emotions and behaviors. The iceberg metaphor (see Fig. 1.1), so often used in explaining the psychoanalytic model of psychotherapy, can really be quite helpful in understanding the role of cognitions and how while they may not be observable are very powerful in terms of behavioral and affective expression. Much like the vast majority of an iceberg's volume is underwater (not seen) and guides an iceberg's movement, one's emotions and behaviors

Fig. 1.1 The iceberg model in explaining the RE-CBT model. (Bernard, 2018a, 2018b)



are strongly influenced by their self-talk (beliefs). Clinical work that focuses on understanding how that which is observable (emotions and behaviors) are influenced by these unseen elements, whether they are under the influence of positive or negative ones is important. We also think this visual may be helpful in distinguishing between more just below the surface level beliefs often seen in Cognitive Therapy (“I am going to fail”) and the deeper beliefs (“If I fail, that means I am a failure.”) that may contribute to more profound negative affect. These distinctions will be elaborated on in the below.

Let’s take a hypothetical clinical example to explain how these two cognitions operate. George, a 14-year-old, has moved to a new neighborhood and has not met new friends. He is sitting quietly in the neighborhood playground while the other teenagers are talking among themselves or playing basketball. He feels very anxious and his associated action potential is withdrawal. He sits alone leaning up against a wall, reading a book. As he sees others gather nearby, George thinks, “They’ll never like me, they’ll think I’m weird, and they won’t want to speak with me no matter what I do.” George has drawn these inferences from his peer’s behavior. In fact, they are predictions about what might happen but never actually has happened. Inferences alone are not sufficient to arouse high levels of anxiety. Some adolescents, although not George, might be perfectly happy to sit by themselves and read books, but George appraises this situation quite negatively and irrationally. His implicit absolute “I need people to like and approve of me” leads him to catastrophize “It’s awful that I don’t have anyone to play with” and, then, to put himself down “I must be a jerk if they won’t play with me.”

Hot and Cold Cognitions

Prior to discussing specific automatic thoughts and irrational beliefs that are consistent with the RE-CBT model, it may be important to highlight the differences between cold and hot cognitions to guide clinical work. Although the concept of hot and cold cognitions is often used in RE-CBT, its history can be traced back to the work of Abelson and Rosenberg (1958) who used the concepts of hot and cold cognitions to make the distinction between facts/knowledge (cold) and appraisals (hot). Cold cognitions may be considered to be the first level of cognition and reflects how one may process information independent of emotion. Hot cognitions are the more emotional of the two, where the manner in which we think about an event is influenced by our emotions (David & Szentagotai, 2006; Gavita & Joyce, 2008).

While cold cognitions (e.g., no one in my class likes me) may be incorrect and we would look at challenging those inferences, they may not lead to an emotional response unless they are negatively appraised (e.g., “They SHOULD like me! It’s TERRIBLE that they don’t. I am a loser”). Gavita and Joyce posit that when classifying cognitions clinicians may want to distinguish between the knowing (cold) and appraising (hot) thoughts. They also suggest clinicians be mindful of the

surface cognitions (inferences) which are easier for clients to be aware of and the more deep cognitions (beliefs or schemas) which can be a challenge to access without support.

Defining Thoughts, Schemas, and Beliefs

While the different CBT approaches all highlight the importance of thinking, the terminology used and specific types of beliefs vary somewhat dependent on the model. The Beckian model of cognitive therapy focuses on automatic thoughts (ATs) that relate to a specific situation and may take the form of inferences or evaluations (Soflau & David, 2017). These beliefs are generally considered to focus on three types or levels of cognitions: automatic thoughts (ATs), intermediate beliefs, and core beliefs (Leder, 2017). These ATs are considered to be surface level and are fairly accessible specific beliefs about a past, present, or future stimuli (e.g., “He hated my presentation”; “I am being boring”; “I will fail”) and have been linked to emotions among children (Beck, 2005; Hogendoorn et al., 2010; Schniering & Rapee, 2002). The intermediate beliefs are often considered to be conditional statements that are distorted and overly rigid in nature (Leder, 2017). An example would be when students think: “If I don’t make the big shot in the game, people will be mad at me.” Finally, the core beliefs/schemas are proposed to be more challenging to access and are highly generalized beliefs about oneself and the world and form the basis for all other cognitions (Leder, 2017). An example would be: “I am a loser” or “Things will never go my way”.

In REBT, the terms *belief* and *belief system* refer to that aspect of human cognition that is responsible for the mental health and the psychological well-being of the individual. Beliefs are a central explanatory construct of REBT, and it is important that the meaning of the term be as clear as possible.

Ellis (e.g., 1977) developed an ABC (DE) theory of emotional disturbance that describes how a person becomes upset. REBT starts with an emotional and behavioral consequence (C) and seeks to identify the activating event (A) that appears to have precipitated (C). While the commonly accepted viewpoint is that, (A) caused (C), REBT steadfastly maintains that it is the individual’s beliefs (B) about what happened at (A) that more directly “create” (C). Disputation (D), one of the cornerstones of the REBT practice of therapeutic change, involves employing the scientific method of challenging and questioning anti-empirical and untenable hypotheses that are illogical and dysfunctional, as well as imperative and absolutistic assumptions (irrational beliefs) that individuals may hold about themselves, about others, and about the world, which lead to the particular interpretations and appraisals that the individual forms about the activating event. When individuals who hold irrational beliefs begin to change their unsound assumptions, to reformulate them into more empirically valid statements, and to believe strongly in the validity of the new ideas, they now have developed new cognitive (philosophical), emotive, and behavioral effects (E’s).

Belief may be viewed as a very broad hypothetical construct that embraces at least three distinct subclasses of cognitive phenomena: (1) thoughts that an individual is thinking and is aware of at a given time about A; (2) thoughts about A that the individual is not immediately aware of; and (3) more abstract beliefs that the individual may hold in general (Bernard, 1981; David, Freeman, & DiGiuseppe, 2010). Eschenroeder (1982) was in essential agreement with this analysis when he wrote that the ABC scheme is a simplification of the complex processes of the perception, interpretation, and evaluation of events and the activation of emotional reactions and behavioral responses:

The B-element of the ABC refers to rather different phenomena: (1) *thoughts and images*, which can be observed through introspection by the individual; (2) *unconscious processes*, which can be inferred post hoc from the individual's feelings and behavior ("unconscious verbalizations"); (3) the *belief system* underlying the person's thoughts, emotions, and behaviors. (p. 275)

The more abstract beliefs that people hold are unspoken and constitute the assumptive framework by which they evaluate, appraise, and form conclusions about what they observe to be happening to themselves, to others, and in the world around them. These abstract beliefs are not expressed in the self-talk of people but can be considered relatively enduring personality traits that affect people's interpretations of reality and often, in so doing, guide subsequent behavior. They are inferred from the types of thought statements that clients are able to articulate to themselves and to the practitioner as well as from their pattern of behavior. For example, students who strongly hold the belief that they desperately need others to depend and rely on, tend to interpret situations in terms of whether they offer that level of personal security and also may seek out environments and relationships that satisfy this self-perceived need.

Abstract beliefs can be differentiated on the basis of whether they reflect absolutistic and imperative qualities (irrational) or relativistic and conditional qualities (rational). Those beliefs that lead to self-defeating emotional and behavioral consequences are almost always expressed as unqualified shoulds, oughts, musts, commands, and demands and are deemed "irrational." Ellis has indicated that if people hold rigid views and beliefs about how they, others, and the world *should* or *must* be under all circumstances, then they are likely to experience some form of disturbance. Beliefs that are expressed not as commands but as more healthier preferences and that are viewed as conditional on and relative to a set of circumstances are defined as rational and lead to more adaptive levels of emotionality and appropriate behavior.

In terms of the ABC model, rational beliefs generally lead to moderate emotions that enable clients to achieve their future goals by facilitating constructive behavior, although rational beliefs may result in extreme levels of some emotions that are contextually appropriate, such as extreme sadness and regret. Irrational beliefs lead to extreme emotional consequences (intense anxiety, anger, or depression) and behavioral reactions (aggression or withdrawal) that are not consistent with the context and interfere with the ability of the individual to improve the situation (Fig. 1.2).

Adverse Events	Beliefs	Emotions	Behaviours	
<ul style="list-style-type: none"> mistakes, failure rejection loss of loved one 	<p>If irrational beliefs dominate interpretation of adverse event ...</p> <p>negative, illogical (not sensible), not true, not helpful thinking</p> <ul style="list-style-type: none"> needing to be achieving/perfect needing approval self-downing 	<p>negative, intense, long-lasting emotions</p> <p>Very Down</p> <p>Very Worried</p> <p>Very Angry</p>	<p>inappropriate, goal defeating behaviour, harmful consequences</p> <ul style="list-style-type: none"> withdrawal loss of confidence 	
<ul style="list-style-type: none"> imminent threat involving possible failure, rejection, discomfort 	<ul style="list-style-type: none"> needing to be achieving/perfect needing approval needing comfort 			<ul style="list-style-type: none"> avoidance disrupted thinking/performance physical symptoms loss of confidence
<ul style="list-style-type: none"> injustice, unfairness frustration that cannot be avoided 	<ul style="list-style-type: none"> being intolerant of others low frustration tolerance 			<ul style="list-style-type: none"> aggression retaliation from others rule breaking
<ul style="list-style-type: none"> mistakes, failure rejection loss of loved one 	<p>If rational beliefs dominate interpretation of adverse event ...</p> <p>positive, logical (sensible), true, helpful thinking</p> <ul style="list-style-type: none"> responsible risk taking non-approval seeking self-acceptance 	<p>less negative, milder, brief emotions</p> <p>Sad</p> <p>Concerned</p> <p>Annoyed</p>	<p>appropriate, goal achieving behaviour, helpful consequences</p> <ul style="list-style-type: none"> seeks support motivated engaged confident 	
<ul style="list-style-type: none"> imminent threat involving possible failure, rejection, discomfort 	<ul style="list-style-type: none"> responsible risk taking non-approval seeking high frustration tolerance 			<ul style="list-style-type: none"> focused on task confident
<ul style="list-style-type: none"> injustice, unfairness frustration that cannot be avoided 	<ul style="list-style-type: none"> unconditional acceptance of others high frustration tolerance 			<ul style="list-style-type: none"> assertion communication problem solving cooperation from others

Fig. 1.2 The relationship of children’s irrational beliefs to their emotions and behaviors. (Bernard, 2004)

Rational emotive behavior theory states that irrational beliefs in the form of *absolutes* (shoulds, oughts, musts, needs) are the psychological core of children and adolescent emotional and behavioral problems (see Bernard, 2004). For example,

- I must be successful.
- I need love and approval.
- The world should give me what I want comfortably, quickly, and easily.
- People must treat me fairly and considerately.

Ellis indicates that there are a number of derivatives of absolutes that also contribute to the intensity of emotional problems including *awfulizing*, *I can't-stand-it-it is* and *global rating* (self, others, world). For example,

- It’s awful to make mistakes.
- I can’t stand to be criticized.
- I can’t stand having to do boring homework.
- People who treat me badly are bad people and deserve severe punishment.
- School is stupid.
- I’m stupid.

As a result of their rigidly held irrational beliefs, young people are prone to misrepresent reality (errors of inference including faulty conclusions, predictions).

Sometimes, these inferences are referred to as *automatic thoughts* and are consistent with the Beck model of CT. For example,

- I will always make mistakes.
- My teacher doesn't like me.
- All homework is boring.
- People always act unfairly to me.
- I'm a hopeless student.

The tendency for young people to selectively attend to and remain over-focused on the negative aspects of their environment is strongly influenced by their core irrational beliefs and feelings. That is, they may look to "gather data" that is consistent with their faulty belief system.

For example, they pay attention to:

- Children who are not wanting to play with them.
- Mistakes and other negative comments offered by their teacher concerning school work.
- The boring aspects of homework.
- Classmates who are mean to them.
- Negative aspects of the way they look.

Common Irrational Beliefs of Children include (Waters, 1982):

1. It's awful if others don't like me.
2. I'm bad if I make a mistake.
3. Everything should always do my way: I should always get what I want.
4. Things should come easy to me.
5. The world should be fair and bad people should be punished.
6. I shouldn't show my feelings.
7. Adults should be perfect.
8. There's only one right answer.
9. I must win.
10. I shouldn't have to wait for anything.

Common irrational beliefs of adolescents include (Waters, 1982):

1. It would be awful if my peers didn't like me. It would be awful to be a social loser.
2. I shouldn't make mistakes, especially social mistakes.
3. It's my parents' fault I'm so miserable.
4. I can't help it. That's just the way I am, and I guess I'll always be this way.
5. The world should be fair and just.
6. It's awful when things don't go my way.
7. It's better to avoid challenges rather than risk failure.
8. I must conform to my peers.
9. I can't stand to be criticized.
10. Others should always be responsible.

While Ellis proposed that demandingness was the core belief that all other derived from, Bernard and Joyce (1984) have offered the view that the irrational tendency of self-downing/self-depreciation rather than being derivative of core absolutes is primary. They argued that children and adolescents who have this trait put themselves down when they are faced with a variety of negative events be they mistakes, rejection, and unfairness of “bad hair” days. A factor analysis of the Child and Adolescent Scale of Irrationality (Bernard & Cronan, 1999) yielded “Self-Downing” as one of a number of distinct factors representing different patterns of irrational thinking. Chapter 2 in this edited volume summarizes the research on measures of irrationality and automatic thinking among youth.

Distinctiveness of REBT and CBT in Clinical Work with Youth

While this edited volume aims to present the theory, science, and applications of REBT and CBT, the use of REBT is not synonymous with the use of CBT (Bernard et al., 2005). Ellis (1980) argued that although general or non-preferential REBT is virtually synonymous with CBT, specific or preferential REBT is not. Preferential REBT includes a deep philosophical emphasis, a humanistic outlook, the seeking of a profound and maintained personality change, the use of active disputing techniques, the teaching of clients how to give up any kind of rating of their egos or their selves (and, instead, only how to rate their acts and performances), and the getting at and eliminating of secondary as well as primary sources of unhealthy negative affect (e.g., anxiety, anger, and depression).

Although preferential REBT is highly suitable for many bright adolescents, it may require too much philosophical analysis and more of an application of rigorous scientific method than many average youngsters, not to mention most young children, are capable of fulfilling. In the case of younger children, non-preferential REBT, or general cognitive behavioral therapy, is usually employed. This is also consistent with the developmental considerations addressed earlier. These students are shown how they upset themselves with irrational and unrealistic beliefs; how to identify or catch these thoughts and ideally they are taught how to actively discuss, debate, and dispute beliefs and to develop more rational and helpful philosophies by which to run their lives. Students often resist this kind of teaching, and especially the internalization of a scientific way of thinking, and as such, they are frequently provided with rational or coping statements (as is explained in several of the succeeding chapters of this book) and are encouraged and reinforced for believing these more sensible beliefs.

CBT subsumes a variety of methods that attempt to modify cognitive content and processes that support problem behavior. The main difference between CBT and REBT is that CBT does not attempt to modify the overall philosophy and assumptive world of clients through the use of disputational methods and other more didactic forms of direct discussion and psychoeducation. It appears that CBT is more problem-focused (or behavior-focused) and defines goals of treatment in terms of specifiable behavior change. REBT views problem behavior (and

emotions) as symptomatic of an underlying belief system that constitutes the core of maladjustment. An effective REBT solution is conceived of as having been achieved when the client has adopted a more flexible, relativistic, and conditional outlook on life, which manifests itself in a more objective and empirically based reality-testing approach, in emotional reactions that are consistent with reality, and in self-enhancing, goal-directed behavior.

A CBT solution involves the client's acquiring cognitive and metacognitive strategies not only for dealing with a presenting problem, but also for dealing with a range of stressful situations that may confront the client in the future. These general and conceptually based strategies may involve the client's learning to think (and act) more reflectively and to adopt a more systematic problem-solving approach to life's difficulties.

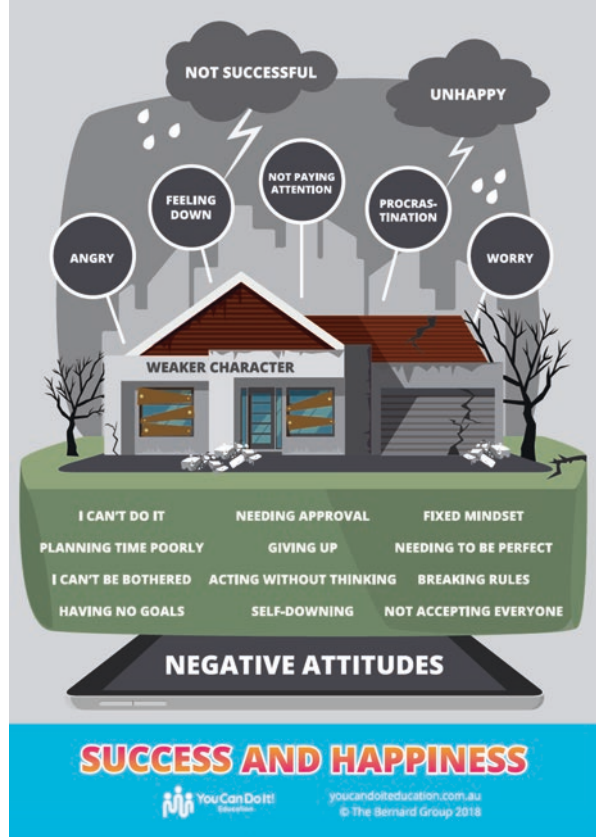
Given the intersection of beliefs, affect, and behavior in the development of client difficulties, REBT interventions are also cognitive, emotive, and behavioral (and not *strictly* cognitive) in its treatment methods. That is, as their beliefs influence their feelings and behaviors, their emotions influence their thoughts and behaviors, and their behaviors influence their thoughts and feelings, REBT encourages the use of a wide variety of intellectual, affective, and activity-oriented techniques that will be demonstrated throughout this edited volume. Figures 1.3 and 1.4 represent all elements of the REBT model in a more pictorial, metaphorical format. These may be useful visuals to share with clients with the key takeaway from the house is that Attitudes are the foundations that determine the extent to which students experience positive wellbeing and flourishing or social-emotional and mental health problems (or blockers).

When a house (or student's life) is built on a rocky, unstable, weak foundation of negative attitudes (or ways that they view themselves and life), the house (the student) will have more chance of experiencing the 5 blockers, plus have weaker character, leading to non-achievement and unhappiness (Fig. 1.3). Alternatively, when a house (or student's life) is built on a firm, stable, strong foundation of positives attitudes (or ways of viewing themselves and life), the house (student) will have more chance of possessing the 5 SELs, plus have a stronger character, leading to achievement and happiness (see Fig. 1.4).

RE-CBT Model of Assessment and Treatment of Children and Adolescents

Chapter 3 in this volume provides extensive details of RE-CBT work with young people summarized in four stages (RATE): Relationship Building, Assessment, Treatment, and Evaluation. The following figure encapsulates and summarizes systematic steps to take when working with a young person. As you will see in the other problem-specific chapters in this edited volume, many integrate multiple components of these steps with appropriate modification as it relates to the areas of concern (Fig. 1.5).

Fig. 1.3 Negative attitudes lead to poor social-emotional difficulties and mental health issues. (Bernard, unpublished)



Allied Cognitive Behavioral Theories

While REBT is generally considered to be the initially developed theory and clinical approach under the CBT tent, there are other complimentary cognitive behavioral theories and techniques that help define additional aspects of cognitive processing and functioning of young people that influence their mental health. Some of these are discussed more in-depth in subsequent chapters, and we will highlight some of these here.

The Interpersonal Cognitive Problem-Solving View of Maladjustment While REBT views irrational beliefs and cognitive processing errors as the source of childhood disorders, other cognitive behavioral theorists have taken a different perspective and see emotional disturbance as resulting from a deficit in the cognitions that are usually present in well-functioning children. Spivack, Platt, and Shure (1976) and Shure (1996) have identified several interpersonal cognitive problem-solving skills. Their research identified several skills in solving social problems that consistently

Fig. 1.4 Positive attitudes lead to success and happiness. (Bernard, unpublished)



distinguish psychopathological from normal populations. The most important skill they have uncovered is alternative-solution thinking (i.e., the number of different solutions that a child can generate to solve a specific practical problem). The second most important skill, consequential thinking, measures children’s ability to predict the social consequences or results of their actions. Once children can generate alternatives and predict sequences, the next skills that seem to be important are the ability to anticipate problems and the implementation of a solution to plan around them. Spivak and his colleagues have termed these “means-end thinking.”

Research suggests that attempts to teach children interpersonal, cognitive problem-solving skills can lead to reduced emotional upset and more adaptive behavior (e.g., Hess, 2014; Urbain & Kendall, 1980). Interpersonal, cognitive problem-solving skills can be effective for several reasons within the context of Wessler and Wessler’s emotional episode model. Problem-solving could occur after the inferences, the appraisals, or the affect. Effective problem-solvers may experience disturbed affect less often because (1) they distract themselves from the appraisal and thereby lift affect—as long as one is thinking about how to go about solving a problem, one is less likely to be entertaining catastrophizing ideas and

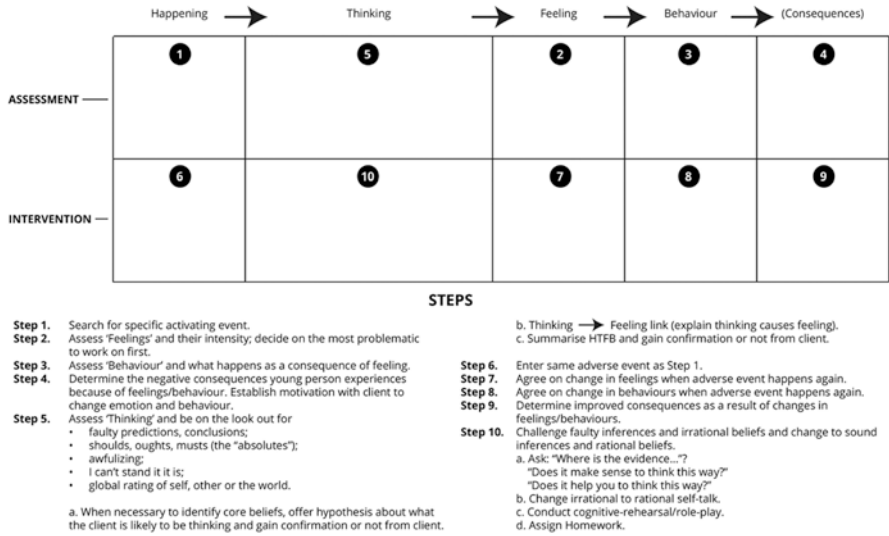


Fig. 1.5 10 steps for RE-CBT assessment and intervention

therefore to become upset; (2) social-problem-solving may bring about solutions to change the activating event and thereby eliminate the problem in the first place; and (3) thinking of alternative solutions may help one change one’s appraisal of a negative event. People who believe they have options may be less likely to view events as awful or catastrophic.

Behavioral Disorders as Verbal Mediation Deficits Meichenbaum (1977, 2017) characterized the thinking styles of children with affective and behavioral difficulties in terms of three mediational deficiencies: (1) they may not comprehend the nature of the problem or the task and thus cannot discover what mediators to produce—a “comprehension” deficiency; (2) they may have the correct mediators within their repertoire but may fail to produce them spontaneously and appropriately—a “production” deficiency; and (3) the mediators that children produce may not guide their ongoing behavior—what a “mediational” deficiency.

Cognitive self-verbalization treatment programs are designed to foster the acquisition both of specific skills and of more general reflective thinking strategies including those processes involved in the treatment of a variety of behavior disorders such as attention-deficit/hyperactivity disorder (e.g., Hinshaw, 2000) and aggression (e.g., Lochman, Whidby, & FitzGerald, 2000). By providing the child with skills that can be employed in problem situations, these programs appear to influence the inferences made (Step 4) by the child when initially faced with a difficult impersonal or interpersonal task. Equipped with a task-specific skill, the child may no longer underestimate his or her coping resources; a result would be a reduction in the affective stress that presumably would previously have been experienced (Step 6). Alternatively, adaptive task performance brings about self-perceived

“need satisfaction,” thereby reducing the frequency with which the child’s demands are not fulfilled. It can be seen that both the interpersonal cognitive problem-solving and the verbal mediational perspectives tend to emphasize direct cognitive behavioral solutions to childhood problems, whereas REBT and CBT are very much oriented toward emotional problem-solving.

The Future

While RE-CBT has demonstrated support in the prevention and treatment of the emotional and behavioral problems of children and youth, there are a number of trends from a scientific as well as applied perspective that we can anticipate in this area. As indicated earlier, there is little question that the understanding of how the cognitive developmental status of children relates to maladjustment will serve as a background to determining the type of cognitive intervention that is best suited to children who manifest different levels of mental and emotional maturity. More than 5 decades ago, Gordon Paul (1967) prompted researchers to transition away from asking “What treatments work?” to asking “*What* treatment, by *whom*, is most effective for *this* individual, with *that* specific problem, and under *which* set of circumstances?” (p. 111). Understanding what RE-CBT techniques work for which students, with what diagnoses/problems, and under which school, family, and peer conditions will lead to greater refinement of the science and practice of RE-CBT.

The use of cognitively oriented preventive mental health programs such as REE and You Can Do It! Education will proliferate as the research presented in this chapter and others in this edited volume supports their use as an evidence-based intervention.

The extent to which faulty thinking processes and the irrational beliefs of parents and teachers influence childhood maladjustment will be more fully analyzed. There are chapters in this volume that discuss the role of irrationality among both of these important groups. The role that significant others can play in correcting the maladaptive thinking patterns and beliefs of younger populations will be of increasing interest. The popularity of cognitively oriented parent and teacher education programs will grow.

The behaviorally oriented cognitive practitioners will begin to recognize (assess and treat) more fully that children and their significant others have emotions that influence both behavioral dysfunctions and the potential effects of treatment. Cognitively oriented practitioners working with children in families and in classroom settings will conduct more systematic assessments of behavioral problems so that the benefits of treatment can be more fully and objectively verified.

There will be an increasing cross-fertilization of cognitive approaches to the problems of childhood. As the contributors to this volume attest, there is a greater acceptance within the cognitive behavioral school of the utility of cognitive practices that have originated in different psychological theories and traditions. It is hoped that this trend will continue.

Test Yourself Questions

1. Discuss some of the philosophical underpinnings to RE-CBT and how this may be integrated into clinical work?
2. How would you describe the primary differences in the application of REBT and CBT?
3. Developmentally, what are important factors to consider before engaging in RE-CBT in clinical work with youth?

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