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Rational emotive behavior therapy: applications for working with parents and teachers

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Terapia relacional-emotiva comportamental: aplicações com pais e professores

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Abstract

Given the high rates of reported emotional stress among parents and teachers, the Rational Emotive Behavior Therapy approach appears to be a useful strategy to promote more effective parent and teacher emotional functioning and increase child positive behaviors and learning. The Rational Emotive Behavior Therapy model may be helpful for clinicians who work with the parents and the family by identifying and subsequently changing their unhealthy ideas, enhancing emotional functioning, and increasing their ability to make effective behavior management decisions. In addition, those who work with educators in a school-based setting may wish to consider implementing Rational Emotive Behavior Therapy methodology in their consultative and therapeutic interventions. Given the data that links stress to unhealthy beliefs among educators, Rational Emotive Behavior Therapy may be an effective tool that warrants further application.

Uniterms: Behavior therapy. Learining. Parents. Teachers.

Resumo

Considerando os índices elevados de estresse emocional entre pais e professores, a abordagem Terapia Racional-Emotiva Comportamental parece ser uma estratégia útil na promoção de um funcionamento mais eficaz entre pais e professores e para aumentar o comportamento positivo e a aprendizagem da criança. O modelo Terapia Racional-Emotiva Comportamental pode ser útil para os clínicos que trabalham com os pais e as famílias, identificando e posteriormente alterando as suas idéias não saudáveis, aprimorando o funcionamento emocional, e aumentando a capacidade de tomar decisões mais eficazes sobre o gerenciamento comportamental. Além disso, quem trabalha com educadores no contexto escolar talvez deseje levar em conta a implementação da metodologia Terapia Racional-Emotiva Comportamental nas suas intervenções clínicas e terapêuticas. A partir dos dados que associam o stress com os pensamentos pouco saudáveis entre educadores, a Terapia Racional-Emotiva Comportamental pode ser uma ferramenta eficaz que merece uma mais ampla aplicação.

Unitermos: *Terapia comportamental. Aprendizagem. Pais. Professores.*

Defining REBT

Rational Emotive Behavior Therapy (REBT) is a pragmatic, present-oriented technique that centers on present beliefs, dysfunctional emotions, and maladaptive behaviors and the relationship among them. REBT and its utility have regularly been examined in terms of its ability to lead to cognitive, emotional,

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and behavioral changes across a number of populations and for various diagnoses. Overall, the notion that REBT is an effective intervention for both adults (Lyons & Woods, 1991; Silverman, McCarthy & McGovern, 1992) and children (Gonzales et al., 2004) has been well supported.

REBT was previously known as Rational Emotive Therapy (RET) and was developed by Albert Ellis in the 1950's. As a therapeutic model, REBT proposes that collaboratively, the clinician and client can work towards reducing undesirable emotions and behaviors by changing the thoughts and beliefs associated with a trigger or activating event (Nucci, 2002). This model implies that emotions are not caused by the actual events in people's lives, but rather emanate from how an individual perceives, interprets, and evaluates these events (Ellis, Gordon, Neenan & Palmer, 1997). It is important to note that cognitions, feelings, and behaviors are interrelated and interact with one another and therefore would be better served clinically if they are viewed together, rather than in isolation. While life may have many common stressors or negative life events, based on the principles of REBT, we may all process these events differently and as such have different negative or maladaptive affect or behavioral responses to these events (Nucci, 2002).

The core of REBT is the ABC explanatory sequence of emotional disturbance. This model can be used to guide clinicians working with parents and teachers, while also providing a didactic explanation to allow individuals to apply this model for themselves independent of clinical intervention. That is, the ABC model can be used to help the individual understand that their negative affective response (e.g., anger, stress, depression) results from how they perceive and evaluate some of these negative life events rather than by the events themselves (Ellis et al., 1997). The ABC model of REBT will be briefly explained below and examples of its use with parents and teachers will be provided.

In the ABC model, the A stands for a perceived unpleasant Activating Event or a set of Activating Experiences (Ellis et al., 1997). The reason that we use the adjective "perceived" is that while there may be some life events that are truly negative (i.e., death of a loved one) there may be other events that for the most part by themselves are not as objectively negative as one perceives them to be. For example, having an unplanned visit from a distant relative may be perceived as a negative event by some and as a positive event from others. This visit is not necessarily as negative a life event as the death of a loved one.

Typically, people tend to believe that it is the situations themselves (A) that cause their emotional responses or consequences (C: described further below). As an example, a parent may incorrectly make the causal link: "If my children would just behave, I wouldn't get angry at them and yell". The REBT model proposes that there exists a mediational step between the activating event (A) and the consequences (C), in which the A is evaluated by the individual which gives rise to the Consequences. This evaluative component is the **B** of the model. The B stands for the beliefs, or cognitions, that an individual has about the Activating Events (Ellis et al., 1997). People may evaluate and interpret these events very differently, as some beliefs can be healthy and flexible in nature (Rational Beliefs; rB) while others may be dysfunctional or inflexible (Irrational Belief; iB) (Ellis et al., 1997). Healthy rational beliefs that are posited to lead to healthy affective and behavioral functioning may take the form of wishes, preferences, wants, and desires while on the other hand, unhealthy irrational beliefs are rigid and dogmatic in nature (Ellis et al., 1997), often leading to unhealthy affective and behavioral functioning. These Irrational beliefs may only serve to increase stress in an already stressful situations (Forman, 1994).

In the example provided above, the parent who gets angry and yells at their child may hold the iB "She should listen to me". Alternatively, you may have another parent who responds affectively and behaviorally in a different manner because they may have a different interpretation of the same child behavior (not-listening). Perhaps these parents may endorse rational beliefs that may be something of the nature of: "While it is important to me that my child listen to me, getting angry does not help her listen, and just causes me more difficulties." While the parents who endorse these cognitions may still try and change their child's behavior, the model proposes that if they truly believe these healthier, rational thoughts will in all likelihood not get them as upset and lead to poor parenting decisions as the parents who endorse those rigidly held, dysfunctional ideas about their child's behavior.

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Ellis posited that beliefs are at the core of emotional disturbance and can be either rational and self-helping or irrational and self-defeating (Ellis & Blau, 1998; Walen, DiGiuseppe & Dryden, 1992). Initially, Ellis described 11 irrational beliefs exhibited by clients (Ellis, 1962; Ellis & Harper, 1975) and subsequently these have been grouped into four broad categories: demandingness of self, others, and the world; global evaluations of human worth (self or others); awfulizing or catastrophizing; and low frustration tolerance (Ellis & Blau 1998; Walen, Giuseppe & Dryden, 1992).

Finally, we get to the C step of the ABC model. The C stands for the consequences that one experiences as a function of their beliefs (B's) about the activating events (A) (Ellis et al., 1997). Ellis posits that these emotional or behavioral Cs that follow from rigidly held irrational beliefs are unhealthy, while those that stem from more flexible Rational Beliefs are more healthy for the individual (Ellis et al., (1997). Using the same example from above, the parent who endorses irrational beliefs related to the not listening, may experience the unhealthy emotion of anger and as such may utilize poor parenting practices in an attempt to change their child's behavior. Alternatively, the parent who held more rational beliefs may get frustrated at their child's behavior, but their parenting practices may be more effective as they are not directly interfered with by their own unhealthy negative affect.

Once REBT helps clients identify their Irrational Beliefs, the next step in the process if to actively challenge and dispute (D) them with cognitive, emotive, and behavioral techniques (Ellis et al., 1997). Through disputation, clients may come to see that the ideas and beliefs that they had did not make sense, were causing them great difficulty, and were not consistent with reality. It is at this point that the goal of therapy becomes replacing these Irrational Beliefs with healthy Rational Beliefs (Ellis et al., 1997) that will lead to more appropriate and productive emotions and behaviors.

Research on REBT

It is important for clinicians who work with children, teachers, and parents to understand how effective are the interventions that they implement. Interventions should be carefully chosen and be influenced by the science of psychology as well as what has been established as effective with varied populations (e.g.., parents vs. teachers; children vs. adolescents; diagnostic classifications). As REBT is considered, for the most part, to fall under the theoretical rationale of Cognitive Behavioral Therapy (CBT), it is important to first understand how effective CBT is and then examine how effective REBT is when working with children and adolescents.

Overall CBT has been an effective intervention for a number of psychological disorders of children and adolescence (Southam-Gerow & Kendall, 2000). However, in a comparison with the efficacy literature for adult psychotherapy, less research has been conducted with children and adolescents. Given this, meta-analytic techniques have frequently been conducted to synthesize the research in order to determine the level of effectiveness of these treatment strategies with children and adolescents (Rosenthal & DiMatteo, 2001). Meta-analyses generate effect sizes which determine the degree of change in standard deviation units (Shaughnessy, E. B. Zechmeister & J. S. Zechmeister, 2006) and allows for combining effect sizes across different studies to determine treatment effectiveness (Bernard, Ellis & Terjesen, 2006; Rosenthal 1994; Rosenthal & DiMatteo 2001). An effect size indicates the degree to which the target behavior changed as a function of the clinical intervention (Bernard et al., 2006). The guidelines proposed by Cohen (1992) (effect sizes of .20, .50, and .80 indicate small, medium, and large effects, respectively) are often used for interpreting the value of effect sizes.

The first meta-analysis specifically evaluating the impact of psychotherapy with children was conducted by Casey and Berman (1985). In their review of 75 studies of children 13 years or younger, they reported an overall effect size of 0.71, similar to the effect size for adult psychotherapy of 0.72 (D. A. Shapiro & D. Shapiro, 1982). A number of other meta-analytic reviews of psychotherapy with youth have produced some consistent results indicating that therapy is fairly effective compared to no treatment (Weisz, Weiss, Alicke & Klotz, 1987; Kazdin, Bass, Ayers & Rogers, 1990; Weisz, Weiss, Han, Granger & Morton, 1995).

Overall, the research has been fairly supportive of CBT with children with effect size estimates ranging from 0.35 (Dush, Hirt & Schroeder, 1989) to 1.27

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(Lewinsohn & Clarke, 1999). In addition, a number of meta-analyses reviewing the treatment effectiveness of REBT with youth have also been conducted, with many of them differentiating between REBT and Rational Emotive Education (REE). REE is designed and considered to be less of a clinical intervention and more of an educational curriculum used in a preventative manner within the classroom setting. The impact of REBT as a clinical intervention generally has garnered some support, but has also created debate at the same time. The first meta-analytic review of REBT with children was conducted by Gossette and O'Brien (1993). The authors reported that while RET did lead to changes on self-reported measures of irrational beliefs, it did not lead to changes on measures of behavior, often a common reason for referrals of children and adolescents (Gossette & O'Brien, 1993). These results somewhat contrast the most recent meta-analysis conducted by Gonzalez et al. (2004). Here, the largest effects were for disruptive behaviors and the overall mean effect size was 0.50; a conclusion by the authors that REBT is effective with this aged population.

REBT with parents

The application of REBT with parents has received considerable attention over the past years. Student social-emotional curriculums such as Michael Bernard's You Can Do It! Education (Bernard, 2003) and parent trainings programs have all recognized the important contribution that parents play in child development. Often times, working with children alone may limit the potential effectiveness of interventions because the context in which the behavior occurs or is maintained is left unchanged. Instead, when interventions incorporate the parents and modify the environment and conditions in which the problematic behaviors occur, a decrease in maladaptive behaviors and an increase in more adaptive behaviors are more probable.

The impetus for working with parents to improve child outcomes has its foundation in the research supporting the parental influence on child outcomes. Countless studies across multiple professional disciplines have found significant relationships between several parenting variables and both positive and negative child outcomes (Frick et al., 1992; Stormshak, Bierman, McMahon & Lengua, 2000). In considering the relationship between parenting behavior and child outcomes, researchers have found that among parents who engage in positive parenting (eg., positive reinforcement, supervision, warmth, etc.) practices, fewer child behavior problems have been reported. Furthermore, parents who engaged in more negative parenting practices, such as the use of harsh and inconsistent discipline, often reported higher externalizing and internalizing problems in both children and adolescents (Frick et al., 1992; Patterson & Stouthamer-Loeber 1984; Rothbaum & Weisz, 1994). These findings not only highlight the importance of parent behavior in maintaining child behavior problems, but provide a rationale for and a mechanism for decreasing child problematic behavior and by intervening at the parental level.

Although interventions aimed at changing child behavior by intervening at a parent behavioral level has had favorable outcomes (Maughan, Christiansen, Jenson, Olympia & Clark, 2005), parents who are experiencing unhealthy negative emotions such as anger, depression, guilt, or anxiety are known to engage in more maladaptive parenting processes (Dix, 1991). This, may in turn, lead to the development of emotional and behavioral problems in childhood. For these parents, traditional behavior management strategies may be less effective or harder for parents to implement when parents are experiencing high levels of negative affect. In such cases, parent negative affect often may contribute to the maintenance and etiology of child problems and can also affect the compliance with and eventual effectiveness of behavioral treatment plans (Cobham, Dadds & Spence, 1998).

REBT with parents recognizes that parents who are experiencing unhealthy negative emotions could be engaging in negative parenting practices that create, maintain, or contribute to children social-emotional difficulties. To change these unhealthy negative emotions and behaviors to more adaptive ones that increase the likelihood of more positive child outcomes, REBT therapists must examine the irrational beliefs sustaining these conditions in parents. The REBT model posits that these irrational and evaluative beliefs and not the activating event itself, leads to unhealthy

negative emotions and behaviors. By disputing these irrational beliefs, parents are encouraged to examine the functionality, logicality, and empirical support for their beliefs. These beliefs are then replaced with more rational beliefs that would lead to healthier negative emotions and more effective ways of parenting. As an example, when working with parents, REBT therapists may also want to consider how the parent's irrational beliefs and feelings of guilt may prevent their participation in the treatment plan.

Several studies have examined the relationships between parent irrational beliefs and unhealthy negative emotions. Bernard (1990) and Joyce (1990) have discussed several parent irrational beliefs that have been shown to lead to extreme parent emotional responses. The core irrational beliefs of the REBT model are often placed into four categories: demands, awfulizing, low frustration tolerance, and global evaluations of human worth (Walen et al., 1992). In regards to parenting, parent demands are unrealistic and absolute expectations of events, of themselves as parents, or of others such as their children. An example of a parent irrational demand is "My child should behave well and do what I say" or "My child must do well in everything" (Bernard 1990, p.300). Bernard posits that parents who hold irrational demands may often experience anger and engage in unhealthy disciplinary practices. Awfulizing beliefs are often exaggerations of negative consequences that are now seen to be terrible and awful in nature. An example of such beliefs for parents may be "It's awful that my child has a problem"(Bernard, 1990, p.300), and anxiety is proposed to often accompany parent awfulizing irrational beliefs (Joyce). Another common parent irrational belief is that of Low Frustration Tolerance (LFT) and is characterized as an intolerance for discomfort. Parents with LFT often have irrational beliefs such as "It is too hard to solve my child's problems"(Bernard, 1990) or "I cannot stand my child's behaviors" and often lead to the emotional experience of anger and anxiety. The last core irrational beliefs that parents may endorse are global evaluations of self-worth. These beliefs imply that the self as a parent or others can be given a single rating of value or worth. An example of this would be "I am worthless because my child has so many problems" (Grieger & Boyd, 1983) and may often elicit parent depression and parental guilt (Joyce).

REBT can be used with parents in several ways that may lead to positive outcomes for both parents and children. First, when working with parents whose children are having social-emotional problems; parents can first benefit from psycho-education about parenting and about the model of REBT as it applies to both parents and children. That is, by teaching parents about what types of parent strategies are associated with child outcomes, parents will be at a better place to evaluate their own strategies and recognize how their behavior impacts their child's social-emotional problems. Furthermore, an increased understanding of these practices may place parents at a better position to understand how the beliefs that a child endorses may be related to their emotional and behavioral responses as well.

In addition to psycho-education, REBT also can help parents manage their unhealthy negative emotions and alter their parenting behaviors. By teaching parents the ABC's of emotions, REBT therapists are providing parents with the skills to identify, dispute, and replace their irrational beliefs with more rational healthy ways of thinking feeling and behaving. REBT therapists would benefit from helping parents see that it is their beliefs about themselves or their child's behavior that is related to their emotional responses and not the situation or the child themselves. For example, a parent who becomes very angry when their child is misbehaving may initially assume that their child's behavior is causing their anger. Instead, an REBT therapist would help parents see that their inferences and more importantly their evaluations of their child's behavior lead to their anger and not the child's behavior.

Through the use of REBT, parents, who can more effectively manage their emotions despite perhaps dealing with challenging problems or situations associated with parenting, are in a better position to help their children develop rational ways of thinking, feeling, and behaving. Through emotive education, parents can discuss with and help children identify their unhealthy beliefs and how they relate to their negative emotions and assist their children in communicating their distress in a more effective means. Furthermore, parents who effectively manage their own emotions will be better able to apply positive reinforcement to promote effective social-emotional behaviors in their children.

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When conducting REBT with parents, several important factors should be taken into consideration. First, therapists should take into account the age of child and the nature of the problem. For younger children, parent involvement in therapy may be more important in ameliorating problematic behaviors (Joyce, 2006). REBT therapists can place careful emphasis on helping parents in evaluating their expectations about their child's behavior in addition to the appropriateness of their treatment goals for the child's developmental age. REBT therapists can also help parents implement effective behavioral parenting strategies to change their child's problematic behavior. Consideration of the nature of the child's problem may lead to the selection of specific strategies for best dealing with the child's problem. For example, child behavior management strategies including reinforcement may be better suited for child externalizing problems. Second, REBT therapists should also take into account how the family's cultural background may influence their beliefs and expectations of their child's behavior. Careful consideration of these factors may influence the therapist's understanding of the case conceptualization and may further guide the selection and development of intervention plans.

REBT provides an invaluable tool for helping both the parent and child develop positive social-emotional outcomes. Through psycho-education and emotional management, REBT can help parents manage their emotions more effectively when in difficult or challenging situations and implement more effective parenting practices that may lead to fewer child social-emotional problems. REBT helps parents become positive models of healthy rational ways of thinking, feeling, and behaving for their child and it helps parents learn the skills to teach their children how to handle difficult situations effectively, problem-solve, and regulate their own emotional experiences.

REBT with teachers

As the presenting problems may first be noticed in the school setting, oftentimes the clinician may be called upon to consult with teachers to more effectively help students. Although the research is fairly supportive for the efficacy of a number of teacher training programs they do not work for all. That is, some teachers may lack the knowledge on how to manage the student's behavior effectively in the classroom. Through teaching them effective behavior management strategies these teachers may be able to implement them successfully and consequently we may see a reduction in the initial behavioral problem. While research has shown that teachers who participate in consultation services believe that their professional skills have improved as a consequence of their participation in consultation, little empirical research exists as to what variables involved lead to this change in teacher skills (DeForest & Hughes, 1992; Knoff, Sullivan & Liu, 1995; Martens, Kelly & Diskin, 1996).

At the same time, not all teachers are able to apply the knowledge that they acquired during teacher training programs. This may occur for a number of reasons and the REBT practitioner may wish to consider why the knowledge gained was not applied. Among the plausible reasons, some teachers may have a philosophical disagreement on the suggested intervention or perhaps not see it as easy to implement and or practical in nature. Others may also experience more cognitive (low frustration) or affective (stress) barriers that prevent implementation.

While many traditional training programs for educators may address and work on the perceived acceptability and practicality of interventions, they may not address the cognitions and the negative emotions (frustration, stress) that the teacher may be experiencing which may have a negative impact on their ability to address the child's behavior in the classroom. For example, Moriarty, Edmonds, Blatchford and Martin (2001) report that quality of teaching is affected by teacher stress and dissatisfaction. As the quality of teaching goes down, this is likely to have a negative impact upon student learning. Given this, failure to address any reported psychological discomfort that may be associated with the profession of teaching or with the students' behavior and only addressing the practical problem may be insufficient and not address both the teachers' and students' needs. Teachers may also become increasingly frustrated with their profession and their students if their stress and frustration is not addressed. If not addressed, these affective states may in turn lead to an increase in frustration and subsequently interfere with their ability to manage students' problematic behavior

(Bernard & DiGiuseppe, 1994). Furthermore, teachers with higher levels of irrational beliefs were perceived to be less effective than teachers who reported lower levels of irrational beliefs (Endes, 1996). This may also stress the importance of addressing these beliefs and their accompanying affective states with educators.

An approach that addresses both the psychological and the practical aspects of teacher training/ consultation is Rational-Emotive Behavioral Consultation (REBC). REBC is based upon the principles of REBT and while the theoretical underpinnings of REBC make sense, it is important to understand just how and where the REBC may be applied when working with teachers. The areas in which REBC may be used are in treatment acceptability, teacher-efficacy, and teacher stress.

Treatment acceptability

As previously indicated, teachers who participate in consultation services may resist during consultation or resist at the intervention implementation stage (DeForest & Hughes, 1992). The teachers' perceived acceptability of both the consultation process as well as the interventions proposed may impact upon implementation and the effectiveness of the intervention (DeForest & Hughes, 1992; Elliot, 1988; Jones & Lungaro, 2000; Reimers, Wacker & Koeppl, 1987; Witt, 1986). Teacher acceptance of the proposed intervention plan is crucial for proper implementation (Kampwirth, 1999; Witt & Martens, 1983). The REBC clinician may work to identify any barriers (efficacy, affective states) that may impact upon whether or not the teacher is accepting of this intervention. However, in a study conducted by Wickstrom, Jones, LaFleur and Witt (1998), direct observations of the actual use of the interventions indicated that teachers implemented the treatment as planned only 4% of the time.. This raises an important point for the REBT based consultant to consider. That is, if teachers report agreement and acceptability of the intervention plan, yet they still resist the implementation of the plan, what factors may impact upon this resistant behavior? Perhaps it may be a result of their perception of how effectively they believe they can carry out the plan (teacher efficacy) or possibly the emotions (e.g., stress) that they experience may interfere with successful plan implementation.

Teacher efficacy

Self-efficacy is based on the work of Bandura (1993) and is generally defined as task-specific self-confidence (Hughes, Grossman & Barker, 1990). Similar to the REBT model, Bandura proposed that an individual's sense of efficacy effects his or her thoughts, feelings, and behaviors. Individuals with a low sense of efficacy in a specific domain, such as a teacher in the classroom, may tend to shy away from difficult tasks, give up quickly, have low aspirations, and are more susceptible to stress, anxiety, and depression. With regards to teachers, these beliefs have been shown to effect their evaluations of their own abilities to facilitate positive behavioral changes in students (Bowser, 2000; Gibson & Dembo, 1984; Reimers et al., 1987). Given this, it appears teachers' thoughts and feelings about their own ability as educators and as individuals who work with children may in fact have an effect on the level of acceptability of consultation. This in turn, may logically impact upon the likelihood that the intervention will be attempted and accurately implemented (Reimers et al., 1987). As such, the REBC consultant working with teachers may wish to take this information into account and target unhealthy, maladaptive thoughts and feelings of the consultees (e.g., of themselves, the intervention, and the situation). As an example, if a teacher thinks that "While it may be easy for others to manage these students, it is TOO DIFFICULT for me", this may in fact be a belief that interferes with their acceptability and implementation of the intervention. Another core belief that the REBC clinician may wish to consider when working with teachers would be when they may think, "If I try and fail at implementing these suggestions, it would be TERRIBLE and I would be a FAILURE". These thoughts may stop them from implementing the proposed intervention and may serve some self-preservation mechanism. That is, if the child does not get better, it is not because they tried and failed and were a failure, but rather because the intervention was never implemented. By addressing these beliefs, we may be able to increase acceptability of the intervention which may, in turn, lead to greater implementation of treatment plans, and promote student achievement and social-emotional functioning.

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Teacher stress

Stress, according to the REBT model, is essentially the way a person perceives, interprets, and evaluates events in their environment. Situations are only considered stressful when those individuals reacting to them perceive them to be (Ellis et al., 1997). Recently, research has focused on the relationship of teacher stress to the school environment (Greenglass, Burke & Konarski, 1997). Bernard (1990) posits that teacher stress is the product of how a teacher reacts and adapts to the job specific demands (daily teacher duties) and threats (actions of others) often encountered in teaching. For educators, daily work stressors may include deadlines, preparing lessons, dealing with difficult students, overcrowded classrooms, staff conflicts, and talking to parents (Greenglass et al., 1997). Blasé (1986) reported that the culmination of daily stressors undermines a teacher's intellectual curiosity and may lead to a lack of self-involvement in preparing and teaching subject matter.

An early model of teacher stress proposed that stress comes from the teacher's perception that they are unable to meet the daily demands placed on them (Kyriacou & Sutcliffe, 1978). This may in fact lead to job burnout, a reduction in ones motivation to work, which is increasingly common in education (Byrne, 1999). The warning signs of job burnout for teachers can include dysfunctional feelings, withdrawal, health difficulties, and eventually substandard work performance (Byrne). If left unchecked, these symptoms can get to such a level that not only does the teacher not want to go to school, but may also impact upon how they educate and deal with children as well as influence other aspects of their lives (Byrne, 1999). While we may not be able to change the job expectations, we can work to change the way that teachers perceive them and as such reduce their level of stress.

A model of burnout proposed by Maslach and Jackson (1981), describes a number of associated constructs that may have implications for an REBC practitioner. They described the concept of emotional exhaustion as referring to feelings of being emotionally overextended and drained by others (Maslach & Jackson, 1981). For teachers, they may report being fatigued in the morning and find it difficult to face another day at work. Their belief, according to the REBT model, may be that "it is TOO difficult, to face another day in this dissatisfying job". Another construct proposed by Maslach & Jackson was that of depersonalization, a callous response toward people who are the recipient of one's services. This may hold significant implications for individuals working with teachers as they may begin to treat students impersonally and not take a personal interest in their behavior or learning. Finally, they propose that the burn-out may also be associated with reduced personal accomplishment, a decline in one's feelings of competence and successful achievement in one's work with people. Here, teachers may begin to believe that they are not making a difference in their student's lives, report burn-out and engage less often. It would be important for the REBT consultant to consider these thoughts as they may interfere with their teaching. That is, a teacher may believe that "I am not a good teacher" and start rating and evaluating their own worth, not just as a teacher but as a person as well. These beliefs can be counter-productive often impacting their effectiveness as an educator by reducing their desire to teach and impacting their perception of their efficacy as a teacher.

The experience of stress and burn-out may have a direct impact on teaching performance and subsequently student learning. Highly stressed teachers who are more concerned about possible student behavior problems may begin to formulate lesson plans that focus more on controlling students rather than "for developing stimulating and meaningfully engaging learning experiences" (Blasé, 1986, p.32). Highly anxious and stressed teachers experience deterioration in teaching performance as they give less verbal support to students, use more hostile speech, convey less warmth, and use ineffective behavioral modification plans (Bernard, 1990). Perhaps the REBT based clinician may wish to have the educator think back to a point when they were not stressed and to examine a) the differences in how they were thinking at that time and b) the differences in their teaching behavior. This may help educators make the connection between their **B**eliefs and their **C**onsequences (stress and ineffective teaching behaviors).

Other variables that have been shown to be related to teacher burnout that may have implications

for the REBT practitioner would be the type of student taught, the role clarity that teachers report, and factors about the school itself. Early research showed that teacher burnout was more prevalent among high school than elementary school teachers (Anderson & Iwanicki, 1984; Schwab & Iwanicki, 1982). It may be important for the REBT clinician working with the teacher to think about the level and type of student taught and how this may be related to their experience of stress.

Additionally, teachers may experience some role conflict or ambiguity about their role. Friedman (1991) reported that role conflict (conflicting job demands) is a major factor in teacher stress. Byrne (1999) describes common examples of role conflict for teachers being (a) quantity and quality of work; (b) meeting the demands of large classes with a diversity of students; and (c) dealing with students and parents. In the school setting, role conflict may occur if a teacher is expected to perform the role of a teacher, but also to monitor the actions of their colleagues, which may be related to feelings of emotional exhaustion (Schwab & Iwanicki, 1982). Role ambiguity occurs when teachers believe that they are not given enough training for their positions, and as such, are unable to complete their jobs in a competent manner (Friedman, 1991). Friedman reports often cited ambiguous situations including (a) unclear and inconsistent policies regarding student discipline, (b) changing curriculum standards, and (c) the perception of being held in esteem by students, parents, administrators, and the general public. The REBT based clinician may wish to examine if the educator has any unhealthy, irrational beliefs about their role that is causing them stress and work towards changing these beliefs and subsequently reducing the stress experienced.

Finally, Friedman (1991) posits that the administrative environment and the physical environment of the school also are related to teacher burn-out. As an example, schools that had measurable academic goals and stressed academic achievement have a higher level of teacher burnout is seen When administrators focus more on "hard" quantifiable measures and regularly follow-up on the progress of students and overall class achievements teachers tend to report more stress (Friedman, 1991). This may also be an area that the REBT consultant wishes to examine and perhaps provide the administrators with some suggestions and feedback to

achieve a balance between assessing student outcome while providing a sound educational atmosphere for teachers.

Measuring teacher Burnout

Although a thorough review of the measures of teaching stress is beyond the scope of this paper, a number of measures do exist and will be briefly discussed below. The Problems in Teaching Scale (Green & Ross, 1996) assesses strategies used by teachers to cope with school stressors. This scale, emphasizes the coping processes (problem-focused, emotion-focused, and avoidance coping) in which individuals appraised potential stressors and then developed adaptive and/ or maladaptive coping strategies to deal with them. The Inventory of Teaching Stressors (Bernard, 1990) has been used to identify particular stressors and the level of stress experienced by teachers. Raters indicate how often the particular stressor occurs as well as indicate how stressful the particular stressor is, on a "1" to "5" Likert scale. The Teacher Coping Skill Inventory (Bernard, 1990) is used to assess a teacher's competence in using classroom management techniques and teachers indicate how competent they believe that they have been in using coping skills in their teaching over the past year, on a "1" to "5" Likert scale. The Maslach Burnout Inventory (MBI) (Greenglass, Fiksenbaum & Burke, 1996) is a 22 item self-report measure of teacher stress and burnout that yields three sub-scales: 'emotional exhaustion', 'depersonalization' and 'personal accomplishment' (Maslach & Jackson, 1996).

In summary, teacher stress and burn-out has a relationship with a number of variables associated with the profession of teaching, but not all teachers experience the same level of stress. The difference in experiences may be a function of the inferences and evaluations that teachers may make about themselves, their students, and their jobs. These beliefs may be rational or irrational in nature and may lead to either a functional/healthy response to the stressor or an unhealthy response. For example, one teacher may believe that all children should always behave in class and that they should have perfect control over their class, whereas another teacher who has more effective coping strategies and understands that children will

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not always behave well, that they may never have perfect control, and perhaps they can find a way to motivate the students in a non-frustrated way. Teachers with irrational beliefs may in turn exacerbate a stressful situation by having an unrealistic view of how children behave in the classroom. That is, these irrational teacher beliefs may only serve to heighten stressful situations (Forman, 1994). Forman posits that teachers who bring with them unrealistic personal goals, and who put themselves down when they are unable to obtain these goals, are more likely to experience stress when compared to teachers who hold fewer irrational beliefs. REBT could be used to help teachers identify and challenge their irrational beliefs, replace them with more rational beliefs, and handle the difficulty associated with the job better.

This premise is supported by research by Bernard (1990) in examining coping strategies in teachers. Bernard differentiated between stress creating and stress reducing attitudes and thoughts of teachers in regards to being evaluated, dealing with difficult children, administrative difficulties, and workload and time pressures. Bernard identified irrational beliefs and thoughts that precede stress reactions and offered suggestions of stress reducing attitudes (Bernard, 1990). The negative effects of teacher stress and burnout on student outcomes is well documented (Blasé, 1996), with stressed teachers being less tolerant, less caring, less patient, and less involved with students (Blasé, 1996). As teacher stress compromises the quality of education, and weakens the teacher-student relationship, clinicians who work with children may wish to consider the role of teacher stress when consulting with teachers about implementing change in the school. Perhaps providing teachers with means to challenge unhealthy patterns of thought and by teaching them appropriate coping strategies, may help decrease the amount of teacher burnout, and lead to effective implementation of the intervention for the benefit of the child.

References

Anderson, M. B., & Iwanicki, E. F. (1984). Teacher motivation and its relationship to teacher burnout. *Educational Administration Quarterly, 20* (2), 94-132.

Bandura, A. (1993). Perceived self-efficacy in cognitive development and functioning. *Educational Psychology, 28* (2), 117-148.

Bernard, M. E. (1990). Ration)al-emotive therapy with children and adolescents: Treatment strategies. *School Psychology Review, 19* (3), 294-304.

Bernard, M. E. (2003). *Investing in parents: what parents need to know and do to support their children's achievement and social-emotional well-being*. Laguna Beach, CA: You Can Do It! Education.

Bernard, M. E., & DiGiuseppe, R. (1994). *Rational-emotive consultation in applied settings*. Hillsdale, N.J.: Erlbaum.

Bernard, M. E., Ellis, A., & Terjesen, M. D. (2006). Rational-emotive behavioral approaches to childhood disorders: History, theory, practice, and research. In A. Ellis & M. E. Bernard (Eds.), *Rational emotive behavior approaches to childhood disorders* (pp.3-84). New York: Springer.

Blase, J. J. (1986). A qualitative analysis of sources of teacher stress: consequences for performance. *American Educational Research Journal, 23* (1), 13-40.

Bowser, D. V. (2000). Teacher self-efficacy and acceptability of behavioral interventions as factors in teachers' willingness to consult with psychologists. *Dissertation Abstracts International-Section A: Humanities and Social Sciences, 60,* 2366.

Burke, R., Greenglass, E., & Schwarzer, R. (1996). Predicting teacher burnout over time: Effects of work stress, social support, and self-doubts on burnout and its consequences. *Anxiety, Stress, and Coping, 9* (3/1), 261-275.

Byrne, B. (1999). The nomological network of teacher burnout: a literature review and \empirically validated model. In R. Vandernberghe & A. M. Huberman (Eds.), *Understanding and preventing teacher burnout: a sourcebook of international research and practice* (pp.15-37). Cambridge: Cambridge University Press.

Casey, R. J., & Berman, J. S. (1985). The outcome of psychotherapy with children. *Psychological Bulletin, 98* (2), 388-400.

Cobham, V. E., Dadds, M. R., & Spence, S. H. (1998). The role of parental anxiety in the treatment of childhood anxiety. *Journal of Counseling and Clinical Psychology, 66* (6), 893-905.

Cohen, J. (1992). A power primer. *Psychological Bulletin, 112* (1), 155-159.

DeForest, P. A., & Hughes, J. N. (1992). Effect of teacher involvement and teacher self-efficacy on ratings of consultant effectiveness and intervention acceptability. *Journal of Educational and Psychological Consultation, 3* (4), 301-316.

Dix, T. (1991). The affective organization of parenting: adaptive and maladaptive processes. *Psychological Bulletin, 110* (1), 3-25.

Dush, D. M., Hirt, M. L., & Schroeder, H. E. (1989). Self-statement modification in the treatment of child behavior disorders: a meta-analysis. *Psychological Bulletin, 106* (1), 97-106.

Elliott, S. N. (1988). Acceptability of behavioral treatments: review of variables that influence treatment selection. *Professional Psychology: Research and Practice, 19* (1), 68-80.

Ellis, A. (1962). *Reason and emotion in psychotherapy.* Secaucus, NJ: Citadel.

Ellis, A., & Blau, S. (1998). Rational emotive behavior therapy. *Directions in Clinical and Counseling Psychology, 8*, 41-56.

Ellis, A., Gordon, J., Neenan, M., & Palmer, S. (1997). *Stress counseling: a rational emotive behavior approach.* New York: Springer Publishing Company.

Ellis, A., & Harper, R. (1975). *A new guide to rational living.* North Hollywood, CA: Wilshire.

Endes, R. B. (1996). The role of irrational beliefs in behavioral consultation: implications for treatment outcomes. *Dissertation Abstracts International-Section A: Humanities and Social Sciences, 56* (8-A), 3055.

Forman, S. (1994). Teacher stress management: A rational--emotive therapy approach. In M. E. Bernard & R. DiGiuseppe (Eds.), *Rational-emotive consultation in applied settings.* New Jersey: Lawrence Erlbaum Associates.

Friedman, I. A. (1991). High and low burnout schools: school culture aspects of teacher burnout. *Journal of Educational Research, 84* (6), 325-333.

Frick, P. J., Lahey, B. B., Loeber, R., Stouthamer-Loeber, M., Christ, M. G., & Hanson, K. (1992). Familial risk factors to oppositional defiant disorder and conduct disorder: Parental psychopathology and maternal parenting. *Journal of Consulting and Clinical Psychology, 60* (1), 49-55.

Gibson, S., & Dembo, M. H. (1984). Teacher efficacy: a construct validation. *Journal of Educational Psychology, 76* (4), 569-582.

Gonzalez, J. E., Nelson, J. R., Gutkin, T. B., Saunders, A., Galloway, A., & Shwery, C. S. (2004). Rational emotive therapy with children and adolescents: a meta-analysis. *Journal of Emotional and Behavioral Disorders, 12* (4), 222-235.

Gossette, R. L., & O'Brien, R. M. (1993). Efficacy of rational emotive therapy (RET) with children: a critical re-appraisal. *Journal of Behavior Therapy & Experimental Psychiatry, 24* (1), 15-25.

Green, S. B., & Ross, M. E. (1996). A theory-based measure of coping strategies used by teachers: the problems in teaching scale. *Teaching and Teacher Education, 12* (3), 315-325.

Greenglass, E. R., Burke, R. J., & Konarski, R. (1997). The impact of social support on the development of burnout in teachers: examination of a model. *Work & Stress, 11* (3), 267-278.

Greenglass, E., Fiksenbaum, L., & Burke, R. J. (1996). Components of social support: buffering effects and burnout: implications for psychological functioning. *Anxiety, Stress, and Coping*, 9 (3), 185-197.

Grieger, R. M., & Boyd, J. D. (1983). Childhood anxieties, fears, and phobias. In A. Ellis & M. E. Bernard (Eds.), *Rational-emotive approaches to the problems of childhood* (pp.211-237). New York: Plenum Press.

Hughes, J. N., Grossman, P., & Barker, D. (1990). Teachers' expectations, participation in consultation, and perceptions of consultant helpfulness. *School Psychology Quarterly, 5* (3), 167-179.

Jones, K. M., & Lungaro, C. J. (2000). Teacher acceptability of functional assessment derived treatments. *Journal of Educational and Psychological Consultation, 11* (3/4), 323-332.

Joyce, M. R. (1990). Rational-emotive parent consultation. *School Psychology Review, 19* (3), 304-315.

Joyce, M. (2006). Rational-emotive behavioral approaches to childhood disorders: History, theory, practice, and research. In A. Ellis, & M. E. Bernard (Eds.), *Rational emotive behavior approaches to childhood disorders*. New York: Springer.

Kampwirth, T. J. (1999). *Collaborative consultation in the schools.* Upper Saddle River: N.J.: Prentice Hall.

Kazdin, A. E., Bass, D., Ayers, W. A., & Rogers, A. (1990). Empirical and clinical focus of child and adolescent psychotherapy research. *Journal of Consulting and Clinical Psychology, 58* (6), 729-740.

Knoff, H. M., Sullivan, P., & Liu, D. (1995). Teachers' ratings of effective school psychology consultants: an exploratory factor analysis study. *Journal of School Psychology, 33 (1), 39-57*.

Kyriacou, C, & Sutcliffe, J. (1978). A model of teacher stress. *Educational Studies, 4* (1), 1-6.

Kyriacou, C., & Sutcliffe, J. (1979). Teacher stress and satisfaction. *Educational Research, 21* (2), 89-96.

Lewinsohn, P. M., & Clarke, G. N. (1999). Psychosocial treatments for adolescent depression. *Clinical Psychology Review, 19* (3), 329-342.

Lyons, L. C., & Woods, P. J. (1991). The efficacy of rational--emotive therapy: a quantitative review of the outcome research. *Clinical Psychology Review, 11* (4), 357-369.

Maslach, C., & Jackson, S. E. (1981). A scale measure to assess experienced Burnout: the Maslach Burnout Inventory. *Journal of Occupational Behavior, 2,* 99-113.

Maslach, C., & Jackson, S. E. (1996). *Maslach Burnout Inventory manual* (2nd ed). Palo Alto, CA: Consulting Psychologists Press.

Maughan, D. R., Christiansen, E., Jenson, W. R., Olympia, D., & Clark, E. (2005). Behavioral parent training as a treatment for externalizing behaviors and disruptive behavior disorders: a meta-analysis. *School Psychology Review, 34* (3), 267-286.

Martens, B. K., Kelly, S. Q., & Diskin, M. T. (1996). The effects of two sequential-request strategies on teachers' acceptability and use of a classroom intervention. *Journal of Educational and Psychological Consultation, 7* (3), 211-221.

Moriarty, V., Edmonds, S., Blatchford, P., & Martin, C. (2001). Teaching young children: perceived satisfaction and stress. *Educational Research, 43* (1), 33-46.

Nucci, C. (2002). The rational teacher: rational emotive behavior therapy in teacher education. *Journal of Rational-Emotive & Cognitive Behavior Therapy, 20* (1), 15-32.

Patterson, G. R., & Stouthamer-Loeber, M. (1984). The correlation of family management practices delinquency. *Child Development, 55* (4), 1299-1307.

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Reimers, T. M., Wacker, D. P., & Koeppl, G. (1987). Acceptability of behavioral interventions: a review of the literature. *School Psychology Review, 16* (2), 212-227.

Rosenthal, R. (1994). Science and ethics in conducting, analyzing, and reporting psychological research. *Psychological Science, 5* (3), 127-134.

Rosenthal, R., & DiMatteo, M. R. (2001). Meta-analysis: recent developments in quantitative methods for literature reviews. *Annual Review of Psychology, 52*, 59-82.

Rothbaum, F., & Weisz, J. R. (1994). Parental care-giving and child externalizing behavior in nonclincal samples: a meta-analysis. *Psychological Bulletin, 116* (1), 55-74.

Schwab, R. L., & Iwanicki, E. F. (1982). Perceived role conflict, role ambiguity, and teacher Burnout. *Educational Administration Quarterly, 18* (1), 60-74.

Shapiro, D. A., & Shapiro, D. (1982). Meta-analysis of comparative therapy outcomes studies: a replication and refinement. *Psychological Bulletin, 92* (3), 581-604.

Shaughnessy, J. J., Zechmeister, E. B., & Zechmeister, J. S. (2006). Research methods in psychology (7th ed). New York: McGraw-Hill.

Silverman, M., McCarthy, M., & McGovern, T. (1992). A review of outcome studies of rational-emotive therapy from 1982-1989. *Journal of Rational-Emotive & Cognitive Behavior Therapy, 10* (3), 111-186.

Southam-Gerow, M. A., & Kendall, P. C. (2000). Cognitive-behavioral therapy with youth: advances, challenges, and future directions. *Clinical Psychology and Psychotherapy, 7* (5), 343-366.

Stormshak, E. A., Bierman, K. L., McMahon, R. J., & Lengua, L. J. (2000). Parenting practices and child disruptive behavior problems in early elementary school. *Journal of Clinical Child Psychology, 29* (1), 17-29.

Walen, S. R., DiGiuseppe, R., & Dryden, W. (1992). *A practitioner's guide to Rational-Emotive Therapy* (2nd ed). Oxford: Oxford University Press.

Weisz, J. R., Weiss, B., Alicke, M. D., & Klotz, M. L. (1987). Effectiveness of psychotherapy with children and adolescent: a meta-analysis for clinicians. *Journal of Consulting and Clinical Psychology, 55* (4), 542-549.

Weisz, J. R., Weiss, B., Han, S. S., Granger, D. A., & Morton, T. (1995). Effects of psychotherapy with children and adolescents revisited: a meta-analysis of treatment outcome studies. *Psychological Bulletin, 117* (3), 450-468.

Whaley, S. E., Pinto, A., & Sigman, M. (1999). Characterizing interactions between anxious mothers and their children. *Journal of Consulting and Clinical Psychology, 67* (6), 826-836.

Wickstrom, K. F., Jones, K. M., LaFleur, L. H., & Witt, J. C. (1998). An analysis of treatment integrity in school-based behavioral consultation. *School Psychology Quarterly, 13* (2), 141-154.

Witt, J. C. (1986). Teachers' resistance to the use of school-based interventions. *Journal of School Psychology, 24* (1), 37-44.

Witt, J. C., & Martens, B. K. (1983). Assessing the acceptability of behavioral interventions used in classrooms. *Psychology in the Schools, 20* (4), 510-517.

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