Abstract
The purpose of this article is to provide detailed descriptions of specific clinical interventions that can be used by REBT therapists working with children and adolescents who are experiencing difficulties with anxiety. It is worth noting that anxiety disorders are among the most commonly occurring mental and emotional problems in childhood and adolescence. While a majority of publications focus on empirical research, there is still a need for articles that address clinical practices. REBT is, first and foremost, a system devoted to the practice of psychotherapy. Whether it is through articles focused on empirical research or clinical applications, the advancement of REBT is the ultimate goal.

One of the most efficient anxiety management techniques involves the use of distraction in which clients are encouraged to substitute a calming mental image to interrupt the anxiety producing thoughts. This article also provides a detailed explanation of rational-emotive imagery (REI), which is a technique that employs relaxation prior to clients generating their own rational coping statements. Finally, a progressive thought-stopping technique is examined. In this intervention, the therapist provides successively less direction and guidance in the hopes that clients will be able to master this technique for use independently.

Keywords: anxiety, children, REBT

RATIONAL-EMOTIVE BEHAVIORAL INTERVENTIONS FOR CHILDREN WITH ANXIETY PROBLEMS

Anxiety disorders are among the most common mental and emotional problems to occur during childhood and adolescence. According to the U.S. Department of Health and Human Services (1999), 13% of children and adolescents...
adolescents ages 9 to 17 experience some type of anxiety disorder. In community samples of adult populations, the range of anxiety disorders was between 5 – 20% with a majority of the estimates lying above 10% (Costello & Angold, 1995). Blanchard, et al., (2006) found that 36% of parents report concerns about the possibility of their children struggling with anxiety.

If left untreated, anxiety disorders can persist into adulthood (Keller, et al., 1992, Pfeffer et al., 1988; Spence, 1988) which may in part explain why the lifetime prevalence rate for anxiety disorders is 28.8%, with a 12-month prevalence of 18.8% (Kessler, R. & Merikangas, K., 2004). The same study reported the most common subtypes of anxiety disorders to be specific phobia (12.5%), social anxiety disorder (12.1%), and post-traumatic stress disorder (6.8%).


Rational-emotive and cognitive-behavioral interventions have also been found to be beneficial in a host of other commonly occurring childhood problems such as low frustration tolerance (Brody, 1974); impulsivity (Meichenbaum & Goodman, 1971); poor academic performance (Block, 1978; Cangelosi, Gressard, & Mines, 1980), and depression (Wilde, 1994). Research also suggests that CBT is effective in the prevention of depression (Clarke, et al., 2001, Gilliam, et al., 1995) and in the improvement of self-concept and coping capabilities (DeVoge, 1974; DiGiuseppe, 1975; DiGiuseppe & Kassinove, 1976; Katz, 1974; Maultsby, Knipping & Carpenter, 1974; Omizo, Lo & Williams, 1986; Wasserman & Vogrin, 1979). Finally, several studies have established cognitive-behavioral interventions to be effective in increasing rational thinking in children and adolescents (DiGiuseppe & Kassinove, 1976; Harris, 1976; Knaus & Bokor, 1975; Miller & Kassinove, 1978; Ritchie, 1978; Voelm, 1983; Wasserman & Vogrin, 1979; Wilde, 1997a).

What follows is a description of several rational-emotive and cognitive-behavioral techniques that have been used in the treatment of childhood anxiety disorders. It should be noted that this is just a sampling of some of the more commonly used techniques and is not intended to be an exhaustive list. A commonly asked question is, “Which is the best one?” It is difficult, if not impossible, to answer because the answer ultimately depends on the client and the situation. Therapists are encouraged to use their clinical expertise to make those judgments.
THE USE OF DISTRACTION

The cardinal tenet of REBT is that emotions are not caused directly by events but are primarily the result of the thoughts and beliefs an individual has about the event. Therefore, if children are able to modify their thoughts about an event, they will change their feelings as well. One of the simplest and most effective techniques designed to bring about a change in thinking involves the use of a distraction technique (Wilde, 1997b; Wilde 1996b; Wilde 1995).

Distraction is not an “elegant solution” as Ellis would say. It does not involve a change in assessment of the event and, therefore, it would not be considered to be bringing about cognitive restructuring. Distraction, as the name implies, merely attempts to help children think of something other than their current situation. This is more difficult than it sounds because when children are getting anxious, the only thing they seem to be able to think about is the situation at hand. That is why clients need to decide what to think about before they start becoming anxious.

Encourage clients to pick "a scene" to use before they encounter the event they become anxious about. This memory should be either the happiest, funniest, or most relaxing scene they can remember. For example:
- A memorable day at the beach or on vacation
- The time they won a game
- A hysterically funny event from their past
- A memorable birthday party

Have clients take a few minutes and think about the distraction scene. You may need to help clients select the scene that fits their individual needs. Now they need to practice imagining this scene several times daily for the next few days or weeks. When clients have some free time have them close their eyes and picture their distraction scene. Clients should be advised to bring in all the details that they can possibly remember to make the scene vivid.

What were the people wearing?
What were the sounds they can remember?
Were there any smells in the air?

Encourage clients to create scenes in their minds just like watching a videotape of the event. It can also be helpful to have them draw their distraction scene and then explain it to the therapist.

The idea is to switch to this distraction scene when the clients find themselves getting anxious. Instead of focusing on the situation they are getting anxious about, they are to concentrate on their distraction scene. Instead of getting anxious before an important examination in school, they are to concentrate on the distraction scene until the feelings start to subside. Whenever they feel themselves getting anxious, they are to switch to their scene.

It is impossible for clients to think of a distraction scene and still become anxious. Since anxiety is produced by beliefs, thinking about a funny or happy
memory will keep them from getting upset or minimize the intensity of the emotions.

**RATIONAL EMOTIVE IMAGERY (A.K.A. THE IMAGINATION GAME)**

What follows is an example of how the imagination game or rational-emotive imagery (REI) can be used with children and adolescents who have anxiety problems. Ellis (1994; 1979) and Wilde (1995; 1996a; 1997b) have used REI extensively in the treatment of anxiety and anger problems. This technique is most effective if there is a particular situation (i.e., certain social situations, public speaking, separation from parents) in which anxiety is likely to occur.

Start by having the child vividly describe the troublesome scenario. Get as many details as possible about the sights, sounds, and events in this situation. Then have the child get as relaxed as possible in his or her chair with both feet on the floor. Spend several minutes describing relaxing images until you can see the behavioral manifestations of relaxations starting to appear. The use progressive relaxation techniques with the successive contracting and relaxing of various muscle groups can be very helpful. After the client appears to be sufficiently relaxed, start with the following dialogue.

Therapist: Anna, I want you to listen very closely to what I'm going to tell you. I want you to be aware only of my voice and focus on what I say. Try to block everything else out of your mind for the time being.

Imagine you are back in your classroom and students are taking turns reading aloud. Picture the room in your mind. See all the posters on the walls and everything else that is in your class. Now go ahead and let yourself feel like you do when it's reading time. Feel all the anxiety you felt back then. Stay with that scene and try to feel just like you felt in the class. When you feel that way, wiggle your finger and let me know you're there.

(Author's note - It's a good idea to look for behavioral signs confirming that the child is actually feeling anxious. The jaw may tighten, eyebrows furrow and many children will shift or squirm in their seats.)

*Stay with that feeling. Keep imagining that you are in your classroom.*

(Author's note - Allow the child to stay in this state for approximately 20 to 40 seconds. Remind him or her to mentally stay in the situation.)

Now I want you to keep thinking you are in the class but I want you to calm yourself down. Stay in the classroom in your mind but try to calm down. Instead of being very upset, try to get calmer. Instead of being really anxious, try to work toward feeling calmer. Keep working at it until you can calm yourself down. When you can make yourself calm, wiggle your finger again.
Usually students can reach a state of relative calm within a fairly short period of time. Once a child has wiggled his or her finger, it is time to bring him or her back to the here and now. Simply say something like, "Okay, now open your eyes." Next ask, "What did you say to yourself to calm yourself down?" If the child was able to calm down, he or she had to be thinking some type of rational coping statement. The only other way to calm down would be to mentally leave the situation (i.e., no longer visualize the classroom). This usually doesn't happen but if it does, try the exercise over encouraging the child to keep imagining the scene but working to calm down.

After completing the imagination game students should then be able to state the thought that allowed them to calm down. A typical calming thought that might have been produced from the above scenario would be, "Even though I don't read well, it’s not that big of a deal. It doesn’t mean I’m a bad person. Other students have problems reading aloud."

Once the child has produced a rational coping statement, write it down. Now he or she can practice this mental imagery several times a day and use this same calming thought each time. In effect, this technique allows kids to mentally practice dealing with a difficult situation in a new, more productive way. It's very important that they practice REI on a regular basis if they are going to learn to handle their anxiety in a more productive fashion.

Sometimes children can learn to do the Imagination Game by themselves after having been led through the technique a few times by the therapist. It is also possible to make a tape recording of this intervention for the child to use at home as some students like using the tape rather than leading themselves through this technique. Both can be effective if used regularly.

**THOUGHT STOPPING**

Ever since Joseph Wolpe (1958) first published descriptions of thought-stopping techniques, clinicians have been applying these types of interventions. There has been a plethora of case studies published over the years claiming reductions in anxiety symptoms with both adults and children. However, the results of experimental investigations have been inconsistent. Several of these studies have suffered from methodological shortcomings such as the lack of a control group or no follow-up analysis to determine if results have been maintained.

The general framework for teaching clients to use thought-stopping techniques follows a progression that begins with the therapist being more overtly involved and gradually diminishing involvement until the client is able to use the intervention independently. This interventions starts by having clients imagine the anxiety-provoking situation and vocalizing their thoughts. When clients first utter an irrational anxiety-producing thought such as, “If I did a bad job of reading in front of the class, I’d die,” the therapist shouts, “Stop.” Practice this first step
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until clients report that the therapist shouting, “Stop” interrupted their irrational thinking. The second step involves having clients merely think of the anxiety-provoking situation and signal the therapist whenever they were thinking an irrational thought. Upon observing the signal, the therapist again shouts, “Stop.”

It essential that the therapist spend time helping clients learn to distinguish between rational and irrational thoughts. It is beyond the scope of this article to delve too deeply into that issue. Interested readers can refer to Wilde (1997a) for detailed information on teaching rational thinking skills to elementary students.

The problem with most thought stopping interventions is that they stop at this point. Clients can learn how to stop a disturbing thought but unless they can replace the anxiety-producing thought with a rational cognition, the original thought will quickly return. The next important step involves having clients think about positive, rational and/or calming thoughts that could substitute for the anxiety producing thought. Clients are taught to imagine the anxiety-provoking situation and when they began to think irrational thought they are to say their rational coping statement aloud. Once again, practice this until clients report that they are able to consistently reduce their anxiety to a manageable level. The use of a self-report scale (such as the subjective units of discomfort scale) with a range from 1-10 can be helpful to quantify the intensity of their emotions. The final step involves having clients practice transferring the rational coping statement from an overt statement to internal dialogue. Now they are to merely think their rational coping statement whenever they notice they are beginning to feel anxious.

SUMMARY

Anxiety problems are among the most commonly diagnosed mental and emotional problems to occur during childhood and adolescence. Research suggests that if left untreated, many children will struggle with anxiety later in life. The interventions discussed in this article are brief and not difficult for children to learn. To maximize the potential for success, children need to be closely monitored and given encouragement. Be prepared for both success and setbacks during the course of treatment. Learning anxiety management skills will take time and effort but the benefits are well worth the effort.

REFERENCES


