REBT with Families

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A pioneer in the field of Cognitive Behavior Therapy (CBT), Albert Ellis helped shape the landscape of psychotherapy with his development of Rational Emotive Behavior Therapy. Starting his career as a psychoanalyst, Ellis later began introducing REBT approaches into his work with families, becoming one of the first psychotherapists to utilize cognitive behavioral interventions in the context of family therapy (Dattilio, Epstein, & Baucom, 1998). The cognitive strategies utilized in REBT lead clients to experience a philosophic shift in their pattern of thinking, and behaviorally based interventions help facilitate changes in the family's patterns of interacting (Ellis & Dryden, 1997). Around the same time that Ellis introduced REBT-based family therapy, behaviorists also began to apply behavioral interventions to the treatment of couples and families (Dattilio et al., 1998). By the 1970s, research studies emerged supporting the use of cognitive strategies, as an adjunct to behavioral interventions, to enhance couples therapy. Specifically, outcome studies support the efficacy of REBT in the treatment of families' emotional difficulties (Ellis & Dryden, 1997). Terjesen, Esposito, Kurasaki, and Kassay's (2009) review of the literature indicates that REBT is as effective as psychotherapy in general when treating children and adolescents. Moreover, Bernard, Ellis, and Terjesen (2006) explain that when parents are highly emotional about their child's actions, they are more likely to engage in ineffective parenting practices, which in turn leads to more negative interactions between the parents and child. Thus, REBT provides a framework to address the individuals' disturbed emotions, and then assist family members with problem solving and skill building to target the negative interactions. While the field was once primarily dominated by a psychodynamic orientation, the research supports Ellis's application of REBT, and points to the utility of applying CBT-based interventions in the context of family therapy (Ellis & Dryden, 1997).

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REBT Theoretical Concepts Within the Context of Family Therapy

Ellis and Dryden (1997) explain that, "Focusing on wholeness, organization, and relationship among family members is important but can be overdone. Families become disturbed not merely because of their organization and disorganization but because of the serious personal problems of the family members" (p. 141). Therefore, it is important to first address intrapersonal problems prior to tackling the interpersonal dysfunction occurring within the family unit.

The ABC Model

As would be done during an individual REBT session, the therapist works with each family member to identify the activating events ("A"), beliefs ("B"), and emotional and/or behavioral consequences ("C") about a recent or reoccurring problem. While assessment is focused on the individual, the process of identifying ABCs is central in better understanding the family dynamic. Specifically, identifying how each person's belief system can contribute to the overall discord and negative interactions occurring within the family. It is not the son missing his curfew that leads to arguing between the parents; rather, the parents argue due to what the father tells himself about his son breaking the family rules, and evaluating how his wife reacts to the situation. These cognitions lead to the father experiencing anger, and arguing with his wife and son.

The "A."

Epstein and Schlesinger (2003) explain that each individual holds beliefs about the other members of the family. Thus, it is these "Bs" that lead to an individual's emotional and behavioral reactions, not the situation. A situation, actual or perceived, may act as a trigger for one person's beliefs about the other members of the family, or the family unit. For instance, Epstein and Schlesinger (2003) note four events that can act as "As" within the family unit:

1. The individual's own cognitions, behaviors, and emotions regarding family interaction (e.g., the person who notices him- or herself withdrawing from the rest of the family).
2. The actions of individual family members toward him or her.
3. The combined (and not always consistent) reactions that several members have toward him or her.
4. The characteristics of the relationships among other family members (e.g. noticing that two other family members usually are supportive of each other's opinion). (pp. 305–306)

The "B."

Cluxton-Keller (2011) notes that when individuals rigidly hold on to unrealistic expectations and demands, these beliefs will lead to emotional disturbance and self-defeating behaviors. These beliefs are called Demandingness. According to Huber and Baruth (1989), demands are often about approval, achievement, treatment, and comfort. In regards to the family system, this way of thinking can perpetuate a cycle of negative interactions amongst the family. Consistent with applications of REBT to individual psychotherapy, family members may also hold evaluative beliefs about the "A." These beliefs are defined as: frustration intolerance, awfulizing, and self-downing, other-downing, and life-downing. Huber and Baruth (1989) discuss different types of irrational beliefs that may arise in family therapy. Specifically, they note that Awfulizing and Demandingness beliefs held by family members contribute to dysfunctional patterns of responding.

Irrational ways of thinking can be unique to the individual, as well as shared as part of the family culture. According to Joyce (2006), "REBT also recognizes that beliefs of both kinds [irrational and rational] can be shared by parents and children to create a family culture. Thus, parents and extended families may induct their children into shared ways of thinking that perpetuate irrational patterns across generations" (p. 180). Huber (1997) shares a similar position, such that during the assessment phase in Rational-Emotive Family Therapy (REFT), he works to identify the common "family belief" that is influencing how the family members interact with each other (p. 127). As Dattilio (2001) explains, each individual has a schema about themselves and the world, as well as about families in general. Additionally, people have a family schemata, which Dattilio (2001) defines as, "… jointly held beliefs of the family that have formed as a result of years of integrated interaction among members of the family unit" (p. 9). Taking this explanation a step further, Dattilio (2001) explains that the family schemata also develops as a result of the family of origin, such that the parents' are influenced by their family experience, which then plays a role in how they navigate the current family system.

One goal of family therapy is to help the individual family members to change their irrational ways of thinking that is leading to unhealthy negative emotions and maladaptive behaviors, and also to help family members learn to think more rationally and in turn engage in more adaptive ways of behaving and feeling. Rational beliefs are non-dogmatic, preferential, and flexible and unlike irrational beliefs are logical and based in evidence (DiGiuseppe, Doyle, Dryden, & Backx, 2014). As Dryden (1984) explains, "[Rational thinking] is generally understood to refer to thoughts that aid and abet individuals in achieving their goals and purposes. By contrast, *irrational* is understood to refer to thoughts which prevent or block goal attainment" (as cited in Huber & Baruth, 1989, p. 23). The categories of rational beliefs are: preferences, anti-awfulizing, high frustration tolerance, self-acceptance, other-acceptance, and life-acceptance (DiGiuseppe et al., 2014).

"Unconditional self-, other-, and life-acceptance."

While working with each family member to develop new rational ways of thinking about problems, the therapist also helps the clients move toward the practice of Unconditional Self Acceptance (USA), Unconditional Other Acceptance (UOA), and Unconditional Life Acceptance (ULA) as a means to change the current family dynamic (DiGiuseppe et al., 2014; Bernard, 2008). In teaching acceptance, REBT therapists help clients acknowledge what one may not like or is unable to change, and choose not condemn oneself, others, or the situation (i.e. I am worthless). Clients learn to separate behaviors from the person, and recognize the connection between globally rating oneself, others, or a situation as leading to disturbed emotions and behaviors (DiGiuseppe et al., 2014). For example, a child may engage in naughty behaviors such as yelling or hitting, but this does not mean he is a bad child. Rather, he acts defiant at times. Similarly, if an adolescent condemns the entire familial unit as "no good" after being grounded by her father, the adolescent will experience anger, which results in tumultuous interactions with her family members. Once the members of the family can learn to unconditionally accept each other, there will be less time spent disturbing oneself about how the family *should* function differently, or how a family member *should* behave, and efforts can be made to change what is within each person's control.

The "B-C" connection.

What is important to consider in family therapy is that despite the origin of each person's patterns of thinking and behaving, each family member has a choice in the way he/she reacts to any given "A." Whether or not patterns of thinking or behaving have been modeled or reinforced, family members *cannot* make each other feel, behave, or think in certain ways (Ellis & Dryden, 1997; DiGiuseppe et al., 2014; Bernard, 2008). Often times, individuals enter therapy with the goal of changing a situation, or another family member; however, not all "As" can be changed. By teaching this concept of emotional responsibility, the therapist can help enhance the clients' motivation to target their cognitions, rather than try to change the other family members. Once the family understands and adopts the "B-C" connection, and recognizes his choice in responding to the "A," the therapist can move forward in helping the clients identify, challenge, and change their irrational ways of thinking.

The "C."

Primary disturbances.

Consequences can take the form of dysfunctional behaviors or unhealthy negative emotions that are characterized as being self-defeating and maladaptive. Specifically, when family members are exhibiting Cs, it is these emotions and/or behaviors that lead to relationship difficulties (Cluxton-Keller, 2011). As in individual REBT, family members may present with a range of unhealthy negative emotions including: anxiety, depression, unhealthy anger, guilt, shame, jealousy, envy and hurt. The accompanying behavioral consequences may be: aggression, withdrawal, avoidance,

or underachievement (DiGiuseppe et al., 2014). More specifically, Huber and Baruth (1989) discuss the role of severe anxiety or apathy can play in inhibiting family members from engaging in adaptive responding, while disturbed emotions in general lead to an individual's resistance in attempting new strategies for problem solving.

Secondary disturbances.

When working with a client to identify their ABCs, the therapist will also want to assess for a possible meta-emotional disturbance, such that a family member may experience an emotional reaction about an emotion (i.e., anxiety about feeling anxious). Joyce (2006) explains that parents may experience guilt about the presenting emotional or behavioral difficulty associated with parenting, a child's challenging behavior, or presenting pathology. Thus, Joyce (2006) indicates the value in thoroughly assessing the beliefs leading to the presenting emotional reactions, as well as checking-in with clients about a possible meta-emotional disturbance.

Key Best-Practice REBT-Based Assessment, Treatment Strategies, and Techniques in Working with Families

The Family Dynamic

According to Cluxton-Keller (2011), Ellis agreed with aspects of family systems therapy, but differed in his approach in that he first targeted intrapersonal difficulties, and then addressed the family dynamic. In REBT-based family therapy, the therapist explores how each individual's reactions and beliefs can perpetuate and trigger negative interactions amongst the family (Cluxton-Keller, 2011). Specifically, irrational beliefs can lead to unhealthy negative emotions and self-defeating behaviors, which then act as an "A" for another family member. For example, take a child presenting with anger when he does not get what he wants, which then results in opposition toward his mother's requests. The mother may think to herself, "Children *should* do as they are told," leading the mother to feel angry. As a result, the mother yells at her daughter about not doing her homework. The daughter then feels depressed because she believes "I am not good enough." In his book *The Rational Management of Children*, Hauck (1967) discusses how parental beliefs contribute to whether a parent exhibits "unkind and firm patterns," "kind and not firm," and "kind and firm" styles of parenting (as cited in Joyce, 2006, p. 178). Hauck (1967) explains that the first two styles are marked by overly rigid and overly lax parenting styles. The latter style is most preferable in that parents are consistent, set clear limits and consequences, separate the child's behavior from the child, and utilize appropriate praise and punishment (as cited in Joyce, 2006, p. 178). Tackling each client's irrational beliefs is integral in changing unhealthy patterns of thinking and behaving that lead to negative interactions. Through this process, the family gains insight into how each person's reactions contribute to the family's overall difficulties.

Empathy

According to DiGiuseppe et al. (2014) and Ellis and Dryden (1997), demonstrating empathy is another integral strategy essential in treating clients. DiGiuseppe et al. (2014) explain, "The empathetic therapist attends not only to the words of the clients but also the nonverbal aspects of their behavior in order to perceive accurately their feeling state" (p. 82). During whole family sessions, the therapist is balancing two roles: attending to the client who is speaking and the target of interventions, as well as monitoring the reactions of the other family members (Friedberg, 2006). Over the course of the session, the therapist may shift her focus and attention many times to keep the other family members engaged, and acknowledge each individual's reactions to what is occurring in the therapy room. Being able to identify non-verbal and verbal reactions in family members allows the therapist to help clients work through disturbed emotions occurring in the moment, as well as display empathy to help foster the therapeutic alliance.

Gaining Commitment and Enhancing Motivation

While a therapist can highlight each family member's role in contributing to dysfunction in the system, this does not guarantee every family member will be motivated to change. Many times individuals enter therapy at the request of another family member, rather than a willingness to change or accept one's role in the dysfunction that is occurring. Therefore, the first step of therapy involves gaining commitment from each family member to actively participate in treatment. This process often includes orienting clients to what will be expected of them during therapy (i.e. attendance, homework, communication, confidentiality, etc.), examining what the clients expect from the therapist, and introducing clients to the therapeutic model. Ellis and Dryden (1997) also suggest asking the clients to take responsibility for their ability to change, whether or not the rest of the family is committed to the process. According DiGiuseppe and Kelter (2006):

> Because people learn emotional scripts from their families and some emotional scripts are culture-specific, it is possible that the disturbed child or adolescent has not changed because he or she cannot conceptualize and experience an acceptable emotional script in place of the disturbed emotion. (p. 264)

Thus, DiGiuseppe and Kelter (2006) suggest employing the "motivational syllogism," which can be utilized to enhance motivation and facilitate agreement on the goals of therapy (p. 263). This involves helping the client explore how her current behavior or emotion is unhelpful, and recognizing there is an alternative way of thinking, feeling, and behaving that will be more effective in reaching the goal.

Cognitive Interventions

After gaining agreement on the goals of treatment, the therapist will generate a case conceptualization to help guide intervention planning. Therapists are trained to practice with a flexible, non-dogmatic style, just as we teach our clients to think and behave in the same manner. This means therapists utilize ongoing progress monitoring and assessment to guide treatment and make necessary adjustments. This may include providing individual sessions to one family member, or referring the client to another therapist for individual work. Modifications may also include adapting interventions based on the developmental level of the child, as well as the cognitive abilities of the adult (Bernard, 2008; DiGiuseppe & Bernard, 2006; Terjesen et al., 2009; Joyce, 2006).

Disputation.

Through the process of disputation, clients learn how their current rigid and dogmatic way of thinking is illogical, lacking empirical support, and inconsistent with reality. By learning to question, and ultimately give-up their irrational beliefs, clients will be able to begin rehearsing more rational ways of thinking about the "A" (DiGiuseppe et al., 2014). As a result, the client remediates his emotional disturbance and is better able to effectively engage in skill building and practical problem solving. Think about the last time you tried to speak clearly and calmly when feeling angry. It is almost impossible to perform successfully when experiencing high emotional arousal. Thus, clients are first taught to change their emotional reaction, and then work on practical problem solving and skill acquisition.

DiGiuseppe and Kelter (2006) suggest that for younger children who have yet to develop meta-cognitive abilities, to focus on skill building rather than utilizing abstract interventions such as disputation. This may include direct teaching of prosaically skills, rehearsing rational statements, and developing an emotional vocabulary. Additionally, DiGiuseppe and Bernard (2006) suggests employing "deductive interpretation," in which the child is presented with hypotheses about what she may be thinking based on the presenting emotions (p. 101). Similarly, adults may present with skill deficits or minimal insight and require education on emotions or prosocial skills, as well as modified interventions to make sessions more salient and successful.

Working with Behaviors in Family Therapy

Behavioral interventions are also incorporated into treatment to help bring about changes in the family system. Ellis and Dryden (1997) discuss the use of contracting to assist family members in resolving arguments. This intervention involves each family member agreeing to change a behavior that may be contributing to disagreements. Thus, rather than working on changing the other, each family member takes responsibility for a behavior within his or her control (Ellis & Dryden, 1997). Therapists may also teach clients prosocial skills to facilitate behavior change. Such skills

include: assertiveness, problem solving, and relaxation techniques. In the case of families with children or adolescents, the therapist may work with the family to develop a behavioral intervention plan to target a child's disruptive, oppositional, hyperactive, or inattentive behavior. Additionally, in the case of a family member exhibiting avoidant or compulsive behaviors, the therapist may utilize exposure exercises (Ellis & Dryden, 1997). At the end of each session, family members are assigned homework assignments to help generalize skills learned during sessions into day-to-day life. Family members work collaboratively with the therapist to generate the weekly homework assignments to target cognitions, behaviors, and/or skills.

Throughout treatment the therapist will want to continuously assess each family member for negative unhealthy emotions or behaviors, which could lead to difficulty following through or utilizing the skills being taught in session. Similarly, the use of ongoing progress monitor is utilized to assess the current treatment plan and structure of the session. For example, if only one family member would benefit from exposure therapy, it is beneficial to meet with that individual separately, or recommend additional therapy sessions with another therapist.

Behavioral analysis.

As mentioned earlier in this section, during the initial session the therapist will orient the clients to therapy, which will include explaining different components of treatment. The therapist can take time to explain the role of both cognitive and behavioral interventions that may be utilized throughout the course of treatment. To better understand the family system, it can be helpful to conduct a behavioral analysis for specific target behaviors. This information may be used to create a behavioral intervention plan for a child or adolescent who is exhibiting behavioral or attention difficulties. In the above example, the therapist and parent may target the child's tantrumming behavior by conducting a behavioral analysis, and determining the function of the behavior. By understanding why the behavior may be occurring, the therapist can help develop proactive and reactive interventions to be used across situations at home, school, or in the community (DiGiuseppe & Kelter, 2006). When introducing behavioral strategies, the therapist will continue to assess and address any irrational beliefs that may be contributing to the maintenance of a family member's maladaptive behaviors, or difficulty implementing behavioral strategies (David, 2014; Terjesen et al., 2009; Gaviţa, Joyce, & David, 2011). For instance, if an adolescent engages in reassurance seeking in regards to obsessions about contamination from germs, the therapist will work with the adolescent and family to understand how providing reassurance helps maintain the anxiety, and interferes with the client's progress. Cognitive interventions would then be used if a family member has difficulty adhering to the intervention plan, due to his or her own irrational beliefs.

Role-playing.

Role-playing is another intervention that can help facilitate the learning and generalization of skills taught during sessions (Ellis & Dryden, 1997). Role-plays allow the clients to receive immediate feedback from the therapist, as well as other family members, and provide opportunities for practice when the client is not experiencing

an emotional disturbance. When individuals are experiencing emotional dysregulation, it is difficult to remember to use new skills, and ensure the skills are being executed effectively. Thus, practicing in more benign situations will better prepare the client to use these skills during more emotionally charged situations. One skill in particular that is often rehearsed and role-played in session is assertiveness (Ellis & Dryden, 1997; DiGiuseppe et al., 2014). After learning steps and scripts for ways to respond assertively, clients can be provided opportunities to role-play in session to work toward responding in an assertive rather than a passive or aggressive manner. Learning to communicate more effectively helps reduce miscommunications and escalations during arguments.

Treatment Guidelines from the Empirically-Supported Therapy Literature that Inform Best Practices in REBT with Families

This section will explore the literature on non-CBT and CBT-based family therapy approaches and discuss how these modalities can support best practices in a REBT framework for family therapy.

Family Problem Solving and Solution Focused Brief Therapy

Evans, Turner, and Trotter (2012) conducted a review of the family therapy literature and two models in-particular fit within the best practices of REBT-based family therapy. According to Evans et al. (2012), research suggests that family problem solving is an effective model to target parent-child relationships. Similar to problem-solving interventions utilized in REBT, family problem solving as described by Evans et al. (2012) involves an 8-step approach which includes first analyzing the problem, and then developing steps to resolve the problem. Evans et al. (2012) also note that a psycho-education intervention, which is often associated with family problem solving, can be beneficial in family therapy. In individual REBT-based treatment, initial sessions include providing clients with psycho-education about interventions, diagnoses, and therapy in general. In the context of family therapy, this psycho-education intervention can be utilized to not only help clients better understand treatment, but also their family member's diagnosis (Evans et al., 2012).

Solution Focused Brief Therapy (SFBT) is another family therapy orientation that can be adapted for use within REBT-based family therapy. Gingerich & Eisengart (2000) explain that SFBT is "… a brief goal-focused treatment developed from therapies applying a problem-solving approach and systemic family therapy" (as cited in Evans et al., 2012, p. 14). While there is limited research regarding family interventions, the studies reviewed suggest efficacious results with individuals. Aligning with

the REBT model, SBFT focuses on the here-and-now and posits that clients can solve their problems even without knowing the exact root of the issue (Evans et al., 2012). SBFT involves setting goals, engaging in problem-solving, and enhancing motivation making this approach consistent with interventions already being utilized in the context of REBT-based family therapy.

Systems Theory

Huber and Baruth (1989) developed a model of family therapy, REFT, which encompass much of the traditional REBT model, but applied to families. REFT emerged from Ellis' REBT model and The Mental Research Institute Strategy, a theory of change based in cybernetic theory. Specifically, Huber and Baruth (1989) explain that cybernetics views interactions within the family as circular rather than linear. Thus, family members' behaviors and reactions become activating events for the other members of the family. The therapist's goal is to help change the family's pattern of responding to each other by focusing on the beliefs leading to the current ineffective problem solving and interactions. Huber (1997) holds the hypothesis that no matter how bad the current family environment may be, the family will have at least one example in which they successfully handled the problem at hand. This information can then be used to teach the family the difference between the irrational thinking leading to the current difficulties and the rational way of thinking they employed when experiencing previous success. This intervention helps support the ABC model in that it facilitates family members' developing rational beliefs. The REFT approach integrates a systems therapy perspective while maintaining a REBT-based case conceptualization in that the family learns that by changing the "family beliefs" (i.e., the belief that is shared by all members of the family), they can change the way the system is functioning (Huber, 1997, p. 127).

Cognitive Behavioral Family Therapy (CBFT)

By the 1980s, the cognitive approaches of Ellis and Beck found their way into family therapy, and CBFT is now prominent alongside other family therapy treatments (Dattilio & Epstein, 2005). Similar to REBT-based family therapy, CBFT focuses on the present, as well as the influence a family member's behaviors and thoughts have on the rest of the family system (Spillane-Grieco, 2000). According to Friedberg (2006), CBFT sessions include components of Beck's Cognitive Therapy, such as mood check-ins, agenda setting, and assigning and reviewing homework. Additionally, interventions in CBFT include self-monitoring exercises, self-instruction, rational analysis, and behavioral enactment (Friedberg, 2006). Spillane-Grieco (2000) also emphasize the importance of teaching clients communication and problem-solving skills, as well as utilizing feedback, modeling, and role-playing to help facilitate

cognitive restructuring and behavior change. CBFT shares similarities with interventions that are often implemented in a REBT approach to working with families, and thus can provide a framework for the implementation of behavioral and cognitive strategies.

Dattilio and Epstein's (2005) review of the research regarding CBFT suggests mixed results. Specifically, Baucom et al. (1998) explain that when studies combine cognitive and behavioral interventions in CBFT "[t]he overall results of those studies indicate that combined CBFT was as effective as purely behavior treatment, although cognitively focused interventions tend to produce more cognitive change and behavior interventions tend to modify behavior interactions" (as cited in Dattilio & Epstein, 2005, p. 10). Furthermore, Sexton, Datchi, Evans, LaFollette, and Wright's (2013) review of the literature suggests that treatments incorporating behavioral strategies yielded positive results, while less specific approaches did not garner the same level of efficacy. Overall, these results support the combined nature of REBT-based therapy, which emphasizes the importance of both behavioral and cognitive change strategies.

Brief Case Example

Jake, a 7 year-old boy in the first grade was referred for individual therapy by his father Steve. Jake resides with Steve who maintains full custody. Jake's mother lives out of state and chose not to participate in treatment. Like Steve, Jake is oppositional and defiant, and presents with anger and aggression when he does not want to comply with a request. Steve is concerned that this pattern of responding is beginning to impede his son's ability to function socially and academically. Steve reported that at times he ignores Jake's disruptive behavior; however, he also finds himself getting angry and eventually giving-into Jake if the situation continues to escalate. Jake's teacher reported observing oppositional and aggressive behaviors when Jake is not motivated to complete a task, or is not receiving individualized attention. If asked to do something he does not want to do, Jake will temper tantrum by yelling or hitting himself. In these moments, he struggles to express why he is upset. According to Jake's teacher, when compliant and attending, he does not demonstrate any academic deficits.

Case Conceptualization

A behavioral analysis of Jake's behavior was conducted to better understand his aggressive behaviors, and develop an appropriate treatment plan. At home, the consequences of Jake's behaviors ranged from Steve becoming angry, attempting to pacify Jake, or ignoring Jake's behavior. At school, the consequences were Jake's removal from a situation he found aversive. It was hypothesized that due to the intermittent reinforcement of Jake's argumentative and aggressive behaviors, he continued this

pattern of acting-out since it led to obtaining desired objects, being removed from a situation he found aversive, or receiving attention. The therapist worked with Steve to develop a goal for treatment, which was defined as reducing Jake's non-compliant behaviors and frustration intolerance by targeting Jake's unhealthy anger and disruptive behaviors, through the teaching of adaptive behavioral and emotional responses. Initially Steven brought Jake to therapy with the intention of the therapist providing individual therapy. The research on treating children with aggression points to the efficacy of parent-based interventions as a component of therapy. Specifically, parents are taught behavioral strategies for addressing disruptive behaviors outside of session, and learn to challenge irrational beliefs about the child and situation that may impede their ability to follow through on the behavior modification techniques (DiGiuseppe & Kelter, 2006). Before treatment continued the therapist worked with Steve to understand the utility of family sessions, as well as individual parent management training sessions as a compliment to individual therapy with Jake.

Treatment Plan

Child sessions.

REBT-based interventions were incorporated into sessions with Jake to help him recognize the consequences of his anger and aggression, and help him develop adaptive emotional and behavioral responses (Bernard et al., 2006). The therapist focused on helping Jake develop an emotional vocabulary to better communicate his feelings, as well as learn about consequential thinking to understand how his current pattern of responding was actually self-defeating (i.e., getting in trouble in school, losing privileges at home). Due to Jake's age, rather than engage in inference chaining and abstract disputation, the therapist utilized a hypothesis-driven approach, which indicated the presence of dogmatic demands and frustration intolerance beliefs based on the presenting emotions and behaviors. Jake was taught rational self-statements to rehearse, such as "I can stand being told no, even though I do not like it when I do not get what I want" and "Just because I want something does not mean I have to get it." Additionally, Meichenbaums's (1977) self-instructional training (SIT) was used to teach Jake concrete steps to regulate himself when he was feeling angry (as cited in Bernard et al., 2006, p. 46). In session, Jake was asked to role-play different situations to practice these skills with the therapist, as well as his father.

Parent sessions.

During parent management training sessions, Steve learned that his current belief system interfered with his ability to engage in consistent limit setting, and follow through on behavioral strategies. REBT-based cognitive interventions were utilized to challenge and change his irrational beliefs and change his unhealthy anger to frustration when Jake began to display non-compliant behaviors (DiGiuseppe & Kelter, 2006). For homework, Steve practiced challenging his irrational beliefs and

replacing them with rational beliefs such as, "Even though I would like Jake to act differently, it does not mean he is going to and I can handle his temper tantrums." Once Steve learned how to regulate his emotional reaction, he was introduced to behavior modification techniques, and a behavior plan was created for use in the home. Additionally, the therapist collaborated with Jake's teacher to create a similar plan at school to help create consistency across settings. Family sessions were conducted so that Steve could practice the behavioral strategies he learned in individual sessions, and allow the therapist to model how to effectively and consistently deliver such interventions. Family sessions were also utilized to provide a multi-informant report of difficulties and successes over the previous week, and utilize role-plays to practice how to respond to problems more effectively in the future. These sessions also provided the therapist an opportunity to observe the family dynamic, explore additional irrational beliefs, and assess for skill or performance deficits.

Treatment Outcome

After three months of treatment, Steve noted that he observed inconsistent progress at home in regards to the target behaviors. It was determined that Steve was continuing to intermittently reinforce Jake's aggressive behavior, which resulted in Jake inconsistently performing the prosocial skills he learned in session. Additional parent management and family sessions were conducted to address Steve's difficulty following through with interventions. The therapist continued to work with Jake to practice behavioral and cognitive strategies, replace his frustration intolerance beliefs, and conduct in vivo exposures to situations Jake found frustrating so he could practice new ways of responding when he was experiencing feelings of frustration.

What I Have Learned About Using REBT with Families

Accommodating Individual Differences: Client Gender, Ethnicity, Socio-economic Status, Intelligence and Other Factors

Understanding past experiences and family culture.

Understanding and acknowledging past experiences can help a therapist be more empathetic in his approach and better prepare the client for future treatment suggestions. Many times a parent may enter therapy feeling fully responsibility for the current dysfunction, and referrals for individual treatment or parent management training may reinforce the belief that "I am a bad parent." Therefore, it is helpful to

understand the family's previous experience with therapy, whether it is in a clinical setting or interactions with a child's school counseling staff.

Learning about the family structure, cultural background, and family values can also help the therapist develop a case conceptualization and better understand the family members' core beliefs. Spillane-Grieco (2000) explains, "Elements such as race, ethnicity, culture, religion, class, gender, parent-child discipline, and so on inform the individual's schemata. Events are then given meaning by the individual based on this structure or schemata. Schemata can be problematic if they are influenced by prejudices and/or misinformation …" (p. 108). Thus, even though REBT-based family therapy emphasizes focusing on current issues, it can be beneficial to understand the development of core beliefs, as some may be rooted in the family culture and passed down through generations. This makes these viewpoints even more engrained in the shared family culture, and the underlying irrational beliefs are even more difficult to challenge.

The therapist will also want to explore if there are other individuals closely intertwined in the family's life. These individuals may be other adults residing in the home, and they can be invited to sessions, especially if he or she has a role in decision-making and child rearing. Recognizing the family's cultural beliefs about caregiving, mental health, and behavioral expectations of children are additional factors to consider during intervention planning. Such that, there may be cultural beliefs shaping expectations for the way a child behaves, or a family interacts. Therapists want to be culturally sensitive to their clients and utilize this knowledge to better understand the client and what may be maintaining irrational beliefs or self-defeating behaviors.

The Do's and Don'ts in REBT with Families

When working with families, there are a number of client and therapist factors to consider, which can either impede or facilitate treatment progress. This section will focus on the "dos'" and "dont's" of working with families, with the aim of providing clinicians recommendations to facilitate family work in clinical settings.

The "do's."

Confidentiality.

When working with families, it is necessary to establish rules of confidentiality during the first session. Helping each family member understand the therapist's legal and ethical obligations in regards to confidentiality can help reduce the chance of confusion or therapeutic rupture later in treatment. The parameters of confidentiality may differ based on the therapist's preferences. For example, if the therapist meets independently with a father and then sees the family, is the information from the individual session confidential? If a therapist believes that keeping this information

confidential could interfere with the family's treatment, the therapist may decide to only meet with the family as a whole. If individual therapy is indicated, the therapist can refer the client to a different therapist. Additionally, when working with adolescents and children, it can be helpful to discuss with the parents how information will be shared. The family may agree that if the therapist is going to share information from a session with their adolescent son, then he will be present during those conversations. These decisions are made collaboratively so the therapist is upholding legal and ethical obligations and so that the clients understand and feel comfortable with the decided parameters.

Agreement on the goals of therapy.

Another "do" is gaining agreement on the goals before delivering interventions. A parent may come to session intent on changing the "A," rather than working on an emotional disturbance. The therapist can use the motivation syllogism, as well as other motivational interviewing techniques, to help move the client toward working on the emotional problem. That being said, agreeing on the goal does not mean disregarding the client's wishes, and a plan can be developed that includes working on emotional and behavioral disturbance, as well as incorporating practical problem solving. Similarly, when there is disagreement on the goal between family members, the therapist will want to ensure all clients are on board with the stated goal before moving forward. Take for example a family with two parents and an adolescent and each wants the other to change. The therapist can point out that while the child wants to change the parents' behavior, and the parents change the child's behavior, it is impossible to control the others' reactions. Therefore, it is prudent to work on each person's emotional reaction and communication skills, so that they can begin communicating instead of arguing about how each person *should* behave.

Therapeutic style.

Most importantly, when considering best practices for REBT with families, therapists want to remain flexible in their approach. If an intervention is not successful, family members are exhibiting resistance, or a client is not ready to work on the primary problem the therapist may shift her approach. For example, if an adolescent is unwilling to attend individual sessions, the therapist can begin working with the parents to implement behavioral strategies in the home to address behavioral difficulties, and continue encouraging the adolescent to participate in treatment. Similarly, if parents are unwilling to attend individual sessions to work on their emotional dysregulation, the therapist can help the adolescent tolerate her parents' reactive parenting style, and teach prosocial skills to help manage arguments at home. The therapist can encourage the parents to at least attend some of the daughter's sessions to gain involvement.

The "dont's."

Treatment and intervention planning.

During a family session there are multiple clients in the room, but this does not mean the same intervention is appropriate for each family member. The therapist will want to take into account the client's ability to engage in metacognition, as well as their emotional intelligence, when choosing strategies. When working with an adult, the therapist may engage the client in Socratic questioning and abstract disputation; however, when addressing a child, the therapist may rely more on presenting and rehearsing rational coping statements. Similarly, one parent may respond very well to humor, however, the other may find it off-putting. During the teaching of specific skills, the therapist will want to consider whether or not the clients are presenting with a skill deficit or a performance deficit. This information can guide decision-making regarding whether the individual requires direct teaching of a skill, or work on irrational beliefs that impede the client from performing the skill. In the above example, the therapist may come to realize that the father is effective in his communication; however, when angry he delivers his message in an aggressive manner. The therapist may help the father work on his anger so that he is better able to perform the skill, while the son will benefit from being taught assertive responses and then provided opportunities for practice.

Progress monitoring is an integral component of family therapy, and encompasses both subjective and objective measures. By establishing short-term and long-term goals individual and family goals at the onset of therapy, the therapist has a clearer picture of how each person is progressing toward meeting the established the goals. Many times a family may enter therapy with hope of creating buy-in for one family member, who refuses to attend individual therapy. In these cases, the other family members may appear motivated; however, the root issue is not the family dynamic, but more so family concerns regarding the behaviors and emotional reactions of one person. In these cases, family therapy can begin to feel like an intervention, and one family member begins to feel attacked or targeted. In other cases, there may be family dysfunction; however, due to family members' individual difficulties, sessions begin to look like four or five individual sessions rolled into one. In a case where the therapist recognizes that family therapy is not clinically indicated at this time, it is prudent that the therapist be able to point to the data and the clients' progress, to help provide more appropriate treatment recommendations. Down the line, it may be beneficial for such cases to resume family therapy, however, another course of treatment may be necessary to resolve primary issues that are impeding pathways to change.

Which Aspects of REBT Deliver the Most Benefit for Change and Which Don't

Strategies that benefit change.

Thorough problem analysis.

During the initial session, REBT therapists are taught to assess, treat, and build rapport simultaneous. DiGiuseppe et al. (2014) suggest that the best way to begin building rapport is to actually do therapy, which can be incredibly helpful in creating buy-in from the resistant client if he/she experiences immediate relief. Since family therapy involves multiple people, this initial problem identification phase will include collecting information from multiple-informants. Problem identification may involve using objective measures, and collecting information from multiple raters, to better understand referral concern. DiGiuseppe and Bernard (2006) explain that problem analysis is on-going and helps dictate the case conceptualization and treatment plan (i.e. identifying the specific thoughts, feelings, and behaviors to target). Both of these stages are important in helping the therapist determine the structure of treatment. It is through this process, that recommendations be made for additional parent management training or referrals for a family member to receive individual therapy.

The elegant solution.

REBT provides a model for addressing clients' disturbed emotions and behaviors by targeting the client's underlying core beliefs for intervention (DiGiuseppe et al., 2014). Thus, rather than challenge the veracity of the client's beliefs, the therapist will work with the client to identify the core underlying irrational beliefs about the situation. Unlike in individual therapy where the therapist only has the client's reporting to rely on, family therapy involves the presence of multiple observers to help provide information. Thus, in family therapy it is possible to determine the veracity of most inferences, based on the reports of other family members. If a child states, "My brother doesn't like me and thinks I'm annoying," the brother will be there to confirm or deny the belief. If the older brother does find his younger sibling annoying and doesn't particularly like spending time with him, it is beneficial to help the child cope with this reality, rather than trying to convince him that there may be evidence supporting the contrary, because we know the belief is true!

Strategies that impede change.

As discussed above, utilizing the elegant solution can be very effective in addressing the primary beliefs leading to the client's presenting problem, and also provide the client relief. However, if the client is not prepared for this approach, or does not understand the rationale, the intervention may have an adverse effect. Take for instance a family coming to therapy due to a father and son's explosive anger. If the wife is experiencing guilt because she thinks "It is my fault they get angry and I am the cause of my family's dysfunction," asking the wife to consider this to be the truth could

come across as lacking empathy and rupture the therapeutic alliance. Additionally, asking the wife to assume this inference is true could come across as colluding with the father and son, who tend to blame her for their aggressive responses. In this case, the therapist may want to begin by disputing the inference, establish rapport, and familiarize the client with the REBT approach. As the therapeutic alliance grows, the therapist may then tackle the underlying irrational belief that "I am a failure as a parent and spouse and therefore a worthless person" (Bernard et al., 2006). As discussed above, interventions are not one-size fit all, thus it is important to consider the context of therapy when delivering interventions.

Conclusion

Since Ellis' induction of REBT into the practice of family therapy, therapists gained a new model for conceptualizing emotional and behavioral disturbance within the family unit. While the treatment interventions remain similar to REBT with individuals, there are various factors to consider with the addition of family members to the therapy room. Understanding the individual, as well as the family dynamic, is integral in developing a strong case conceptualization and guiding the interventions that are implemented. Respecting and understanding the family's culture and values, as well as the interpersonal relationships within the family, can help guide the integration of both behavioral and cognitive strategies. On-going progress monitoring and assessment is critical in addressing new issues that arise over the course of treatment. Maintaining flexibility in one's approach, and considering each client's needs, can lead to positive results in addressing intra- and interpersonal difficulties, as well as the overall family dynamic.

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