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A Cognitive-Behavioral Approach to Family Therapy

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Abstract Although cognitive behavioral spectrum approaches with individual children are plentiful and demonstrate effectiveness, cognitive behaviorally oriented clinicians are frequently left to their own devices when it comes to treating families. Cognitive behavioral family therapy is a relatively recent development and there are precious few reports of its clinical use. This article presents a conceptual foundation and clinical rubrics for the practice of cognitive behavioral family therapy. Basic theoretical background information is presented and places the therapeutic processes and procedures in a proper context. Session structure in cognitive behavioral therapy is illustrated and the way it propels therapeutic momentum and adds focus to each session is explained. Rudimentary processes of self-monitoring, self-instruction, rational analysis, and behavioral enactment are described and augmented with case material. Finally, the conclusion offers directions for further theory building, research, and clinical practice.

Keywords Cognitive behavior therapy · Family therapy

Introduction

Cognitive behavioral psychotherapy with young children and adolescents is receiving an increasing amount of attention (Friedberg & McClure, 2002; Kazdin & Weisz, 2003; Kendall, 2000; Reinecke, Freeman, & Dattilio, 2004). While cognitive behavior therapy with children and adolescents is an effective and widely used therapeutic modality, practitioners are provided with little guidance regarding working with parents and other family members. Children's problems occur in a familial context and accordingly, family members play a role in the initiation, maintenance, as well as exacerbation of children's problems.

However, there are few cognitive behavioral approaches to family therapy. This is unfortunate for several reasons. First, children and adolescents infrequently refer themselves to therapy and typically are brought to therapy by powerful others such as peers, teachers, and institutions (Leve, 1995). Second, cognitive therapists working with individual youngsters rarely hold enough reinforcers and create sufficient contingencies to effect generalizable and enduring changes in the family context. Weekly or biweekly therapy sessions are less influential in comparison to daily interactions with parents and other siblings. Moreover, homework assignments and therapeutic gains can be supported or sabotaged by family members. Finally, behavioral and cognitive behavioral therapy approaches to family therapy show considerable promise (Dattilio, 1997, 2000, 2001, 2002; Dattilio & Epstein, 2005)

Accordingly, this paper presents a theoretical rationale for cognitive behavioral family therapy and offers several practical clinical guidelines for providing cognitive behavioral family therapy. The paper begins with a theoretical description of cognitive behavioral family therapy, proceeds with a discussion of session structure, and concludes with descriptions of pivotal cognitive behavioral family therapy practices.

Theoretical context

Dattilio and his colleagues (1997, 1998, 2000, 2001, 2002; Dattilio & Epstein, 2005) have written extensively on

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cognitive behavioral approaches to family therapy. Dattilio (1997) noted that cognitive behavioral family therapy emphasizes the reciprocal interaction of family members' cognitions, emotions, actions, and relationships. Moreover, he outlined four pivotal theoretical assumptions in family cognitive behavior therapy. First, family members strive to maintain the family environment and use this homeostasis to ostensibly meet their needs. Second, family members' cognitive processes such as attributions, expectations, standards, and accompanying cognitive distortions influence family life. Third, problems arise when the cognitive processes block members' sense of satisfaction. Finally, cognitive behavior therapy presumes that addressing the cognitive components of the problem will be an efficient and effective way to modify dysfunctional emotional, relational, and behavioral patterns.

Dattilio (2001) argued against many myths that are perpetuated about cognitive behavior therapy neglecting systemic issues and family relationships. He noted that cognitive behavioral family therapy integrates a systemic perspective clearly appreciating circularity and reciprocity of relationships. More specifically, Ginsburg, Siqueland, Masia-Warner, and Hedtke (2004) remarked that parents may see anxiety as disastrous, see their role as having to protect vulnerable children, and then unwittingly sabotage their children' self-efficacy. Consequently, the children doubt their competence and engage in avoidance behavior. Indeed, families promote rules and implicit codes regarding cognitive processes and content (Waters & Barrett, 2000).

According to a cognitive behavioral perspective, the family environment is the milieu where children and parents' cognitions are played out. Consider this example. A nine-year-old patient sees herself as fragile, easily overwhelmed and unable to cope with the adversities of grade school. Her parents believe protecting their child from negative outcomes defines good parenting. Accordingly, they are controlling and overprotective. Due to her anxieties, the patient avoids potentially stressful situations and excessively defers to her parents.

The family members' beliefs are shared and complement each other. They all believe "anxiety is to be avoided at all costs" and collude with each other to make this happen. The child thinks "I'm fragile and vulnerable" and the parents' over-protectiveness reinforces this assumption. A cognitive behavioral family therapist identifies these misinterpretations, modifies circular maladaptive interpersonal patterns, guides problem-solving efforts, helps the family members test out their assumptions and schemata as well as develops more accurate appraisals.

Cognitive behavioral family therapy has both similarities and differences from traditional family therapy. Similar to traditional family therapy approaches, cognitive behavioral family therapy sees the child's problem as embedded in a familial context and appreciates reciprocity. The problem is not seen as totally residing totally within the child. Like systems theory, cognitive behavioral family therapy recognizes that a change in one person in the system changes the other individuals within the family. Cognitive behavioral family therapy emphasizes the central role of cognitions and posits that by changing family members' beliefs, systemic change will ensue. Moreover, cognitive behavior family therapy hypothesizes that the most efficient way to change beliefs is through cognitive restructuring, rational analysis, and behavioral enactment.

Cognitive behavioral family therapy differs from traditional family therapy in several ways. First and most importantly, cognitive behavioral family therapy differs from traditional family therapy on the basis of conceptual foundations. Cognitive behavioral family therapy is firmly grounded on the cognitive model of psychopathology, the hierarchical structural organizational model, and the content-specificity hypothesis. Second, due to its reliance on collaborative empiricism, cognitive behavioral family therapy is transparent and observable. While many traditional family therapy approaches also use homework, cognitive behavioral family therapy sees homework as pivotal rather than merely peripheral. Unlike traditional family therapy approaches, cognitive behavioral family therapy employs a signature session structure including mood check-ins, homework review, agenda setting, homework assignment, and eliciting feedback.

Cognitive behavioral family therapy differs from approaches, which advocate seeing parents in adjunctive sessions. First, in cognitive behavioral family therapy, the family is seen together for the entire session. Second, the therapeutic focus is placed on the reciprocal nature of family members' cognitions and behavior. Third, the identified child is not the sole target for change and the other family members represent additional intervention points as well as change agents.

Cognitive behavioral family therapy is indicated when the child's inaccurate beliefs are initiated, maintained, and/or exacerbated by competing or complementary beliefs of other family members. Anxiety, depression, and disruptive behavior spectrum conditions are all amenable to cognitive behavioral family therapy. Additionally, the age of the child is also a consideration. Generally, cognitive behavioral family therapy is recommended for younger children rather than adolescents. Adolescents are in various stages of independence, parents hold less reinforcers for adolescents, and teenagers tend to view peer relationships as being more meaningful than parent-child relationships.

Session structure

Cognitive therapy's session structure (Beck et al., 1979; Beck, 1995) is well suited to cognitive behavioral family

therapy. Mood check in, homework review, agenda setting, processing session content, homework assignment, and feedback/summaries represent the six parts of session structure. Utilizing these components facilitates therapeutic efficiency and productivity.

Agenda setting with a family values each member's contribution to the session. Different family members may present at each session with varying agendas. Processing session content in cognitive behavioral family therapy requires the therapist to have broad clinical peripheral vision. In individual therapy, therapists only attend to one person's reactions, thoughts, and feelings. On the other hand in cognitive behavioral family therapy, the therapist needs to put eyes on each member of the family noticing how they respond to each other.

Consider this example of cognitive behavioral therapy with an eight-year-old boy. When the mother starts lecturing about her son's misbehavior (e.g. "He has no right to be angry. I was never so spiteful as a child. My parents would not permit it."), the child sees his mother as being "too critical and mean," the father sees the child as too lazy" and the mother as "overprotective," and mother sees the child as "angry and willful" and the father as "uninvolved." Accordingly, they each have unique agendas for the session. The therapist then encounters the challenging task to integrate these diverse perspectives into coherent therapeutic foci.

The alert therapist recognizes the son's and father's reactions (e.g. "When mom was talking, how were you feeling? What was running through your head?"). The son responds, "I felt anger. She is so unfair. She doesn't understand the pressures I am under." The father reports feeling anxious stating, "I hate conflict. Why can't they get along? Their arguing makes me feel out of control." The therapist then identifies the competing and complementary belief systems. Additionally, the therapist designs interventions to modify individual cognitions. (e.g. test of evidence, reattribution).

There are a variety of homework assignments to apply in cognitive behavioral family therapy. Dattilio (2002) suggested that homework assignments increase patients' awareness, increase their commitment to follow through on therapeutic changes, and encourage collaboration. Bibliotherapy, audiotapes/videotapes, activity scheduling, self-monitoring, behavioral task assignments, and cognitive restructuring are common homework assignments.

Eliciting feedback and summaries from family members is another crucial task in cognitive behavioral family therapy. Each member may find different aspects annoying and helpful. Feedback provides a window into the similarities and differences between family members. Through feedback, the therapist is able to discern shared and idiosyncratic beliefs. Similarly, obtaining summaries allows the therapist to see what each family member is taking away from the session. For instance, the child may see the emphasis on the session, as "My parents are too critical." The father may see the message as "My son is out of control. My wife is too inconsistent. I have to make things work out correctly." The mother may conclude," No one cares about making this family work out but me." Unfortunately, the family leaves the session by continuing to blame each other for the distress. Summaries then provide the opportunities to clarify and modify inaccurate summaries before a session ends.

Summaries are obtained verbally or in writing (e.g. What is the take away message? What is the lesson from today?). For some youngsters, this can be too much of an abstract ask. In these instances, therapists could ask the child, "What is the title of today's meeting? (Friedberg & McClure, 2005). Further, some family members may abdicate their summaries and copy other members' conclusions. To prevent this circumstance, cognitive behavioral family therapists encourage family members to separately write down their summaries or complete a session feedback form (Friedberg, Miller, Perymon, Bottoms, & Aatre, 2004).

Components of cognitive behavioral family therapy

A modular approach to cognitive behavioral therapy includes several basic components, which are sequentially delivered. Self-monitoring, self-instruction, rational analysis, and behavioral enactment represent the fundamental procedures.

Self-monitoring

Self-monitoring requires patients to observe and record specific physiological, cognitive, behavioral, emotional, and interpersonal processes. Recording these data points provides a springboard for intervention and anchors evaluation of progress. Dattilio's (2000, 2002) *Circle of Perception* exercise is an excellent self-monitoring task, which reveals the degree of alliance/alienation members perceive. He recommended each member get a clean piece of unlined white paper, a pen or pencil, and receives the instruction to draw the family system using one circle to represent each member. They are told to make a diagram where members' circles are placed due to their perception of emotional closeness. If circles touch or connect, they are considered aligned and close. If a distance separates them, it represents less closeness.

In the second part of the exercise, the family members' take another piece of paper and draw how they would like to see the family. Dattilio (2002) suggested processing the drawings by asking what went through their minds about the exercise, whether they noticed differences in the first and second drawings and in what ways did the drawings differ from each other? In my own work with families, I modify this exercise using circles cut out of construction paper labeled with the family members' names. Each family

member creates a diagram and then shares it with the others. The paper circles make the task somewhat more concrete for families who have difficulty with more ambiguous or abstract tasks.

Daily Thought Records (DTR) are easily integrated into family work. Consider the following example where all the family members encounter a common stressor (e.g. a family argument). However, each individual member has different attributions and feelings associated with the disagreement. The twelve-year-old daughter sees her parents' reactions as unreasonable due to a violation of her perceived rights (e.g. "They have no right to tell me what to do. They are too bossy."). The father is depressed and says to himself, "My family is a mess and I am helpless to change it." The mother on the other hand is enraged at both the daughter and father thinking they both devalue her e.g. "(I am the only one who does anything to make things work out. No one in the f_____ family appreciates me."). Comparing the thought diaries for the same situation provides the foundation for subsequent self-instructional or rational analysis intervention.

Self-instruction

Simply, self-instructional techniques target thought content (e.g. automatic thoughts) and cognitive processes (e.g. cognitive distortions). They change misappraisals of specific situations to more accurate explanations. Self-instructional interventions work to change the nature of each family member's internal dialogue. Dattilio et al. (1998) recommend testing automatic thoughts in the presence of other family members so they support each other's restructuring efforts.

A favorite personal self-instructional technique with families is having the family members independently list the acceptable and non-acceptable feelings within the family. Different family members hold individual rules for emotional expression. Some personal imperatives may be shared by several family members (e.g. "Anger is acceptable for a person to express, but anxiety is not."). However, other rules may be in conflict with each other. For instance, a nine year old female patient believes, "Emotions can be shown whereas her parents think," "Strong people don't show their feelings." Identifying, testing, and modifying these beliefs increases family members' empathy toward each other and reduces the conflict over covert rules.

While self-instructional techniques in cognitive behavioral family therapy are commonly used with responsive families, unorthodox and less doctrinaire methods are necessary for families who are more entrenched in their pathological cognitions and relationships. Greco and Eifert (2004) argued that figurative and metaphorical language are often more powerful interventions than rational linguistic techniques. Metaphors are very helpful ways to promote families' understanding and identification of maladaptive cognitions. Dattilio (1998) described a family that was simultaneously aggressive yet self-protective of each other with a powerful wolf metaphor. He reflected on the metaphor by remarking that wolves represented a sense of juxtaposed primitive aggression and protectiveness. The metaphor provided a new way for the family to view their interactions. When working with families who are overprotective with their teenage children, I frequently use a new car as a metaphor. For example, I explain,

> "You know when you buy a brand new, shiny car some people park it in the garage and even put a car cover on it. You inspect it and polish it over and over. Some people will take two parking spaces to make sure no one nicks the sides. Others may not even drive the car out of the garage. They may just keep the car covered in the garage for safekeeping."
>
> "It's kind of like that for you and your parents. They see you as their bright, shiny unblemished car they want to polish and protect. They are afraid you will get a scratch or dent. You want to go out and test drive the car putting it through its paces in traffic and on rough roads."

The metaphor helped me align with both the child and the parents. Moreover, perspective–taking was promoted. The child sees the parents' behavior as valuing rather than controlling her. The parents understand that it is not very fun to be always "covered" and housed in the "garage."

Rational analysis

In rational analysis, the patient collects the data and then crafts conclusions and judgments, which make sense of new information. Patients objectively evaluate the facts confirming or disconfirming their hypotheses about each other and craft alternative explanations if their hypotheses are disconfirmed.

Greco and Eifert (2004) introduced several novel experiential methods well suited for rational analysis in cognitive behavioral family therapy. These activities promote what Greco and Eifert called "unified detachment." Family members objectively view and interpret family data. For example, Greco and Eifert suggested parents and children might draw, act-out, or otherwise describe the color, shape, or texture of the family conflict. Each member's drawing or description is shared and members draw conclusions based on the incoming data.

Another activity developed by Greco and Eifert involved inviting the family members to sit on one side of the room and an empty chair is placed on the other side of the room. The conflict or problem is then placed on the chair and the family members may take turns identifying/addressing it. This is an interesting technique because it removes the problem from

an individual person and brings the family together to objectively tackle the problem. A poster or white board might also be placed on or behind the chair to record the patients' comments and descriptions. Once each member's depiction of the problem is recorded, family members' analyze the responses and derive a synthesizing conclusion.

The "window of acceptability" exercise is inspired by Greco and Eiferts' work. This activity identifies a family's perceptions about communication and conflict as well as laying common ground for communication. First, the therapist demonstrates the task by drawing a different size window on paper or a white board. She then explains that people's perceptions of windows may be large, medium or relatively small. The task is for each family member to draw his/her own perception of the window of acceptability. If they believe there is wide latitude in the level of appropriate communication of feelings and interpersonal conflict, they would draw a big window. If there were little room for variation, the window would be small. After the drawings are completed, they are shared and compared. Phase I of this exercise is completed by processing the similarities and differences in each member's windows.

Phase II involves fleshing out more specifics. Family members write the things they see as inappropriate in spaces outside of the window. The behaviors they see as appropriate are housed inside the window. Phase II is completed either in session or for homework. Subsequently, the family agenda involves discerning where they agree and disagree. The family then must problem-solve and negotiate regarding differences.

Incomplete sentence fragments are used to identify and modify covert family rules in order to propel rational analysis. For instance, useful fragments include: "Mothers should always . . . ," "Fathers should always . . . ," "Children . . . ," "Brothers . . . ," "Sisters . . . " "Getting angry is . . . " "The worst thing about being anxious is . . . ," and "Being in control . . . " Therapists tailor the stems to the particular family. Family members then share their completed stem with the others. Finally, therapists process the points of convergence and divergence in the sentence completion.

Behavioral enactment

Minuchin and Fishman (1981, p. 81) eloquently stated, "Enactment can be regarded as a dance in three movements." In the first stage, therapists conceptualize the family and fix their sights on which maladaptive patterns to target. Next, therapists organize and set up the experiments or situations, which will elicit the dysfunctional patterns. Third, therapists and families try out alternative behaviors and interaction patterns in the situations.

It is pivotal that a cognitive behavioral family therapist learn first-hand the ways families work. Families describe their interaction patterns and styles, but this is similar to drawing a sketch outline without adding the color. In order to truly appreciate family dynamics, therapists need to see the family in "action." For this reason, experiential exercises are opportunities for families to enact and modify their dysfunctional patterns. The key is to make hidden emotions, cognitions, and interpersonal behavioral patterns transparent.

Completing a craft or a model is a favorite intervention. Building or making something involves giving instructions, following directions, receiving feedback, and frustration tolerance. The task should be entertaining, moderately difficult, and result in some desired outcome (e.g. a toy plane, a key chain). Making a key chain with beads and a plastic lanyard is a good example. A parent reads the directions and instructs the child. Through this process, the therapist observes the way the parent gives instructions and how comfortable he/she is in a directive or authoritative role. The way the child responds to the parental direction is also revealed. Thoughts and feelings are elicited at emotionally salient points (e.g. "When you gave instructions, how did you feel and what went through your mind? When mom and dad told you what to do just then, what did you say to yourself?"). Choosing a moderately complex craft is also therapeutically productive. Therapists see how families manage frustration and intervene to help them modify unproductive beliefs and behaviors. Cognitions are elicited in the "moment" during the making of the craft and after the craft is completed. Additionally, moderately difficult tasks are likely to elicit anxiety in families. Therapists observe whether parents are overly intrusive or protective. Do they wish to do it for the child? Are they afraid the child will make a mess? Do they fear the family will "fail" the task and what will that mean to them?

The craft task also illuminates the various subsystem and individual processes. For example, how do the parents work together in the task? Are they competitive, cooperative, belittling, sabotaging, supportive, etc? How do they include the child in the task? Do they triangulate him/her? What are parents' cognitions about their roles in the task? Are they comfortable taking direction from the other? Are they reluctant to take the lead?

Consider this family example. A mother of a ten year old is reluctant to set limits, give direction, and generally assume an authoritative role with her young daughter. The father is a tireless problem-solver, "efficiency expert" that makes most of the family decisions, and enforces the family rules. The ten-year-old patient responds to this systemic dynamic with depressed and anxious feelings in addition to her fair share of oppositional, non-compliant, and defiant behaviors.

In the craft exercise, I invited the mother to take the lead with giving directions as the father and daughter worked together following mom's directions. The enactment yielded several productive intervention points. First, the father

became very agitated and impatient with the mother (e.g. "We'll never get this done. We'll fail at this task."). The mother felt anxious and thought, "He's going to criticize me. He thinks I am a moron." The child acted out reacting to the family tension (e.g. "This sucks. I can't stand it. I should do something to change things.") Subsequently, the task allowed me to process mom and dad's delegation of parenting duties, perceptions of each other, and their appreciation of the way it shaped their child's behavior. It also allowed me to align with the child and help the parent realize the child's unruly behavior was a misguided effort to help the situation. Finally, we were able to test the accuracy of their cognitive appraisals.

Working through a difficult task while being guided by the therapist provides families with concrete referents for change and increases their perceived competence. Families can refer to points where they managed frustration or provided their child "freedom" to fail and subsequently developed ways to generalize their success to other contexts. Further, working successfully toward shared goals changes the family climate and reflects systemic change.

Traditional board games, competitive/cooperative sport games, and theatre exercises are potentially productive ways to elicit, identify, and modify family cognitions, feelings, and interaction patterns. Playing a board game with family members offers several advantages. First, the therapist learns how members compete and/or cooperate. Do the members cheat? Do they gang up on others? How do they handle winning? How do they manage losing? Do they taunt? Do the parents align with different children when they are winning or losing? How do family members take turns? How do they follow the rules? For instance, a distressed family was experiencing significant communication problems where members interrupted each other and shouting matches ensued. Not surprisingly, playing a simple board game was arduous for them. However, the board game allowed the therapist to intervene behaviorally (e.g. model and reinforce turn taking) as well as cognitively (e.g. "When Jimmy interrupts your turn, what pops into your head?")

The Blind Car (Boal, 1992) is a theatre game that fits nicely into cognitive behavioral family therapy. In this activity, one family member is the "driver" and the other family member closes his/her eyes and becomes the blind car. The driver steers the car by gently applying pressure to the shoulders to turn left or right, to the back of the neck to go in reverse, and hold the shoulder to stop. Speed is determined by the amount of pressure. The therapist can have multiple pairs of family members go at once or set up a simple and safe obstacle course. The object of the game is steering the blind car safely through the traffic. Each family member takes turns playing each "role." The game lends itself to several natural intervention points. First, the therapist observes how well each car trusts its "driver." Second, therapists process which role each family member prefers and the rationale for their choice. Clearly, this sets up a discussion of control issues.

Coloring books are good cognitive behavioral family materials. When working with parents who have difficulty giving commands and young children who struggle with compliance, I often set up a behavioral enactment where the parent directs the child to color a specific part of the drawing with a particular color. The task makes the parents' commands visible. For instance, some parents offer vague, diffident commands (e.g. How would you like to color the flower yellow?) whereas others give good specific commands (e.g. Color the flower purple), but do not garner the child's attention. Moreover, the task makes the system transparent. Some children respond readily to this simple and enjoyable command while others react against perceived control (e.g. I want to color it **red!**) Finally, the coloring task yields systemic information regarding contingencies (e.g. Did the parent praise the child? How does the parent respond to the non-compliance?).

Conclusion

This article delineated the distinctive nature of cognitive behavioral family outlining the theory, processes and procedures associated with cognitive behavioral family therapy. Clinicians were alerted to elements of session structure, self-monitoring, self-instruction, rational analysis, and behavioral enactment. Moreover, myths and misconceptions about cognitive behavioral family therapy were dispelled. The similarities to and differences from traditional family therapy approaches were explicated. In sum, the manuscript provides information that is theoretically sound and clinically handy.

There is important work to be done and compelling questions to explore. How can outcome be evaluated in cognitive behavioral family therapy? Who should be included in family sessions? What combinations of family members are preferable and most effective? What measures could be used and/or adapted to evaluate outcome? What predicts good/poor outcome? What are the most pivotal aspects of cognitive behavioral family therapy? What cognitive behavioral constructs must be modified to account for family functioning? What formal and informal measures could be developed to assess family schemata? Ideally, this article provides clinical heuristics, which can serve as launching pads for additional research and professional practice.

The frontier for cognitive behavioral family therapy is broad and offers tremendous opportunities. In its brief history, cognitive behavioral therapy has transcended many initial boundaries and expanded its applications. This extension of applications is associated with many clinical breakthroughs with individuals and groups from varying diagnoses heretofore thought to be inappropriate for

cognitive behavioral therapy (e.g. bipolar disorder, schizophrenia, etc). Directing attention to treating the cognitive, emotional, and interpersonal processes that plague distressed families continues the forward thinking style, which characterizes cognitive behavioral approaches.

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