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Training in Family Therapy: Perceptual, Conceptual and Executive Skills*

KARL M. TOMM, M.D.†
LORRAINE M. WRIGHT, PhD.‡

This paper presents a comprehensive and detailed outline of family therapy skills to aid in providing a more precise focus in the training of clinicians in family therapy. The skills are based on an integrated treatment model within a systems framework. Four major functions performed by a family therapist are separated and are further differentiated into general therapeutic competencies. Specific perceptual, conceptual, and executive skills are described in the form of instructional objectives and are listed under each competency. Occasional clarifying notes or examples are cited along with particular skills. Clinicians and trainees should find this outline a useful guide in skill development.

Although family therapy as a theoretical orientation and clinical method is still at an early stage of development, several distinct approaches are emerging in different training centers (1). The particular theoretical approach of the Family Therapy Program[1] at the University of Calgary is based on general systems theory, communications theory, and cybernetics. However, psychodynamic and social-learning concepts are

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† Associate Professor and Director, Family Therapy Program, Division of Psychiatry, Faculty of Medicine, University of Calgary.

‡ Assistant Professor and Clinical Coordinator, Family Therapy Program, Division of Psychiatry, Faculty of Medicine, University of Calgary.

[1] The Family Therapy Program is supported by a grant from the Division of Mental Health Services of the Department of Social Services and Community Health of the Province of Alberta. The program carries a caseload of approximately 200 families at any time, accepts 600 new referrals a year, and trains psychiatric and family practice residents and students from psychology, social work, and nursing.

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also incorporated within the systems framework. The actual clinical method focuses on problem-solving by clarifying behavioral interaction and is more cognitive than other current approaches in family therapy.

There is a growing need in the field to document explicitly the specific interventions involved in conducting family therapy. Increased explicitness would facilitate the training of clinicians in family therapy and also allow more accurate comparison of the similarities and differences among training programs. For the last several years, we have been working on differentiating specific skills and elaborating on explicit model of family therapy for the training program at the University of Calgary. The model we have developed grew originally out of the work of Nathan Epstein and represents a further elaboration of the seminal efforts of Cleghorn and Levin (2) to define specific family therapy skills. In keeping with the latter, the skills presented in this paper are written in the form of instructional objectives for training therapists.

This model has evolved by assimilating many concepts and techniques of other therapists and approaches to therapy. In addition, wide-ranging ideas gained through informal professional contacts at conferences and workshops have been incorporated. Thus a detailed bibliography would be unwieldy and difficult to prepare. Rather than attempt to trace original sources, the effort has been to work toward a synthesis and integration to achieve a broad-based yet coherent and teachable model of family therapy.

THE TREATMENT MODEL

The family therapy model at the University of Calgary has been organized at three levels of therapist activity: functions, competencies, and skills. Four major overall functions performed by a family therapist are differentiated. Several general therapeutic competencies are delineated within each major function. Each competency in turn includes multiple, specific family therapy skills.

The four major therapist functions are *engagement, problem identification, change facilitation* and *termination.* These functions tend to follow in a linear progression both during the course of a given interview and for the overall course of therapy. In practice, however, a clinician moves back and forth among the four functions, depending on the responses of the family at any stage in the ongoing treatment.

Engagement refers to the process of establishing and maintaining a meaningful working relationship between the therapist and the family. *Problem identification* is essentially an ongoing assessment process. It includes not only clarification of the presenting problem but also the process of identifying other problems in the family and the significant interrelations that may exist among these problems. *Change facilitation* is the core of the therapeutic process. It includes interventions aimed at altering interpersonal patterns of interaction and individual family members' behavior, thinking, and experience. Efforts toward change are directed at replacing problematic patterns with adaptive ones. *Termination* is the process of relinquishing the relationship between the therapist and the family in a manner that encourages the family to maintain constructive changes and allows the family members to increase their ability to solve problems in the future.

Table I summarizes the general therapeutic competencies within each major function. A competency refers to a macroscopic skill or general ability of the therapist. The subsequent detailed outline clarifies and elaborates each competency with a cluster of more specific, microscopic skills. These detailed skills are paired, so that a perceptual/conceptual skill is matched with a corresponding executive skill.

The "perceptual/conceptual skills" refer to what is taking place in the mind of the therapist and form the basis for his overt actions referred to as "executive skills." The perceptual aspect refers to the thera-

TABLE I

Family Therapist Functions and Competencies

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E. Implement New Adaptive Patterns
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IV. TERMINATION

A. Assess Family Initiative to Terminate
B. Initiate Termination When Indicated
C. Conclude Treatment Constructively

pist's ability to make pertinent and accurate observations. The conceptual aspect refers to the process of attributing meaning to observations or of applying previous learning to the specific therapeutic situation. Because what we perceive is so intimately interrelated with what we think, it is extremely difficult to separate the perceptual from the conceptual components of most perceptual/conceptual skills.

The executive skills also comprise two components, namely, the therapist's affective response and his overt intervention. The affective component of the executive skills refers to the therapist's ability to use his own emotional reactions constructively by channeling them into specific therapeutic activity. When a particular student is unable to perform a specific executive skill, it is useful to explore whether he has developed the perceptual/conceptual basis for that specific skill. Hence the value of matching these skills in pairs.

Where possible, the specific skills within a general competency are listed in logical sequence. Thus, during the course of an actual interview, several skills may occasionally be used in the sequence in which they are presented in this outline. However, considerable flexibility in the application of these skills must be envisioned. An experienced therapist may utilize several skills simultaneously and in varying combination or sequence depending on the immediate process of the interview. Furthermore, a specific skill may contribute to more than one function and reflect several competencies. The placement of skills with such multiple characteristics within a particular competency of the overall framework is often somewhat arbitrary. Inclusion of the same or similar skills within other appropriate competencies has been avoided to minimize redundancy. Thus the organization of this treatment model should not be taken as a rigid prescription for sequential therapeutic activity.

The following comprehensive outline is aimed at the advanced trainee. In actual training at the Family Therapy Program, a more abbreviated and simplified list of selected beginning skills is introduced to new students before this outline is presented. This listing is comprehensive in the sense that it incorporates beginning and intermediate as well as advanced level skills. The reason for this is that each student or clinician may have particular areas of competency that may be more fully developed than others. For instance, a beginning trainee may be highly skilled in establishing a positive relationship with a family but have limited ability to break maladaptive interaction patterns. Alternatively, an advanced trainee may be skilled in elucidating the presenting problem but still have difficulty accepting family initiative to terminate. A complete listing of these competencies and their specific skills allows the trainee or clinician to identify his own areas of strength or weakness within the context of this particular therapeutic orientation.

I. ENGAGEMENT

A. Develop a Rationale for the Family Approach:

PERCEPTUAL/CONCEPTUAL SKILLS	EXECUTIVE SKILLS
1. Understand the basic axioms of systems theory as applied to a family unit in which a member presents with behavioral problems.	1. Bring the whole family together for conjoint interviewing and explain the rationale for involvement of all members of the household.
i.e., The member is best understood in the context of the whole family. Change in one family member affects every other member. The whole tends to maintain a homeostatic equilibrium, etc.	e.g., "It is useful to know how others in the family see the problem and how they are affected by it"; "Being able to see how you cope with problems as a family helps me understand the situation more fully."
2. Realize that individuals and families, as biological and interpersonal systems, are goal-directed and strive toward optimal health by solving problems.	2. Identify, validate, and support the family's past and present efforts at mastery of their problems, whether or not their attempts have met with success.
3. Realize that active participation and involvement with the family results in the creation of a therapist-family system that enables negentropic change.	3. Maintain a moderately high level of involvement and input during conjoint interviews and provide a model for clear, concise communication.
4. Realize that the therapist's role is to enhance the family's ability to mobilize its own natural resources to solve problems.	4. Clarify the therapist's task of facilitating and strengthening the family's own problem-solving skills and avoid undermining their ability to do so.
i.e., The therapist-family system is transient, and therapy should be oriented toward eventual termination rather than any therapist-family dependency.	e.g., "I really can't be a better parent than you"; "My job is to help *you* manage your problems more effectively."

B. Establish Positive Relationships:

PERCEPTUAL/CONCEPTUAL SKILLS	EXECUTIVE SKILLS
1. Realize that by deliberately acknowledging each family member, engagement with the whole family system is enhanced.	1. Give recognition and status to all family members through some direct interaction with each one.
2. Recognize undue anxiety related to the uncertainty of being in a new setting of a therapy room and of not knowing how to behave in the situation.	2. Provide a basic orientation to the setting and rules of therapy and seek family permission for any special procedures such as observation or videotaping.
3. Realize that empathy, warmth and genuineness tend to strengthen interpersonal involvement and the maintenance of relationships.	3. Respond with sensitivity and congruence, conveying warmth toward *all* family members.
	i.e., Supportive and positive statements should be based on the real events and actions.

4. Recognize overt or covert distress in family members as a result of coming for professional help.

i.e., Seeking help outside the family unit does imply the personal failure of family members to reach a solution. This sense of failure may be a source of considerable emotional turmoil.

4. Inquire into family reactions about coming to therapy, provide support, and avoid condescending or guilt-inducing statements.

e.g., "It's a big step to come for therapy. 'How do you feel about being here?' *not* "So you've got a problem, have you?"

C. Convey Professional Competence:

PERCEPTUAL/CONCEPTUAL SKILLS	EXECUTIVE SKILLS
1. Recognize different levels of cognitive development and functioning among family members.	1. Adjust all communications to the cognitive level of the intended recipients.
e.g., Young children can understand nonverbal communications more readily than verbal contact.	e.g., Make more use of body movement, facial expression, and tone of voice when relating to children.
2. Recognize idiosyncratic language usage in the communication patterns within a particular family.	2. When working with a given family, adopt the same expressive words and phrases that family members use.
e.g., In some families no one ever gets "mad." In others, members may become "annoyed" but never "angry."	i.e., First establish effective therapist-family communication; new words and meanings may be introduced later.
3. Appreciate that the family must experience the therapist's ability to cope with emergency and welfare affect.	3. Convey the capacity to tolerate a wide range of affect by allowing the expression of intense emotional turmoil.
i.e., The social rule of avoidance and suppression of negative feelings does not apply in the therapy room.	i.e., The therapist's acceptance of and ease in dealing with the open expression of affect will facilitate more open disclosure on the part of the family.
4. Recognize the function of family loyalties in members' avoidance of socially embarrassing disclosure.	4. Respect family loyalties but explain the importance of open inquiry as a crucial element in the therapeutic process.
e.g., Children are taught not to say certain things in the presence of outsiders.	e.g., "The more you allow me into the privacy of your family life, the more likely I can be helpful."
5. Appreciate the need for appropriate interpersonal boundaries when discussing certain sensitive issues.	5. Respect appropriate interpersonal boundaries by exploring particular issues within appropriate subsystems.
e.g., The marital sexual relationship should not be explored in the presence of children.	e.g., "We could explore that area later when I see you as a couple."
6. Recognize that premature self-disclosures concerning other family members may raise resistance to further therapy.	6. Interrupt excessive or inappropriate disclosure and temporarily support the family's usual coping/defense mechanisms.

D. Maintain the Therapist-Family Alliance:

PERCEPTUAL/CONCEPTUAL SKILLS	EXECUTIVE SKILLS
1. Appreciate the need for an explicit agreement regarding expectations and goals of treatment.	1. Contract explicitly with the family for a certain number of sessions to work on specific problems.
2. Appreciate that participation in therapy of *all* members of the executive subsystem increases the likelihood of maintaining engagement with the family.	2. Work toward including the whole executive subsystem in the therapy process as much as possible.
e.g., Fathers in particular must be involved for effective family work. If a grandparent is in the home, his or her role in decision-making should also be explored.	e.g., Coach wife to convey to absent husband that his participation would be helpful, not that he participate to be helped. If this fails, contact him directly.
3. Recognize differing degrees of engagement among family members attending a session.	3. Intensify engagement with the family member least committed to therapy (when appropriate).
e.g., Note nonverbal cues such as minimal talk time, leaving coat on, ignoring conversation.	e.g., A transient individual alliance may be required and may be achieved by "joining" the disengaged member.
4. Recognize inadvertent negative reactions to particular therapeutic interventions.	4. Explore and validate the family's reactions to these interventions; clarify the intent and accept responsibility for inadvertent effects.
i.e., A family member's overreaction to certain statements may impair or even break the engagement with the therapist.	e.g., "Now I realize it hurt you when I said that. What I wanted you to recognize was that. . . ."
5. Recognize his own therapeutic errors when these have occurred.	5. Admit to therapeutic errors and apologize to the family when it is appropriate to do so.
N.B. The therapist should be sufficiently aware of his own limitations and conflict areas to know when these are liable to impair his therapeutic impact.	
6. Recognize the need to take initiative to call family members when contact lapses.	6. In order to resume therapy (when appropriate) or to clarify unexpected failure to return, initiate contact directly by phone, mail, or visit or indirectly through third parties.

II. PROBLEM IDENTIFICATION

A. Elucidate the Presenting Problem:

PERCEPTUAL/CONCEPTUAL SKILLS	EXECUTIVE SKILLS
1. Orient the therapist's full attention to be	1. Listen actively to family concerns, ask

receptive to the family's various perceptions of the presenting problem.

2. Realize the importance of obtaining a complete and accurate account of the nature and development of the presenting problem.

3. In attributing meaning to specific behaviors, realize the importance of clarifying the context in which they occur.

i.e., A clear vignette of a problematic event in the life of the family often reveals significant family dynamics.

4. Recognize that multiple sources of information allow for more precise delineation of a problem.

i.e., Family members often readily elaborate on or correct one another's reports, especially when invited to do so.

5. Use the information presented to develop tentative hypotheses regarding the presenting problem.

6. Review the data collected and the feedback obtained to distill out the core elements of the presenting problem.

7. Initiate reconceptualization of the presenting problem as a family system problem.

e.g., The family may inadvertently maintain the problem since the common focus of concern that accompanies it provides stability in an otherwise shaky family system.

open-ended questions, and explore ambiguities.

2. Obtain a precise description of problematic behaviors and the sequence of events relevant to the problem.

3. Inquire about the interpersonal and situational context of problematic behaviors and the reactions of others in the environment.

e.g., "What is usually going on when the problem emerges?"; "How do other family members respond?"

4. Encourage participation by several family members; stimulate them to share their knowledge and experience of the presenting problem.

e.g., "You haven't said too much; how do you see the problem?" "Do you agree with what has been mentioned?"

5. Reflect the therapist's emerging understanding of the presenting problem in order to obtain corrective feedback.

6. Summarize the essence of the presenting problem for validation by the family.

7. Explore the function that the presenting problem may be serving the system by identifying other problems in the family.

e.g., This may be approached indirectly by blocking the recurrence of the presenting problem or more directly by shifting onto other issues.

B. Center on the Immediate Process:

PERCEPTUAL/CONCEPTUAL SKILLS

1. Realize that the content of the first few moments of an interview may have a disproportionate effect on the therapist's orientation and conceptual set.

2. Realize that if behavior problems are current, some reflection of them may be manifest and recur in the immediate process.

EXECUTIVE SKILLS

1. Avoid premature closure on preliminary information and hypotheses and attend closely to the immediate process of interaction.

2. Watch for evidence of problems in the expressive and regulatory aspects of the ongoing communication.

3. Recognize relevant observable here-and-now behaviors that substantiate problems already described.	3. When appropriate, comment on the observable behavioral evidence in the immediate process in order to confirm or clarify the nature of the problem.
N.B. There is no substitute for observational validation. Don't rely on verbal reports alone.	e.g., "I can see what you mean—the boy is demanding. Even in here he keeps coming to you for attention."
4. Recognize events in the immediate process that appear problematic but have not yet been identified as such by the family.	4. When appropriate, invite comment on potentially significant observable events that may be outside the conscious awareness of family members.
N.B. This is where the therapist's conceptual skills add something new to the system.	e.g., "The boy seems to interrupt whenever the two of you disagree."
5. Evaluate the ongoing process events of the immediate interview and select a focus of inquiry that is salient.	5. Direct inquiry into the most appropriate, immediate issue in a clear, focused manner.
6. Recognize deliberate or inadvertent diversion from a focused discussion.	6. Refocus the discussion: when necessary label the tendency to defocus as confusing the issue or changing the subject.
i.e., The family may try to avoid important issues by changing the subject and thus covertly take control of the interview.	e.g., To parents: "I notice that you keep referring to your son when we talk about your disagreements. Let's just talk about the two of you."
7. Recognize spontaneous new behaviors or significant new disclosures that provide an opportunity to take the interview to a deeper level.	7. Shift the focus to explore important new facets of the immediate process when it is timely to do so.
8. Recognize verbal references to past events that seem to continue to have a major impact on present behavior.	8. Explore relevant history intermittently in the context of specific issues and problems but avoid long digressions.
N.B. Comprehensive routine history- taking is time-consuming and offers little information regarding the current significance of data obtained.	e.g., "You mentioned he acts the way your brother did." "What was your reaction to your brother then?" "In what way is your son similar now?"
9. Recognize discrepancies within the verbal information obtained and between linguistic content and other channels of communication.	9. Where appropriate, elicit further clarification of relevant information in verbal, paraverbal, and nonverbal communications.
e.g., Signs of affective arousal are often extremely valuable external markers to guide the process of uncovering exploration.	e.g., Pursue the origins of frustration conveyed in the voice even when there has been no evidence of conflict in the immediate speech content.
10. Recognize the moment-to-moment impact that the therapist is having on the family.	10. Respond to and cope with family reactions to the therapist in the immediacy of the interview.

i.e., Continuously monitor nonverbal responses of family members as well as speech content.

11. Recognize the impact that the family and its members are having on the therapist.

e.g., When the therapist reacts with strong negative feelings toward a particular family member, the possibility of "suction" (see below) should be considered.

12. Recognize the therapist experience of "suction" into implicit family rules and maladaptive beliefs and reconceptualize the process at a therapist-family system level.

i.e., Suction refers to the process of being drawn into the equilibrium-maintaining rules and beliefs of the family system. A clue to possible suction is the feeling that the session is "not going anywhere."

e.g., "You seemed surprised at what I said." "Do you find it annoying that I am asking about these other issues?"

11. Utilize the affect aroused in the therapist to identify the process of the system and to energize constructive interventions.

e.g., Frustration in the therapist could be used constructively to confront a difficult problem area in a clear focused manner.

12. Resist overt and covert pressures to be taken in by problematic rules and beliefs and avoid conforming to family expectations that would constrict the therapeutic process.

i.e., Withdraw mentally from the interaction in order to reflect more fully on the process. If necessary, leave the room temporarily to escape the suction or discuss the process with a supervisor.

C. Identify And Explore Interpersonal Problems:

PERCEPTUAL/CONCEPTUAL SKILLS

1. Realize that direct interaction from family member to family member during the interview is more likely to expose unrecognized relationship problems.

N.B. This is particularly true when their discussion is centered on current unresolved issues.

2. Discriminate specific behaviors that appear to regulate spontaneous interaction between family members.

e.g., Wife raises a contentious issue with husband, he breaks eye contact, turns his head away, and she stops talking.

3. Recognize the temporal association between regulatory behaviors and particular events and hypothesize interaction sequences that incorporate problematic behavior.

e.g., Wife raises an issue with husband, he turns away, she corrects son who makes a

EXECUTIVE SKILLS

1. Allow spontaneous interaction between family members, or stimulate it deliberately, rather than maintain an exclusively therapist-centered discussion.

e.g., To wife "Ask your husband what he thinks you've been saying," rather than to husband, "What do you think of that?"

2. When appropriate, comment on potentially problematic regulators and invite clarification of the stimulus or control characteristics of these behaviors.

e.g., "I noticed that your husband turned away when you asked him. . . . What effect does that have on you?"

3. Inquire about sequences of interaction and seek validation of linkages between particular antecedents and their consequences in the immediate process of the interview.

e.g., To husband "What just happened when you turned away?". . . . "Are you say-

sarcastic comment, then father smiles.	ing that you turn away whenever she seems to blame you?"
4. Conceptualize some sequences of maladaptive interaction as a triangulation process.	4. Observe for recurrent patterns of family behavior that confirm or deny a triangulation process.
i.e., A common method of dealing with tension in a dyad is for both to displace onto a third party.	N.B. Usually the third person becomes actively involved in maintaining the process by drawing the focus to himself.
5. Conceptualize some recurrent patterns of symmetrical or complementary interaction in the form of circular feedback loops.	5. Watch for family behaviors that confirm, deny or clarify the component parts of a circular pattern of maladaptive interaction.
i.e., Cybernetic feedback loops of behavioral communication and control constitute an important part of the systemic aspect of family systems.	e.g., Wife is frustrated, blames husband; husband feels guilty and consequently withdraws; wife feels more frustrated . . . and thus the circle continues.
6. Conceptualize some events in the life of the family as reflecting inappropriate interpersonal or subsystem boundaries.	6. Elicit descriptions of routine family life to clarify the location, nature, and intensity of boundaries within the family and between the family and outsiders.
N.B. Depending on the developmental stage of family members, particular boundaries may be too rigid or too loose.	e.g., Privacy rules, sleeping arrangements, type of information shared, degree of autonomy in decision-making.
7. Hypothesize underlying affective involvements between family members that could explain several interaction patterns.	7. Observe for family behaviors that confirm or deny alignments, coalitions, and splits between family members.
i.e., The therapist conceptualizes the interpersonal bonds of "deep family structure" or may draw a family map of underlying attachment or alienation.	e.g., If mother and son sit together and respond quickly to each other, while the father sits alone across the room and tends to be ignored by both, one would conceive of an alignment between mother and son with the father split off.
8. Recognize some behaviors as reflecting covert family rules that may operate to suppress individual growth and constructive change in the system.	8. Watch for family behaviors that confirm, deny or clarify maladaptive family rules.
i.e., Rules are organizational elements of interpersonal systems reflecting the truism that "the whole is greater than the sum of the parts."	e.g., The family behaves as if "we must not confront father/husband," although this may never be explicitly stated by family members.
9. Conceptualize collective family beliefs, including family myths, that tend to justify and maintain maladaptive patterns of behavior.	9. Stimulate family members to share their beliefs about their family to validate or correct the therapist's hypotheses.
i.e., Family beliefs may serve family systems in much the same way that psycho-	e.g., "Does father hold special status and authority in your family?" "In what way do

logical defenses serve individuals in maintaining homeostasis.

you see yourselves as different from other families in the community?"

D. Clarify Individual Problems[2]:

PERCEPTUAL/CONCEPTUAL SKILLS	EXECUTIVE SKILLS
1. Realize that individuals vary in degree of awareness of their own and others' problems and of their willingness to disclose their problems in the presence of other family members.	1. Start exploration of an individual's problem by asking directly how he perceives it himself, making allowances for level of awareness and situational context.
2. Recall that, by virtue of extended contact, other family members have a wealth of data concerning any one member.	2. Stimulate other family members to share their perceptions concerning an individual's problems.
3. Recognize the risk of stimulating a maladaptive interaction process of blaming when inviting other family members to comment on an individual's problem.	3. Seek the individual's consent to explore another family member's perceptions of his problems and curtail the inquiry if blaming becomes severe.
4. Integrate data from the individual's behavor, cognition, and affect to formulate intrapsychic problems.	4. Summarize some individual problems at a level that can be understood by the family for validation or corrective feedback.
e.g., Fear is aroused when the individual approaches a certain issue. The issue is then avoided rather than mastered. Thus the avoidance sustains, and through failure even augments, the fear related to the issue.	e.g., "Her problem with anger is that she's afraid to tell you what she feels. So she keeps it to herself and doesn't learn how to handle disagreements. Instead, she becomes more resentful and more afraid of what might happen if she let go."
5. Anticipate the potential hazards of labeling certain problems as individual or exposing them too explicitly in the presence of other family members.	5. Defer exploring some individual problems with the whole family until the developmental level of members and potential risks are better understood.
e.g., The therapist may inadvertently reinforce maladaptive beliefs or create greater resistance or both.	i.e., The advantages and disadvantages of exploration with individuals alone or in subsystems should be considered.

E. Integrate the Assessment:

PERCEPTUAL/CONCEPTUAL SKILLS	EXECUTIVE SKILLS
1. In completing a comprehensive assessment, realize the importance of identifying family strengths as well as weaknesses.	1. Explore the constructive problem-solving resources of the family as part of the context in which problems occur.
2. Realize that multiple factors at the physical, psychological, and interpersonal levels may be involved in any particular problem.	2. Explore multiple factors at multiple levels to obtain a full assessment of the whole family.

[2] Numerous additional skills regarding individual psychotherapy could be included here, since much individual work does occur during family therapy. However, only a few skills considered relevant to the family context are outlined.

3. Realize that most families have multiple problems and that to attempt to explain everything with one diagnosis is either too simplistic or too abstract.	3. Enumerate multiple problems rather than adhere to a single unitary diagnosis.
i.e., Careful differentiation of separate problems allows for more specific and focused therapy.	e.g., Maintain one or more problem lists as part of the clinical record.
4. Recognize that some problems can only be clarified gradually as therapy progresses or become evident only after change has occurred.	4. Define and formulate problems at the level at which they are presently understood and redefine them as more data become available.
5. Carefully differentiate primarily individual from interpersonal problems, while maintaining a clear awareness of the interrelatedness between them.	5. Help the family recognize the interrelatedness of problems by pointing out the simultaneous components of individual and interactional problems in the immediate process.
i.e., A family therapist needs to be skilled in individual as well as interpersonal work.	e.g., "Although you [to wife] have difficulty being assertive without being critical and you [to husband] are hypersensitive, your [to both] pattern of criticism and withdrawal that we just saw aggravates both."
6. Realize that the manner in which a problem is conceptualized influences the nature of subsequent therapeutic intervention.	6. Formulate each problem that is to become a focus for therapy in the form of an operational definition or a hypothesis that can be tested.
e.g., To define a problem as interpersonal implies intervention at the interpersonal level.	i.e., A useful operational definition will imply a goal for treatment as well as the possible means of achieving that goal.
7. Realize that interpersonal problems are more visible and hence more accessible to specific therapeutic intervention than individual (intrapsychic) problems.	7. When possible and appropriate, redefine individual problems at the interpersonal level in order to increase the therapeutic leverage for change.
8. Differentiate physical, psychological, and social problems that may affect the behavior of a particular individual.	8. Enumerate the problems of each family member and record them on an individual problem list.
i.e., Much of this conceptual work may be carried out during subsequent documentation by record-keeping between actual interviews.	e.g., Mother —Severe diabetes Daughter—Fear of academic failure Father —Unemployed for past six months.
9. Differentiate structural, functional, and developmental problems that may be present at various levels of interpersonal systems.	9. Enumerate and list interpersonal problems at the most relevant systems level (whole family system, marital subsystem, parent-child subsystem, sibling subsystem, family-community suprasystem).
i.e., Structural problems include issues re-	e.g., Whole-family-system problems:

lated to family composition and boundaries. Functional problems include expressive/communicative issues and difficulties in daily instrumental tasks.

(a) single-parent family (structural)
(b) covert family rule—"Don't cry" (functional)
(c) eldest son left home suddenly two years ago (developmental)

10. Review the list of problems intermittently and select a focus for therapy that would be pragmatic and acceptable to the family.

10. Involve the family in selecting a target problem or problems, in setting goals, and in elaborating a plan of management.

III. CHANGE FACILITATION

A. Break Maladaptive Interaction Patterns:

PERCEPTUAL/CONCEPTUAL SKILLS	EXECUTIVE SKILLS
1. Estimate the family's capacity for change by reviewing family strengths and previous problem-solving efforts.	1. Refrain from introducing changes that exceed the capabilities of the family or its members.
N.B. Therapeutic trials may be required to gain an accurate assessment.	i.e., It is antitherapeutic for the therapist to foster unrealistic expectations of change by the family.
2. Realize the critical importance of gaining at least some support of the executive subsystem in any effort to introduce change.	2. Initiate those changes that at least one member of the executive subsystem is liable to recognize as useful.
3. Recognize specific maladaptive interaction patterns *while* they are occurring during the interview.	3. Interrupt maladaptive patterns of behavior and take control of the immediate interaction.
N.B. Although a full manifestation of some problems may never emerge in actual sessions, reflections of them tend to "leak" despite efforts to make a good impression.	i.e., With experience in arresting problematic interaction in therapy, the family may generalize outside of sessions.
4. Realize that by altering the structural relationships between people, interactional patterns are interrupted.	4. Intervene to control maladaptive patterns by restructuring family interaction verbally or physically.
N.B. Directional orientation and spatial location of a person's body are strong factors in maintaining or changing interactional patterns.	e.g., "Talk to your husband about that" [instead of to the son]. Or, "I'd like you two [father and son] to switch chairs" so that the father sits between the mother and son.
5. Realize that facilitating a mutually exclusive behavior is an effective method of controlling problematic behavior.	5. Direct the family to carry out behaviors that are incompatible with the maladaptive behaviors.
	e.g., "Let's see you try to convince him that you really love him" when the pattern has been one of blaming.
6. Recognize the need for explicit requests	6. Instruct family members to clarify be-

or directions to stop certain behaviors, especially in regard to children.	havioral expectations for one another and to follow through on the limits set: model if they are unable to do so. e.g., "Tell the children what you expect of them in here, and do what you would at home if they don't."
7. Realize that a clear and focused expression of anger may be constructive in inhibiting problematic behavior or in weakening an inappropriate alignment.	7. When appropriate, facilitate the adaptive expression of anger of one family member in order to block the recurrent problematic behavior of another.
8. Recognize persistent resistance to therapeutic intervention and evaluate the potential of paradoxical instruction in overcoming such resistance. e.g., By directing a negativistic individual to do what he's already doing introduces a "therapeutic bind." Paradoxical instructions may be introduced for behaviors occurring during the session or as tasks between interviews.	8. In carefully selected situations, deliberately prescribe an individual's own problematic behavior in order to gain paradoxical control of maladaptive interaction. e.g., "Keep blaming him. That's it, louder and harder! And you, just turn away from her, keep looking away, ignore her." "I want you to practice these next week."
9. Recognize that some maladaptive patterns are tenacious and require separating the participants involved by putting them in different rooms. N.B. To allow circular argument to escalate out of control may have serious destructive consequences.	9. Direct one or more family members to leave the room temporarily. If resistance is extreme, the therapist could leave the room with the cooperative family members. e.g., An observation room from which the "expelled" member or members could observe through a one-way screen but not participate is useful in order to continue working under such difficult circumstances.
B. Clarify Problematic Consequences:	
PERCEPTUAL/CONCEPTUAL SKILLS	EXECUTIVE SKILLS
1. Realize that family members are more capable of constructive change when they have a clear and immediate awareness of specific components of maladaptive behavior patterns.	1. Ask the family to describe the problematic behavior that is occurring in the immediate process, and reinforce their articulated awareness when it is accurate. e.g., "What's happening right now?"... "That's right, that's what I see too."
2. Recognize when family members are not aware of and hence cannot describe maladaptive patterns of interaction that are occurring between them.	2. Label the pattern for the family by detailing the preceding moments of maladaptive interaction and seek the family's recognition of the sequence and its recurrent pattern.
3. Realize that placing a problem into a	3. Stimulate family members to reflect on

future time perspective facilitates recognition of undesirable consequences.

4. Realize that individual family members must recognize and accept responsibility for their own contributions to problematic patterns before they can initiate deliberate corrective efforts.

e.g., The failure of a particular member to recognize his own responsibility may lie in his perceptual punctuation of the sequence of events. For instance, if $A_1 \rightarrow B_1 \rightarrow A_2 \rightarrow B_2$ etc., B may only perceive $(A_1 \rightarrow B_1)$, $(A_2 \rightarrow B_2)$ whereas he also needs to see $(B_1 \rightarrow A_2)$, $(B_2 \rightarrow A_3)$.

5. Recognize when family members evade conscious awareness or responsibility for their own problematic behaviors.

N.B. Some people need to be confronted over and over again before they are willing to make any changes.

6. Realize that individuals are more receptive to corrective feedback when they experience acceptance and support.

i.e., "A spoonful of sugar helps the medicine go down."

the eventual outcome if problematic patterns were to continue.

4. Stimulate each family member to evaluate his own contributions to the problems by exploring the impact of his behavior on the cognition, affect, and behavior of other family members.

e.g., "What happens when you turn away from her?" Or use other-affect queries such as "What do you think she feels when you do that? Why don't you ask her and find out?"

5. Confront family members on the problematic consequences of their own behaviors.

e.g., "Did you realize the impact that your behavior is having on her?" "Is that what you want her to feel?" "Then what are you going to do about it?"

6. Provide verbal or nonverbal support before and after direct confrontation whenever possible.

e.g., The sandwich technique: "You're pretty bright. Can't you see that your overcontrolling discipline is driving your daughter away. I'm sure you can change—and she'll want to stay."

C. Alter Affective Blocks:

PERCEPTUAL/CONCEPTUAL SKILLS

1. Realize that the affective arousal of emotional discomfort may operate to block either adaptive or maladaptive behavior.

2. Realize the potential adaptive function of certain negative emotions in inhibiting problematic behavior and conceptualize particular applications to enhance internal controls where appropriate.

e.g., When anticipatory shame, guilt, or fear is available and not suppressed, it serves a useful function in blocking the associated behaviors that are problematic or anti-

EXECUTIVE SKILLS

1. Convey the importance of expressing and clarifying affective experience in order to better comprehend the maintenance of overt behavior patterns.

2. In selected instances, implement affective blocks by mobilizing shame, guilt, or fear in relation to specific problematic behaviors.

N.B. Sometimes the appropriate affect is mobilized by removing inappropriate defenses. At other times, potential consequences that are realistic can be introduced to gen-

social.	erate the affect: "She may indeed run away if you hit her again."
3. Recognize spontaneous emotional distress that is recurrent or persistent as maladaptive and conceptualize it as a block to problem-solving and change.	3. Remove inappropriate affective blocks by encouraging open discussion of the emotional turmoil of family members; validate their experience, clarify the context, and provide support.
N.B. Such affect is usually a valuable "marker" that may lead to elaboration of relevant conflictual issues.	e.g., Point out nonverbal evidence of their affective responses and share the therapist's own immediate response where appropriate.
4. Realize that specific identification of affective states allows for more differentiated and deeper therapeutic intervention.	4. Stimulate family members to further self-reflection and verbalization of specific affective experiences by entertaining alternative possibilities.
e.g., If the predominant affect is fear while the therapist explores feelings of guilt, progress will be impaired.	e.g., "Does it make you feel ashamed or guilty, or do you find it more frightening than anything else?"
5. Recognize that fear of anticipated outcome, regardless of its justification in terms of the real situation, is a common source of undesirable inhibition.	5. Explore catastrophic expectations with a view toward desensitizing inappropriate and unrealistic fears.
	e.g., "What is the worst thing that could happen if you started. . . . ?" "Ask him if that fear is a real probability or not."
6. Realize that once covert anger has been openly expressed, clarification of its frustrating origins is more useful than further catharsis alone.	6. After facilitating the overt expression of covert anger, curtail the projective aspect and stimulate self-reflection by exploring the underlying frustration.
	e.g., "You seem quite angry and bitter. I suppose I would be too if I were in your situation. But what exactly is it that is so frustrated in *you*?"
7. Realize that sadness expressed through weeping is an adaptive tension release and is less destructive to other family members than the expression of anger.	7. Facilitate and legitimize open weeping as a healthy response to any type of loss. But differentiate the controlling aspect of whining from the psychological pain of weeping where necessary.
8. Recognize the vulnerability of the family member who is disclosing sensitive issues, emotions, and thoughts and realize the opportunity to stimulate a positive interactional event.	8. Mobilize family members to provide validation and support verbally or nonverbally; model if the family is unable or unwilling to do so.
N.B. These are critical moments in therapy. Whereas a positive response (even after a	e.g., Ideally, cue other family members nonverbally to respond spontaneously. Other-

negative disclosure) could be a constructive experience in providing a deeper basis for trust, a negative response could inflict disproportionate wounds that might be a setback.

wise, "You must feel like wanting to comfort her; go ahead," or "This is not the moment to be angry about what he did but to recognize that he is being honest and open about it, which I'm sure you can see is extremely difficult but must make you feel good toward him."

9. Recognize increasing resistance, behavioral disorganization, or regression to more primitive levels of awareness and cognitive functioning in family members under too much stress.

9. Provide support and slow the therapeutic process when an issue is too stressful and disorganizing and help other family members to alter their expectations as well.

10. Recognize accessibility to associations that can be reached through immediate affective experience but that may become sealed off when the affect is no longer being experienced.

10. While the affect is aroused, elicit verbal expression of immediate cognitive associations relevant to the (earlier) experience that is being reenacted.

i.e., Information so obtained is usually more germane to understanding interpersonal problems than later "objective" reports that are more liable to be edited.

e.g., If a family member breaks into tears, stimulate support, then before the weeping stops and the sadness is suppressed, inquire "What were you thinking when you began to cry?"

D. Initiate Cognitive Restructuring:

PERCEPTUAL/CONCEPTUAL SKILLS

EXECUTIVE SKILLS

1. Realize that every individual develops an internalized cognitive representation of the world that orients his ongoing behavior.

1. Encourage verbalization by family members in order to expose relevant personal constructs and family belief systems.

N.B. Individuals may no longer be aware of past experiences or earlier beliefs that provided the basis for present behavior patterns and that may continue to underlie them.

e.g., In order to reconstruct "unconscious" beliefs and values, elicit examples of behavior from which inferences may be drawn.

2. Recognize simple confusion due to impaired perceptual input or the lack of integration of relevant ideas.

2. Clarify issues by repeating salient points and carefully linking relevant concepts and events.

3. Recognize inaccuracies or discrepancies in interpersonal perception and realize the importance of corrective feedback from one family member to another.

3. Using other-cognition queries, guide interaction between family members in order to clarify errors in interpersonal perception.

i.e. It is quite remarkable how some people can live together so long and yet hold such different views and distorted perceptions of each other's views.

e.g., Rather than [to husband] "What is your point of view?" ask [wife] "How do you think he sees the situation?," or [to husband] "What do you think she thinks your point of view actually is?" "Ask him/her and find out."

4. Recognize beliefs that are shared by the whole family and that inhibit constructive feedback or interfere with problem-solving and adaptive change.	4. Call into question collective beliefs, values, or goals that appear to be problematic and initiate open discussion and reevaluation of relevant issues.
5. Recognize irrational beliefs, unrealistic expectations, or immature values held by particular family members.	5. Challenge maladaptive ideas, stimulate the individual's willingness to hear other views, and facilitate corrective feedback from other family members.
N.B. Another family member's critical attitude can be turned to advantage here if the therapist is able to maximize the specificity of corrective content and minimize the pejorative blame.	e.g., Guide the individual in a negative inquiry: "What's wrong with what I said?" "What do you mean it's immature?" "Just how does that cause problems?"
6. Recognize the emotional reactions that accompany a significant change in a preexisting cognitive set or belief system.	6. To prevent new affect from blocking further progress, encourage the expression and discharge of emotion (especially through laughing or crying) while modifying a previous cognitive set.
7. Realize that the use of alternative language structures, such as poetic forms and humor, facilitates the crystallization and understanding of salient or new concepts.	7. Use metaphor, simile, overstatement, paradoxical statement, etc., to clarify, distill, and emphasize concepts that have adaptive potential. e.g., She's like a watermelon seed: the harder you press her, the farther she goes."
8. Realize that new information or reorganization of existing ideas are required for new understanding or insight.	8. Provide appropriate new information or a reformulation as required to develop more adaptive comprehension.
9. Realize that an existing negative belief may often be restructured by providing an alternative frame of reference. N.B. By being exposed to this restructuring other family members may also alter their perceptions, and the new framework becomes a topic of discussion at home.	9. When possible, reframe preexisting negative concepts that are problematic in more positive and constructive terms. e.g., "The reason your parents get mad at you is not that they don't care for you, but that they care too much and get so upset about what might happen."
10. Recognize when family members need to realize that certain goals can never be achieved by striving for them directly.	10. Guide family members to reflect on certain basic truths and paradoxes of life in order to redirect family efforts into more productive channels. e.g., "Respect cannot be demanded but can perhaps be earned." "A teenager's sense of responsibility cannot be developed through more control but perhaps with judicious freedom."
11. Realize that by conceptualizing issues at a higher level of logical type it is possible to transcend a stalemate or double bind.	11. Describe and define relevant issues at different conceptual levels to stimulate new family understanding.

e.g., By raising an individual problem to the interpersonal level, complications of blame and guilt are reduced. By focusing on the inconsistency itself the bind of opposite directives can be overcome.

e.g., [To wife] "You complain and then he withdraws." [To husband] "You withdraw and she complains." [To both] "It's really quite irrelevant who started it. You are now both in a vicious circle. Since there is no beginning to a circle, there is no point to blaming or feeling guilty."

12. Recognize the need for personal reflection as well as repeated discussion over time to alter an established belief system.

12. Encourage family members to consider new ideas further and to continue to discuss specific issues at home in order to reach a reality-based consensus.

i.e., A new social reality is gradually developed over time by thinking and talking through issues again and again.

e.g., Depending on the interests and intelligence of family members, specific reading may be suggested.

13. Recognize those beliefs that require corrective experience through participative action in a new situation or context before a cognitive change can be effected.

13. Encourage family members to expose themselves to relevant types of new experiences outside therapy or direct them to try new behaviors in the session.

e.g., Prejudices usually require corrective experiences for any substantial change.

e.g., The possibilities here are enormous. In the session they include role reversal, family sculpture, Gestalt exercises.

E. Implement New Adaptive Interaction Patterns:

PERCEPTUAL/CONCEPTUAL SKILLS	EXECUTIVE SKILLS
1. Understand the basic principles of learning theory, identify specific reinforcers that are effective in the family, and recognize adaptive behavior when it occurs.	1. Using operant principles, apply social reinforcements to strengthen appropriate behaviors at any time during the sessions and encourage family members to do the same.
2. Realize that an individual experiences more gratification when he takes personal initiative in being constructive than if he is directed to do so.	2. Stimulate each family member to identify new adaptive behaviors for himself and support his suggestions when they are constructive.
3. Recognize a family member's reluctance or inability to identify constructive changes in his own behavior.	3. Elicit the family member's willingness to be receptive to suggestions and invite specific behavioral suggestions from other family members (or offer some).
4. In conceptualizing desirable changes for the family, review the natural forces and direction of change in the present development of this particular family and its members.	4. Coach the family in implementing changes that are compatible with appropriate developmental tasks for the whole family as well as its individual members.
5. Conceptualize adaptive changes in underlying affective involvements and in the interpersonal boundaries between family members.	5. Introduce adaptive changes in behavior during the interview by redirecting interaction patterns and altering spatial and seating arrangements to rearrange subsystems.

i.e., A "healthier" deep family structure is hypothesized and revision of the "family map" becomes a therapeutic goal.

e.g., In changing a maladaptive alignment between mother and son, define a boundary between them, minimize their overinvolvement with each other, and stimulate greater involvement between the father and son and between the husband and wife.

6. Conceptualize adaptive patterns of circular interaction that would be mutually reinforcing and could replace maladaptive maintenance patterns.

6. Help family members negotiate and implement simultaneous changes and, when appropriate, direct them to initiate the new behaviors in the session.

7. Recognize a family member's self-conscious hesitation to take the initiative to implement new behavior during the actual interview.

7. When directing a hesitant family member to take initiative in the interview, deflect attention onto the recipient of the proposed action.

e.g., "Show her that you really do care right now. I'd like to see how she'll respond."

8. Recognize that family members are often more receptive to change when in a moderate degree of crisis.

8. When required, refocus on preexisting or underlying conflictual issues in order to stimulate motivation for behavioral change.

9. Realize that changes in a *relationship* are more likely to occur when the family members involved are in some degree of crisis simultaneously.

9. To achieve optimal anxiety levels for different family members, intensify or diminish the degree of crisis experienced by specific individuals through confrontation and support, respectively.

i.e., The therapist orchestrates a delicate balancing act in order to achieve a new consensus, with change occurring at the relational level.

e.g., "Your're really being grossly unreasonable, stubborn as an ox as a matter of fact, whereas despite her pain your wife is willing to make a positive move."

10. Recognize when family members are interacting with each other in a more constructive or problem-solving manner during the session.

10. Relinquish control of the interaction and avoid interrupting when adaptive patterns of family interaction emerge.

N.B. When the pervasive interaction at home is negative, the family needs the opportunity to experience positive interaction with each other in the session.

i.e. Having created the context in which constructive interaction can occur, the therapist should sit back and allow it to happen without being intrusive.

11. Realize that explicit feedback to one another about the constructive interaction that has occurred has a further positive impact.

11. Elicit verbalization of the positive experience and stimulate feedback to one another concerning the constructive event.

i.e., The full potential of constructive effort may not be realized until others become aware of it.

e.g., "Find out how she feels about your actually following through here and giving support in this awkward situation."

12. Recognize that new behaviors need deliberate effort and must be rehearsed out-

12. Assign realistic and concrete behavioral tasks as homework. Seek explicit commit-

side of therapy to become established as stable patterns.

13. Recognize that anticipation of positive consequences strengthens the commitment to maintain constructive changes in behavior.

ments to carry them out within a specific time period.

13. Facilitate hope by stimulating interaction between family members to clarify the future consequences of adaptive change.

e.g., "Find out how she would feel and what she'd do if you did in fact blame less and give her more support with the kids."

F. Mobilize External Resources as Required:

PERCEPTUAL/CONCEPTUAL SKILLS	EXECUTIVE SKILLS
1. Recognize the absence of adequate progress in therapy.	1. Openly admit to lack of progress and explore possible inhibiting factors both inside and outside of the family.
2. Recognize the influence of the family's social network in providing support or retarding adaptive change and consider mobilizing these resources.	2. Coach family members to mobilize external resources and to influence them to be constructive. When indicated, ask the family to invite friends or relatives to sessions.
e.g., The possible lack of external support for single-parent families must be identified early lest the therapist become "sucked into" becoming the primary resource.	e.g., A family-of-origin interview often clarifies some problems dramatically and opens up new intervention possibilities for resolution of certain problems.
3. Recognize unexplained deterioration in the family (or a member) or when the therapist is losing control of the therapy process and is unable to regain it.	3. Seek immediate supervisory, consultative, or co- therapy counsel or consider transferring the family to another therapist.
	i.e., No therapist should expect to be able to handle every situation.
4. Recognize when individuals and families require further additional input and the expertise of other professionals or agencies besides family therapy.	4. Carefully select and refer particular family members to other professional resources for appropriate treatment as required.
e.g., Psychotropic medication, individual psychotherapy, or therapeutic separation may be required to break up extremely tenacious maladaptive patterns.	e.g. Arrange for hospitalization or placement as required but continue family therapy lest the family close ranks behind the member admitted.
5. Recognize the risk of violence, including suicide and homicide, particularly when there is a pattern of circular incremental escalation of anger.	5. Articulate realistic risks (in the presence of adult family members), jointly evaluate their severity, and mobilize other professional or natural resources to provide adequate controls and support.
6. Recognize problems of multiple professional involvement due to poor interprofes-	6. Initiate and maintain contact with other professionals who are involved in relevant

sional communication or to inappropriate competition.

problems and, when required, arrange joint conferences (which should include the family.

IV. TERMINATION

A. Assess Family Initiative to Terminate:

PERCEPTUAL/CONCEPTUAL SKILLS	EXECUTIVE SKILLS
1. Recognize family members' initiative to terminate therapy when it emerges or is implied during the interview.	1. Explore family members' rationale for termination to differentiate reasonable from inappropriate motives.
e.g., Families may drop out of treatment prematurely if the basis for further therapy has not yet been established by clarifying related problems.	e.g., Genuine logistic difficulties in arranging to get everyone to sessions are quite different from resistance due to sudden "improvement" reflecting a "flight into health."
2. Reflect on the progress of therapy and recognize what problems remain and what goals have not yet been achieved.	2. Initiate a review of family problems and offer to renegotiate the therapy contract.
3. Realize that when the stress of the precipitating crisis subsides the motivation for family members to continue in therapy wanes.	3. When appropriate, point out unresolved issues and emphasize the general benefits of continuing therapy to develop better interpersonal, problem-solving skills.
4. Recognize those situations where family problems are particularly liable to deteriorate and identify the gains that would be lost as a result of premature termination.	4. When warranted, strongly encourage the family to reconsider their desire to discontinue sessions and mobilize spokesmen inside or outside the family who are most likely to anticipate potential benefits of further therapy.
N.B. In those rare situations where a child is at serious risk of violence or neglect, legal authorities may have to be mobilized.	i.e., If the wife is the most vulnerable and has the most to gain by continuing, her frank opinions should be sought.
5. Recognize when termination is inevitable and realize that when the therapist's commitment to continue therapy is significantly greater than the family's further change is improbable.	5. Accept family initiative to terminate and respect their right to do so without undue pressure or prejudice even when the therapist disagrees.

B. Initiate Termination When Necessary:

PERCEPTUAL/CONCEPTUAL SKILLS	EXECUTIVE SKILLS
1. Recognize the attainment of therapeutic goals or the presence of sufficient problem-solving skills in the family to achieve them on their own.	1. Stimulate the family to review the present status of their problems and to consider termination when problematic issues have been resolved or adequate progress has been made.

2. Realize that families terminate with more confidence when they recognize the improvement in their own problem-solving skills and when adaptive patterns have been maintained longer.	2. Seek family members' perceptions of their own contributions toward the constructive changes that have occurred and reduce the frequency of sessions. e.g., Often a paradoxical question like "What would each of you have to do to bring the problem back?" elicits a more explicit statement of their understanding.
3. Recognize hesitance or reluctance to terminate in some family members.	3. Encourage disclosure of fears related to the termination process and elicit support from other family members. e.g., "What do you think would happen if we stop sessions now?" "Could you respond to her concerns?"
4. Recognize the lack of movement in some families despite considerable effort and consider the cost effectiveness of continuing therapeutic efforts.	4. Clarify the therapist's limitations and initiate termination, pointing out that family members may become more receptive to change at a later date.
5. Recognize when ongoing sessions have become counterproductive because they have covertly undermined family members' initiative to take action or to seek more appropriate natural network support. i.e., Prolonged therapy fosters excessive dependency. It is inappropriate, for instance, for a wife to seek support from a male therapist *rather* than her husband.	5. Clarify emergent problems and confront the family on the inappropriateness of relying too heavily on the therapist to implement change and for general interpersonal support. N.B. The therapist must be prepared to actually terminate, since continuing the sessions implicitly contradicts the confrontation.

C. Conclude Treatment Constructively:

PERCEPTUAL/CONCEPTUAL SKILLS	EXECUTIVE SKILLS
1. Realize that the impact of the therapist will continue after termination and that family members will be more receptive to future professional intervention, should it be required, if therapy ends constructively.	1. Review unresolved family problems by suggesting directions for future change and strive to conclude (most interviews and certainly the overall therapy) on a positive note. N.B. A final parting on negative interaction leaves the family with unnecessary unfinished business with the therapist.
2. Recognize that in most instances family members have in fact made constructive efforts to solve problems.	2. Summarize positive efforts and constructive intent of family members whether or not substantial improvement has occurred.
3. Realize the importance of formal closure as part of the fulfillment of the therapeutic contract.	3. End the therapy process with a face-to-face discussion when possible; otherwise follow up by phone or letter.

4. Realize that family members have allowed the therapist into the privacy of their family life and have given him an opportunity to be helpful.

5. Recognize that individuals and families appreciate the availability of back-up support to call on in times of stress.

4. Express personal appreciation for family openness and for the opportunity to have worked with them to solve problems.

5. Leave the family with an open invitation for further family therapy should crises recur.

CONCLUDING COMMENTS

Advanced family therapists will recognize most of these skills as already part of their own repertoire even though they may not have explicitly described or labeled them. Some experienced clinicians are undoubtedly using additional techniques that have not been included in this list. To trainees and other therapists, however, several of these skills may be new and we hope will introduce some useful alternatives in their work with families.

The authors are sensitive to the fact that skills for the practice of family therapy are not developed merely as a result of reading articles. There is no substitute for the opportunity, while learning to work with families, to observe experienced and skilled clinicians exercising their competence. Even more important is the availability of supervisory feedback to help trainees refine and elaborate their basic interpersonal relationship skills and to apply them effectively in appropriate clinical situations.

The goal in preparing this outline has been to provide an overall conceptual framework and a more precise focus on specific skills for training therapists in family therapy. The exercise of delineating these skills and the experience of teaching them has proved to be very helpful in the training program at the University of Calgary. The outline itself is used as the basis for a series of seminars. Perceptual/conceptual skills are discussed in depth along with descriptive examples and videotape illustrations. Executive skills are described in terms of specific therapist statements and demonstrated live or on videotape. Students are encouraged to exercise particular executive skills in role-playing. Supervisory feedback is provided during live interviews using a telephone intercom and after sessions through discussion and videotape review. Although there are many other facts of the training program at Calgary, this outline of skills provides a clear and consistent description of the family therapy model presently being taught.

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Reprint requests should be addressed to Karl M. Tomm, M.D., Director, Family Therapy Program, Division of Psychiatry, University of Calgary, 2920 24th Avenue NW, Calgary, Alberta, Canada T2N 1N4.