

*System for Observing Family Therapy Alliances
(SOFTA-o)*

TRAINING MANUAL (Revised 2005)

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OVERVIEW AND DEVELOPMENT OF THE INSTRUMENT

The System for Observing Family Therapy Alliances (SOFTA-o) was developed to fill an important gap, to estimate the strength of the working alliance in conjoint family treatment. To date, no single indicator of the therapeutic process has been shown to be more powerful in predicting client outcome than the therapeutic alliance (Horvath & Symonds, 1991). Not only is the alliance a meaningful predictor of therapeutic success across theoretical orientations (Bachelor, 1991), but also clients' perspectives on the alliance early in treatment consistently predict outcome weeks or months later (Horvath & Symonds, 1991).

For individual psychotherapy, the alliance can be assessed using a variety of measures -- client- or therapist-reported as well as observer-reported (Tichenor & Hill, 1989). In the couples and family literature, however, there is only one published instrument, Pinsof and Catherall's (1986) integrative alliance scales. Research on this measure, which is based on Bordin's (1979) tri-partite conceptualization of the alliance, has been shown to be reliable and predictive of session impact (Heatherington & Friedlander, 1990) and treatment outcome for both couples and families (Bourgeois, Sabourin, & Wright, 1990; Johnson & Talitman, 1997; Pinsof & Catherall, 1986; Quinn, Dotson, & Jordan, 1997).

Like the individual alliance measures, Pinsof and Catherall's (1986) instrument focuses far more on therapist behavior than on family members' behaviors. Indeed, little is known about what observable behaviors contribute to a strong alliance in couples and family therapy (Friedlander & Tuason, 2000). In the absence of this knowledge, therapists (and supervisors) can only rely on clinical judgment in assessing the strength of the alliance. To fill this gap, we developed an observer rating scale of client behaviors for this treatment modality. Subsequently, we developed an observer scale for therapist contributions to the alliance, with parallel dimensions and several complementary items.

Observer scales of the individual therapy alliance could not be adapted to couple and family therapy because the presence of multiple family members, children as well as adults, makes this format unique in several respects. Two dimensions of our instrument reflect this uniqueness. These dimensions are operationally defined as *Shared Sense of Purpose Within the Family* and *Safety Within the Therapeutic Context*. The former was included because family members do not always value the therapy equally. It has been demonstrated that a "split" alliance (i.e., some family members are more involved and more strongly aligned with the therapist than others) occurs frequently (Heatherington & Friedlander, 1990). Our instrument reflects Pinsof's (1994) recommendation that alliance measures include the *within-system alliance* -- family members' collaboration with one another in relation to the therapy. The latter dimension, Safety, reflects another unique aspect of family treatment (Friedlander & Tuason, 2000). In several respects, family therapy involves more and different risks for clients than does individual therapy. When people come for help with their families, they risk having secrets or shameful events revealed against their will. Some may find out that their spouse or partner is planning to leave them. Others may be punished or physically hurt by family members who are angry about what took place in the session. Indeed, clients' most important relationships can be put at risk when they seek professional help in a family context.

To construct the instrument, we began by reviewing the theoretical and empirical literature on therapeutic relationships in couple and family therapy. This process resulted in the identification of a set of descriptors illustrating both a positive and a negative alliance. These descriptors were then used to create an initial pool of items illustrating different aspects of client involvement and collaboration. Guiding the item construction was the requirement that each item be an observable behavior. Thus, for example, rather than, “Family members are interested in each other’s perspective,” the item reads, “Family members ask each other for their perspective.”

To refine the initial item pool, our research team ($N = 4$) observed 12 videotaped family sessions for which we had the clients’ self-reported perspectives on the alliance from an earlier study (Heatherington & Friedlander, 1990), i.e., data from Pinsof and Catherall’s (1986) integrative alliance scales. With the knowledge of each family member’s perspective on the alliance, we searched for individual and family behaviors that might be indicative of their feelings and cognitions. Item editing occurred through repeated comparisons and negotiation of our ratings. Discrepancies prompted us to clarify items and discard those that were difficult to rate.

Originally, we attempted to rate each behavioral indicator on a 7-point Likert scale for every family member. Because this process was difficult and laborious, we clustered similar items and inductively identified 4 underlying dimensions. Then, we independently wrote definitions of these constructs, compared and integrated them, and decided which items logically related to each dimension. Testing this new procedure by rating 6 different videotapes indicated that the instrument’s interrater agreement could be improved considerably.

Next, we used a sorting task to assess the face/content validity of the instrument. To do so, we randomly ordered the 45 items and asked 17 family therapy process researchers in the U.S. and Canada to indicate which items reflect each of the 4 underlying constructs. The item, “Family members ask each other for their perspective,” for example, is located in the cluster reflecting the *Shared Sense of Purpose Within the Family* dimension. If at least 3/4 (75%) of our respondents selected the same dimension for a given item, it was retained; if not, it was eliminated or moved to a different cluster. (Participants were invited to select more than one dimension but to circle the most important one.) Participants were also asked to comment on the items or suggest additional ones.

The sorting task was also completed by seven Spanish family researchers. The SOFTA-o was translated into Spanish, and the participants performed the same task and commented on the cultural appropriateness of the items and the four underlying dimensions.

Results of both this sorting task by participants in North America and in Spain indicated a high degree of consistency, and most of the items were viewed as behavioral exemplars of the dimensions we had originally selected. Indeed, the majority of items were viewed similarly by well over 75% of the judges in both samples. Based on the criteria described above, several items were moved from one dimension to another or modified in wording. (A couple of items were removed that did not reach the 75% criterion in only one sample; we decided that it was important

to make the English and Spanish instruments identical.) None of the items needed to be eliminated because of a lack of cultural appropriateness for Spanish clients.

A similar process was undertaken to create the therapist version of the SOFTA-o. That is, we began by identifying a pool of items, some of which are parallel to the client items, conducted a face/content validation using a sorting task with experts in North America and Spain, and added, removed, and modified items based on these results.

Item descriptors were written (included in this manual) to provide raters with specific guidelines about the exact meaning of the items and the contexts in which they should be marked. Familiarity with the item descriptions is an essential part of the rating task.

The SOFTA-o is designed to be completed by trained raters while observing a videotaped family therapy session. As described below, after recording the presence of specific items in the entire session, raters make global ratings each SOFTA-o dimension on a -3 (extremely problematic) to +3 (extremely strong) ordinal scale, where 0 = unremarkable or neutral. Specific guidelines help raters determine the appropriate rating based on the valence, frequency, intensity, and context of the observed behaviors. In the client version, individual family members are rated separately on Engagement, Emotional Connection, and Safety; the entire couple of family unit is rated on Shared Sense of Purpose. In the therapist version, the therapist is rated on each dimension.

At a minimum, the raters should be graduate students in a mental health specialty, but a great deal of clinical experience is not necessary. It is recommended that at least two judges observe and rate the same family session for purposes of assessing interrater reliability, i.e., intraclass correlations.

OPERATIONALIZATION OF DIMENSIONS

While the SOFTA-o was designed for couples and family work, the first three dimensions could also apply to individual sessions, inasmuch as the behaviors of individual family members are rated. The fourth dimension, however, Shared Sense of Purpose Within the Family, is designed to rate, at a minimum, two family members seen conjointly. Depending on the investigator's purpose, the entire family system or subsystems (e.g., sibling, parental) could be rated on this dimension.

The instrument is designed to be pantheoretical, that is, to reflect aspects of the alliance that are not theory-specific. It is our assumption that all four dimensions are crucial for a solid working alliance in couples and family therapy, but some dimensions may be more salient than others depending on the therapeutic approach, the treatment setting, or the stage of therapy. The dimensions that seem most likely to vary by context are *Safety* and *Emotional Connection to the Therapist*, but the accuracy of this assumption is an empirical question that remains to be investigated.

The following are the operational definitions of the four dimensions in the SOFTA:

ENGAGEMENT IN THE THERAPEUTIC PROCESS: the client viewing treatment as meaningful; a sense of being involved in therapy and working together with the therapist, that therapeutic goals and tasks in therapy can be discussed and negotiated with the therapist, that taking the process seriously is important, that change is possible

EMOTIONAL CONNECTION TO THE THERAPIST: the client viewing the therapist as an important person in his/her life, almost like a family member; a sense that the relationship is based on affiliation, trust, caring, and concern; that the therapist genuinely cares and “is there” for the client, that he/she is on the same wavelength with the therapist (e.g., similar life perspectives, values), that the therapist’s wisdom and expertise are valuable

SAFETY WITHIN THE THERAPEUTIC SYSTEM: the client viewing therapy as a place to take risks, be open, vulnerable, flexible; a sense of comfort and an expectation that new experiences and learning will take place, that good can come from being in therapy, that conflict within the family can be handled without harm, that one need not be defensive

SHARED SENSE OF PURPOSE WITHIN THE FAMILY: family members seeing themselves as working collaboratively in therapy to improve family relations and achieve common family goals; a sense of solidarity in relation to the therapy, “we’re in this together;” that they value their time with each other in therapy; essentially, a felt unity within the family in relation to therapy

It should be noted that, like other multidimensional alliance measures (e.g., Horvath & Greenberg’s [1989] Working Alliance Inventory or Pinsof & Catherall’s [1986] Integrative Psychotherapy Alliance Scales), the four SOFTA-o dimensions are not mutually exclusive. Indeed, because they are conceptually interdependent, they are moderately correlated. Thus, a client’s sense of safety is closely related to his or her emotional connection to the therapist and feeling engaged in the process. All of these dimensions are likely to be stronger when the entire family shares a common sense of why they are in therapy and what they hope to accomplish as a result.

THE RATING TASK

There are two parts to the raters’ task. The first involves noting the presence of behavioral indicators as the session unfolds. The second involves making a judgment about the strength of each dimension immediately after viewing the entire session. The assumption underlying this method is that rating the four alliance dimensions is made by noting the presence of specific behavioral indicators, and that these observable behaviors reflect family members’ covert feelings, thoughts, and attitudes about the treatment process and relationship with the therapist.

Behavioral Items

The instrument is divided into four sections, reflecting the four dimensions described above. Behavioral indicators are listed under each dimension. In the client version, columns are labelled with the names (or roles, e.g., “mother”) of family members.

Raters watch the videotape, stopping and rewinding as needed. Whenever one of the listed behaviors is observed, e.g., “Client expresses optimism or indicates that a positive change has taken place,” the rater checks it in the appropriate blank space, e.g., under “mother” or “son.” If using the paper and pencil version, the rater is free to use idiosyncratic marks (such as checks, plusses, questionmarks, etc.) to recall the importance or clarity of each behavior. It should be noted that the items at the bottom of the list reflect a *lack* of engagement, *poor* emotional connection, a *lack* of safety, and a *lack* of a shared sense of purpose.

The rater is free to stop and rewind the tape as needed to be as accurate as possible about the presence of the behavioral indicators. During training, if several raters observe the tape simultaneously, any one of them may rewind the tape at any point. However, for purposes of assessing interrater reliability, the judges should not observe the sessions together or discuss their observations until the final, global ratings are made.

The majority of items reflect clearly observable behaviors, such as open upper body posture or crying or agreeing to do homework. However, a few items require the rater to make some inferences based on the client’s (or therapist’s) observable behavior. As one example, consider the item, “Client implies or states that therapy is a safe place.” This item should, of course, be checked if the client explicitly states that he/she feels “safe.” However, the behavior may also be present if a feeling of safety is implied but not explicitly stated. If a client were to say something like, “We decided not to talk about it anymore at home because we might keep on fighting,” the judge should infer that therapy is viewed by the client as safer than the client’s home for arguments. In other words, the rater is expected to make some inferences based on the verbal expressions of family members. The judge rater not, however, make inferences about “implied” behaviors on the basis of nonverbal behaviors alone. These distinctions are clarified in the Item Descriptions section of this manual.

Rating Each Dimension

Clients. At the conclusion of the session, the rater should make ratings for each of the four dimensions for each family member in the blank spaces provided. The anchors (extremely problematic, unremarkable/neutral, extremely strong) refer to the valence, intensity, and frequency of the behavior and its meaningfulness or contextual significance in the session. In the paper and pencil version, with the exception of the Sense of Purpose dimension, there are four columns of blank lines next to each indicator, one for each of 4 family members. (The investigator labels these columns for each family member.) At the end of each section is a 7-point, Likert scale, with anchors -3 (extremely problematic), 0 (unremarkable or neutral), and +3 (extremely strong); blank spaces are used for the final ratings. (Note that only one space is provided for the Shared Sense of Purpose dimension, since only one rating is made for the family or couple as a whole.)

As discussed earlier, the individual items are assumed to be behavioral indicators of the more global, underlying dimensions, which are defined in more subjective terms (i.e., in terms of the clients' cognitions and affect). Raters need to use the check marks they made on the individual items to make their overall ratings rather than rely simply on an intuitive sense about each dimension.

In developing the instrument, we realized that it is impossible for a rater not to make comparisons of the strength of the alliance across family members while watching the videotape and making ratings. Thus, the rating of each family member can be influenced by how the judge rates other family members. For this reason, we created the following guideline: The rater should first look at the check marks and decide who in the family is the *least* involved, connected. This person should be rated first, followed by the family member who is the *next least* involved, and so forth. In this way, the most involved or committed family member is rated last.

When using the client version, to facilitate the process of going from the check marks to the ratings, raters should use the following guidelines for the *Engagement, Safety, and Emotional Connection* dimensions:

- 3 = extremely problematic**
- 2 = moderately problematic**
- 1 = somewhat problematic**
- 0 = unremarkable or neutral**
- +1 = somewhat strong**
- +2 = moderately strong**
- +3 = extremely strong**

- 1) If *no* checks are made in a given dimension, the score should be 0. This means that the alliance is unremarkable, not skewed in either a negative or positive direction, and the client is viewed as at least moderately aligned (otherwise, he or she would be protesting the therapy or would leave the room). In family therapy, it sometimes occurs that a client does not speak during a given session, particularly if there are many people in the room. If there are no negative or positive indicators and the client does not speak, the rating should be 0.
- 2) If *only negative* items are checked, the score must be less than 0. Rate the client as -3 (extremely problematic) *only* if it's clear that the person is antagonistic to the therapy and demonstrates that antagonism behaviorally -- otherwise the score would be a -2 or -1 depending on a decision about how negative the behaviors seem to the rater.
- 3) If *only positive* items are checked, the rating *must* be above 0.
- 4) If the only positive item is nonverbal (open upper body posture, eye contact, mirrored body language), the rating should be +1 (somewhat strong).

- 5) A +3 (extremely strong) is given *only* if it's clear that the client is *highly* invested in the therapy, as demonstrated by showing a great deal of vulnerability (Safety) or taking a very active part in the therapeutic process (Engagement) or there is clear, important caring demonstrated toward the therapist (Emotional Connection). Otherwise, the score should be a +1 or +2 depending on how positive the rater views the behaviors. If the client is crying from the heart, for example, the rating would probably be a +2 (moderately strong).
- 6) If there are *both positive and negative* items checked, the rating should be either -1, 0, or +1 depending on an assessment of the balance in frequency or meaningfulness of the checked behaviors. In this case, a 0 means neutral, i.e., that the negative and positive items are judged to cancel each other out.
- 7) A -3 (extremely problematic) is given *only* when it's clear that the client is *absolutely not at all* invested in the therapy.

The rater's task is, nonetheless, somewhat subjective. Some behaviors, particularly the nonverbal ones, can occur throughout the session (e.g., "Family members mirror each other's body posture"), whereas most of the other behaviors are likely to occur once or a few times. Here is where the judge needs to decide on the significance, or clinical meaningfulness of the behavior. If, for example, a family member "agrees to do homework assignments" once and with minimal enthusiasm, the rating might be +1. If the family member asks for details about the assignment and talks about when, how, and under what circumstances it will be done, the rating might be +2. If the family member is particularly enthusiastic and committed to the assignment, the rating might be +3.

As another example, consider the item, "Client refuses or is reluctant to respond to the therapist." If this occurs once or minimally, the rating would be -1. If the client spends a fair amount of the session refusing to speak, the rating could be -2. If the session is entirely spent this way, the rating would be -3.

For *Shared Sense of Purpose*, one rating is given for the entire family or couple. The judges should be aware that this dimension refers to a shared sense of purpose *about the therapy*, not about the family in general or the presenting problem. In other words, a couple might enjoy each other's company a great deal yet have very different views on the value of therapy for improving their relationship. Alternately, everyone in the family might agree that Bobby has a problem; this agreement reflects a shared sense about what the problem is, but not necessarily a shared sense of purpose *with respect to the therapy*. The parents, for example, might indicate that the focus of therapy should be Bobby's misbehavior, but Bobby might state that the therapy is a complete waste of time or that he thinks the therapist should focus on his parents' strictness and his father's alcoholism. In this case, the sense of unity within the family with respect to the therapy is not optimal.

Raters should use the following guidelines to go from the behavioral ratings to the overall rating for *Shared Sense of Purpose*:

- 1) Judges first need to see how many family members have positive and negative items checked.
- 2) If there are *no* items checked *for any family member*, the rating should be 0, i.e., *unremarkable*. As with the other ratings, the assumption is that there is at least a moderate sense of purpose within the family if everyone is there and is not showing any behavior indicative of a poor alliance.
- 3) If there is *at least one positive item and no negative items checked for every family member*, the rating should be at least +1, and could be +2 or +3, depending on the rater's judgment of the number and meaningfulness of the checked items.
- 4) If there is *at least one negative item for only one family member and no positive items checked for anyone*, the rating should be -1 or -2, depending on the judgment of just how negative the behavior is in the session.
- 5) If *two or more family members have only negative items checked*, the rating should be -3 or -2.
- 6) If there are *both positive and negative items checked for any one family member*, the judgment should either be -1, 0, or +1 depending on an assessment of the balance in frequency or meaningfulness of the checked behaviors.
- 7) If there is a major disagreement between family members expressed in the session about the value of therapy or what is going to be accomplished there, the rating should be -3, *even if* no other negative items are checked.

Therapists. The rating guidelines for the therapist version are identical to those above. Note that while the clients' behaviors *reflect the strength of the alliance*, the therapist's behaviors *reflect contributions to the alliance*. Thus, a rating of +3 means that the therapist is contributing very strongly to the clients' Engagement, Safety, and so on, whereas a rating of -3 means that the therapist's behavior is highly detrimental to the clients' experience of each dimension of the alliance.

RELIABILITY

Like other multidimensional alliance measures, the four SOFTA-o dimensions are not mutually exclusive. Indeed, they are conceptually interdependent. Thus, a family member's sense of safety in the session is closely related to his or her emotional connection to the therapist and to feeling engaged in the process. The degree to which all family members are active collaborators is reflected in their shared sense of purpose. Reciprocally, when the family shares a common sense

of why they are in therapy and what they hope to accomplish, individual family members feel a stronger bond with the therapist.

Interrater reliability is computed, as an intraclass correlation, when there are at least two raters. In our development of the SOFTA-o, we conducted an initial reliability test with 28 archived videotapes of family sessions that had been used in other process studies. Six graduate student judges achieved mean ICC and reliabilities as follows:

<i>Dimensions:</i>	<i>ICC</i>
Engagement	.89
Emotional Connection	.88
Safety	.74
Shared Sense of Purpose	.95

In subsequent work with the SOFTA-o, we have achieved intraclass correlations varying from .72 to .95 across dimensions, in both English and Spanish, and for the therapist version as well as the client version of the SOFTA-o.

The final rating, the one used for any analysis of the data, should be the consensus rating. That is, if two raters make the same rating (e.g., 0) and the third individual rates the client (or therapist) differently (e.g., -1), the rating used in the analysis would be 0. If the three ratings are all different, the two closest ones could be averaged. For example, the three ratings are -1, 1, and 2. In this case, the -1 would be dropped, and the rating used in the analysis would be 1.5. When only two raters are used, it is preferable for them to negotiate their ratings, although averages may also be used.

TRAINING RATERS

Whether the paper-and-pencil instrument or the e-SOFTA is available, and whether or not the SOFTA-o is being used for clinical supervision (or self-supervision) or for research, accurate training is crucial. Some features are common to training for practice and for research. Whatever the purpose, raters need to gain a clear understanding of the SOFTA theoretical model, which is best obtained by reading Friedlander, Escudero, and Heatherington's (in press), *Therapeutic Alliances in Couple and Family Therapy. An empirically-informed guide to practice*, particularly Chapters 2-8. In other words, raters need to understand the conceptual model underlying the instrument and be familiar with the operational definitions of the four SOFTA-o dimensions and the item descriptors within each dimension. Reading the many clinical examples in our book is particularly helpful, particularly when accompanied by group discussions with a supervisor or investigator who is already familiar with the model.

Once raters are familiar with the SOFTA-o, they should become quite familiar with the behavioral items so that, when rating a session, they can easily remember where to locate a given item within the instrument. Recall is particularly important when using the e-SOFTA, because the

rating screen only shows one dimension at a time; if a user wants to rate a session on all four dimensions, he/she must switch back and forth between dimensions to locate the items.

If using the instrument for research, the trainer should focus raters on the operational definitions, which need to be referred to whenever in doubt about the presence of a given behavior. A number of items have discriminating features that are explained in the item descriptors. Of course, discussions like this can also be highly useful for clinical practice.

Whether using e-SOFTA or downloading just the training vignettes from the website (www.softa-soatif.net), raters should work with all of the training vignettes before proceeding to their own data. There are 32 total, 16 in English and 16 in Spanish (8 therapist, 8 client). These brief excerpts (no more 2 min.) have several behaviors, both positive and negative, and focus on a single dimension at a time. Users should rate each vignette and then compare his or her ratings with the “Solution” (also available within e-SOFTA and from the website www.softa-soatif.net), paying close attention to the qualitative comments that explain the marking of individual items and the exact time of the marking. When using the computer program, the time stamps can be used to locate the correct segment and to re-play the video at the precise moments any errors were made (see TUTORIAL within e-SOFTA). The operational definitions of items (i.e., item descriptors) should be consulted whenever the raters make errors.

When using the SOFTA-o for clinical purposes only, once the rater’s results on the training tapes compare favorably with the “solutions,” the rater can begin working with his/her own videos. We recommend training raters on *either* the client or the therapist version first rather than attempting to learn the entire system simultaneously. Because there are fewer individuals to observe at a time, the therapist version is more easily learned. For research purposes, it is ideal to have two teams of raters, one working only with client behaviors and one working only with therapist behaviors. We strongly recommend *against* trying to rate both clients and therapists simultaneously, even after raters are familiar with the instrument.

To achieve good interrater reliability, we recommend selecting 6-12 practice videotapes that are representative of the investigator’s final data set. Ideally, these training tapes should have few clients and good sound and video quality, as well as examples of negative as well as positive Engagement, Emotional Connection, Safety, and Shared Purpose. The difficulty level should be increased gradually as raters become fluent with the task.

We recommend working with a single dimension at a time. Either a VCR can be used or videos can be loaded directly into e-SOFTA. Moreover, when just beginning, raters should work together with a few tapes, sharing their observations and deciding on the ratings together. Next, raters should try rating all four dimensions simultaneously, again sharing their observations with each other.

Of course, to assess interrater reliability, raters must observe the same sessions independently. During the rating of actual data, members of the rating team should rate the same sessions during the week and come together to compare their results and negotiate to consensus when necessary. Because rating is tiring, we recommend that users do not rate more than two full

sessions at a time. It is essential for raters to meet regularly to compare their results before they get “cold,” as rater drift can be problematic with this system as it is with any observational rating or coding system.

Raters should closely compare their behavioral tallies as well as their global dimension ratings. Practice should continue until the raters, as a group, tend to make dimensional ratings that differ by no more than a single scale point at least 90% of the time. Then reliabilities can be computed.

Reliability, assessed by intraclass correlation, is assessed separately for each SOFTA-o dimension. At least 10 therapist tapes or 5 client tapes are needed to achieve enough reliability. It is possible to lighten the raters’ burden by using partial sessions when assessing reliability, although the entire session should be used for research analyses.

Good reliabilities can typically be achieved in 10-15 hours of training. In selecting raters, the investigator need not choose individuals who are highly experienced clinically. SOFTA-o does not require a great deal of clinical sophistication, and even students with little or no clinical experience can achieve good reliabilities. Good social skills are, of course, necessary, since judgments need to be made on the meaningfulness of the SOFTA-o items in context. We also recommend using both male and female raters if at all possible, inasmuch as women and men tend to see interpersonal behavior differently. Attention to detail and conscientiousness are essential characteristics for SOFTA-o raters, as they are for any rating system.

At times, for whatever reason, rater may consistently come up with different results from the others’. If there are at least two other raters being trained, this individual’s reliability can easily be checked by computing the intraclass correlation value with and without his or her ratings. If the inclusion of this individual’s ratings diminishes the reliability value by .10 or more (on practice videos), we recommend not using him or her for the actual research data.

Reliabilities can be affected the nature of the clinical material, the raters’ diligence, and/or the frequency with which raters meet to negotiate their results. Whenever raters have more difficulty with one or two dimensions, a training “booster sessions” is advised. We cannot overemphasize the importance of frequent meetings, both during training and when the actual research data are being rated.

When using the SOFTA-o for clinical purposes, it is not necessary to recall the dimensions’ and items’ operational definitions, but a group discussion of these definitions can be highly worthwhile as students learn the system. Indeed, the nuances in the SOFTA-o have value for clinical practice and supervision as well as research.

CLIENT ITEM DESCRIPTORS

ENGAGEMENT IN THE THERAPEUTIC PROCESS

Client indicates agreement with the therapist’s goals.

After the therapist has explicitly identified or described the purpose for therapy or the goals for the treatment, the client says something that indicates acceptance of the therapist's perspective. The client might explicitly ("Yes, that's good") or more implicitly agree (e.g., "Well, that makes sense because..." or "Let's get started then").

Client describes or discusses a plan for improving the situation.

With or without prompting from the therapist, the client explicitly describes what he or she will do or think in working toward improvement. It could be an elaborate plan, such as "making sure to give each family member a compliment every day," or a more diffuse idea, such as "trying to look on the bright side of the situation." The client must explicitly articulate what he/she will do, *not* merely agree with the therapist's plan or suggestion in order for this item to be checked. This would not include situations where the client is telling others what to do.

Client introduces a problem for discussion.

With or without prompting from the therapist, the client explicitly identifies something specific that he/she would like to deal with in the session (e.g., "I think we need to talk more about how we communicate when we are angry"). The client must initiate the topic, *not* merely agree with the therapist's suggestion or identification of a problem in order for this item to be checked.

Client agrees to do homework assignments.

A "homework assignment" might be specifically prescribed by the therapist (e.g., "Over the next week, I'd like you to..."), or might be a more general suggestion (e.g., "One thing you might try that has helped other people in your situation is to..."). The client must explicitly say something to indicate he or she will carry out the "assignment." A mere head nod or "mhm" is *not* sufficient to check this item. If, however, the client asks a question about the homework that suggests that he/she plans to do it, such as, "Should I also write down everything my wife does?", this item can be checked.

Client indicates having done homework or seeing it as useful.

This item is checked either in response to the therapist's questioning about the "homework" assignment (a specific plan or a general suggestion), or without being asked, the client mentions the value of the homework or at least indicates having attempted it. If the client indicates that he/she decided not to do the homework or could not find time to do it, this item should *not* be checked.

Client expresses optimism or indicates that a positive change has taken place.

With or without questions from the therapist, the client describes feeling hopeful or seeing that change is possible, either for him/herself, for other family members, or for the family as a whole. This item can be checked if there is a straightforward expression of “things are looking up,” or “we can make a change,” or “we’re getting somewhere now” or if the reference to optimism is indirect, such as “Well, I always think about the positives.” Optimism implies hope for positive change, whether it be a small behavioral difference, saving a marriage, or keeping a teen out of trouble. This item can also be checked if the client’s comment relates to a positive sense about the therapy, such as “Now that we’re here, we can really work on this.”

Client complies with therapist’s requests for enactments.

In response to the therapist explicitly asking a client or some clients to do something *in the session*, the client does so. This might involve specific behaviors, such as changing chairs to face each other, or talking with another family member about something that the therapist suggests (e.g., “Why don’t you two talk and try to come to some understanding about how you are going to deal with...”). The “enactment” need not be an elaborate technique, like family sculpting, but simply following the therapist’s suggestion to do something or try something differently in the session (e.g., breathing deeply before speaking, holding hands, looking in each other’s eyes).

Client leans forward.

This item is only checked when the client *moves to lean forward* in response to something being discussed in the session or when being asked a question by the therapist or another family member. If the client is sitting forward throughout all or most of the session, this item is checked only once. If the client moves back and forth in the seat in response to what is being discussed, each discrete forward movement is checked.

Client mentions the treatment, the therapeutic process, or a specific session.

This item is to be checked when the client brings up the therapy as a topic (its value, the need for it, what is going on in the process, etc.). Examples would include remarking that the previous session brought up a lot of issues or that the client looks forward to the session or asks how long the therapist thinks the therapy will need to continue. If the client has negative things to say about the therapy, this item is *not* checked (see negative item about “feeling stuck”). Further, the item is *not* checked when the client merely responds to questions the therapist asks regarding the therapy (e.g., “How did you feel about last week’s session?” or “How do you think this process is going for you?” or “What would you like to talk about today?”). Note that if the client mentions in the treatment in the context of improvement or optimism (e.g., “Things have been better since we started coming here”), the item “client expresses optimism...” should take priority.

Client expresses feeling “stuck,” questions the value of therapy, or states that therapy is not or has not been helpful.

This negative item is checked when the client explicitly mentions dissatisfaction with the way the therapy is going, the need for it, or the direction it is taking. This expression of negative attitude or emotion may or may not be in response to the therapist's question or to the question of some other family member. This item is *not* checked if the client's response is vague, such as "I don't know," or "Okay, I guess," even if a negative attitude is suspected. Such vague expressions might be indicators of another negative item, i.e., showing indifference. That is, for this item to be checked the expression of dissatisfaction must be clear and overt.

Client shows indifference about the tasks or process of therapy (e.g., paying lip service, "I don't know," tuning out).

Paying lip service refers to superficial compliance with what is being asked or suggested by the therapist or other family members. Indifference may be shown nonverbally, as in doing something else (e.g., cleaning out a pocketbook, filing nails), not following the flow of conversation, looking around the room at what's in the office. As with other nonverbal items, it is more than just a momentary lack of attention, and for this item to be checked, nonverbal behaviors need to be fairly obvious. Verbally, people can show indifference by a notable lack of energy or enthusiasm (e.g., "Sure, if you like, we can try that"). Indifference tends to be inferred from tone of voice. More obvious comments might be, for example, "Okay, but I doubt it will make any difference in the long run." This item should *not* be checked for young children, who can be expected to let their attention wander during a session. Showing a lack of investment in participating in the session.

EMOTIONAL CONNECTION TO THE THERAPIST

Client shares a lighthearted moment or joke with the therapist.

This item refers to a behavioral connection through humor or good will, typically signalled by laughter. The comment could be initiated by the therapist or the client, but both parties need to be simultaneously amused for this item to be checked.

Client verbalizes trust in the therapist.

The client's comment might be an overt statement like "I trust you," or a more implicit remark that suggests trust, such as, "I know whatever I say here stays in this room" or "This is something I couldn't talk about with other people." The comment is more than an indicator of feeling safe in the therapy context; it needs to connote a personal sense of trust in the therapist, a recognition that the therapist is a trustworthy individual. Other examples include, "I believe what you're telling me." In distinguishing between this item and "feels understood or accepted," the crucial element is trusting the therapist or trusting that what is said in therapy will be held in confidence. If the comment indicates that the clients *feels* trusted *by the therapist*, consider the item "feels understood or accepted."

Client expresses interest in the therapist's personal life.

Clients sometimes ask questions about the therapist's situation, such as whether he or she is married or has children or whether the therapist is spiritual or religious, or where the therapist grew up. This item can be checked if a direct question is asked or if, in response to the therapist's self-disclosure, the client follows up with a comment that suggests interest in the therapist as a person. As one example, the therapist talks about his grief when his father died, and the client asks, "Was he very old?" This item is *not* to be checked if the client asks about the therapist's credentials or professional experience, or if the question is delivered in a manner that suggests defensiveness, a lack of confidence, or testing ("How do you feel about gays?").

Client indicates feeling understood or accepted by the therapist.

This item implies more than a sense of safety and comfort in therapy; it requires some indication that the client feels valued, respected, or trusted by the therapist. An explicit verbal comment might be made, such as, "I know *you* don't judge me like other people do" or "I could tell *YOU*, but no one else." Alternately, the client's response might be nonverbal, such as tearing up after the therapist makes an empathic comment. Nonverbal responses like these, however, should only be checked if there is a clear implication of feeling understood or accepted.

Client expresses physical affection or caring for the therapist.

This item is checked when, for example, the client offers his/her hand at the end of a session, or asks for a hug. Caring can be inferred from comments like, "Are you feeling better? You were sick when we were here last week," or "What you think means a lot to our family."

Client mirrors the therapist's body posture.

For this item to be checked, arms and the legs must be placed similarly. It is not necessary to try to determine whether the therapist mirrors the client or *vice versa*. (That is, a connection between client and therapist is reflected in the mirroring, regardless of who mirrors whom.) This item should only be checked once during a session, unless the client is clearly and obviously mirroring every move of the therapist. Mirroring can be associated with specific body posture changes, as when the therapist shifts body position notably when the discussion becomes more intense and the client mirrors that movement. When working with adolescents, it is common for therapists to mirror the adolescent's informal body posture.

Client avoids eye contact with the therapist.

For this nonverbal item to be checked, the client must, clearly and consistently, avoid eye contact with the therapist. There can be momentary "peeking" at the therapist, however.

If the client avoids eye contact for a substantial period of time (minutes, *not* seconds), this item can be checked. Also, when the therapist asks a question (“Do you want to continue our sessions?”) or says something directly to the client in a context in which eye contact is expected, if the client avoids making eye contact, the item should be checked.

Client refuses or is reluctant to respond to the therapist.

This item is checked when, either verbally or nonverbally, a client fails to respond to a direct request (question or remark) from the therapist, indicating either a negative reaction to the therapist or not wanting to comment. A lengthy silence in response to a question is one example if, in context, the silence suggests a clear reluctance or refusal to engage when invited to do so. Silence that occurs because the client is thinking hard about what to say should *not* be checked. Verbal expressions of reluctance include, “I’d rather not talk about it,” or “It’s none of your business” or “That’s personal.” If the client is clearly reluctant but later relents and does respond hesitatingly, the item can be checked if the reluctance was notable or prolonged.

Client has hostile or sarcastic interactions with the therapist.

This item is checked only if there is tension in the room and/or anger is expressed, *not* merely a disagreement about what was meant or what should be done. Essentially, this item connotes a disrespect or de-valuing of the therapist on the part of the client.

Client comments on the therapist’s incompetence or inadequacy.

Typically, it is client “hostages” who make cutting remarks about a therapist’s competence. This item is checked when the client’s comments suggest a belief that the therapist is not behaving therapeutically, ethically, doesn’t know what he/she is doing, can’t possibly understand, doesn’t have sound credentials, and so forth. This item speaks more to the therapist’s ability to work with the client than to feelings about the therapist as a person. Deprecating personal remarks are indicated by the item “hostile or sarcastic interactions with the therapist.”

SAFETY WITHIN THE THERAPEUTIC SYSTEM

Client implies or states that therapy is a safe place.

The client might not necessarily use the word “safe,” but the implication in his/her words is that he/she feels safe. This item requires some kind of verbal indicator; nonverbal indicators are *not* sufficient for this item to be checked. Implicit examples are when someone says he/she decided to wait until the therapy session to discuss something with a family member or says something like, “It’s okay to cry in here” or “I didn’t know whether I would have the courage to tell you, but...” or “I’m glad we finally made it here.” The point is that the client suggests that the therapeutic environment is valued for its

safety, not only as a place to solve problems. At times the indicator may be quite subtle, as “I don’t know quite how to say this, but I’ll just take the plunge,” or “I hope you [other family member] don’t mind my saying this, but....”

Client varies his/her emotional tone during the session.

This item refers to a nonsubtle tone variation. Of course, all clients vary their tone over the course of a session, but this item suggests variability with emotions like anger, sadness, fear, happiness, which is signalled by tears, laughing, angry words or tone of voice. This item is *not* checked if the client is fairly neutral or calm throughout the entire session or if the client is crying *or* hostile and angry throughout it all. Also, this item is *not* checked if the tone is simply excitement. In other words, emotion refers to feelings of sadness, anger, happiness, or fear. Note that this item can only be checked once, *not* every time the tone varies because it refers to the presence of a plasticity of emotions.

Client shows vulnerability (e.g., discusses painful feelings, cries).

For this item to be checked, either the process of the session is a difficult one for the client (shown by crying, for example) or the content of what the client is discussing is difficult and painful (shown by hesitation, anxiety, or verbal expressions of how hard it is to talk about something). Sometimes the content of the client’s messages alone suggest vulnerability, as when one family member asks another if he loves her or when one family member asks another for help or forgiveness (i.e., the client is clearly “going one-down” in interaction with another client or the therapist). Some clinical judgment may be needed with this item. The judgment here is whether the communication seems to be difficult *for the client*. For some clients, admitting depression or anxiety would be a sign of vulnerability (shown by tone of voice or nonverbal manifestations of unease), whereas for others, such an admission is *not* a sign of vulnerability.

Client has an open upper body posture.

Although some people naturally sit in an open position, this item is checked when *in response to what is occurring in the session* the client shifts to an open upper body position. The item is also checked (once) if the client sits that way naturally throughout the session. If the client moves back and forth from open to closed body posture in response to the surrounding interaction, each time he/she opens up, the item should be checked.

Client reveals a secret or something that other family members didn’t know.

For this item to be checked, it must be clear that the client is saying something that is news to other family members. (The “something” needs to be something meaningful, not mundane, such as what the client had for dinner.) The information may or may not be a SECRET that has been deliberately withheld (e.g., the father’s alcoholism, the wife’s affair, the child’s failing grade) but some important piece of information, a fact, that was

not common knowledge, such as the daughter having reached puberty or the fact that the son doesn't respect his father. For this item to be checked, the revelation of material is significant enough to signal that the speaker feels safe enough to tell others something that was previously hidden or private, i.e., something it did not feel safe to disclose at home.

Client encourages another family member to “open up” or to tell the truth.

Commonly, this item is checked when a parent gently (not harshly) urges a child to speak, but it may also be a statement between adults like, “It’s okay. You can tell [therapist]” or “This is the place to discuss it,” or “We won’t get anywhere if you don’t tell me how you really feel,” and so forth. For this item to be checked, the tone of voice must be one that encourages rather than demands disclosures, i.e., suggesting that it is safe to talk about these things in therapy.

Client directly asks other family member(s) for feedback about his/her behavior or about herself/himself as a person.

It is risky to ask other people for their candid impressions of oneself. This item is checked only when the client explicitly asks for feedback about behavior, as in “Do you think I’m doing better?”, or about how he/she is perceived by others, “Do you think I’m overweight? attractive? a good parent? nice enough to my mother?” Questions could also include how the other person construes the speaker’s behavior, as in, “Why do you think I did that?”

Client expresses anxiety nonverbally (e.g., taps or shakes).

This negative item implies a lack of safety in the therapy environment. Although some people are naturally more anxious than others, this item is to be checked only when there is a clear, overt sign of anxiety, such as fidgeting, shaking, quavering voice, and so forth. If the anxiety persists at the same level throughout the session, it should be checked only once, unless the anxiety is so heightened or disruptive that it warrants additional check marks. If the anxiety is demonstrated in response to something that is said or takes place in the session, the item should be checked each time the overt anxiety is manifest. Note that this item only refers to *nonverbally* communicated anxiety. If the client talks about how anxious he/she feels in the session, the item “shows vulnerability” should be considered instead.

Client protects self in a nonverbal manner (e.g., crosses arms over chest, doesn’t take off jacket or put down purse, sits far away from group, etc.)

Self-protecting behavior can have many meanings, and this item should only be checked when the context of the session suggests defensiveness. For example, many people cross their arms over their chest for comfort. But the item should be checked when the arms crossing is clearly in relation to what is being said in the session. As an example, the father crosses his arms when the therapist asks the daughter, “How would you describe

your relationship with your father?" Another example would be the wife crossing her arms as the husband starts to talk about her lack of sexual interest. At times a client might cross his/her arms on arrival in the therapy room, and this is a defensive pose. Thus, if the arms crossing is not clearly in relation to what is going on, this item should *not* be checked. If the arms crossing occurs throughout the session *and* there are *other* clear, nonverbal signs of defensiveness (hand on forehead while looking down, legs crossed in air as if to create a barrier, looking anywhere but at other family members, coat over lap), this item should be checked. Clinical judgment can be used here; if the behavior seems defensive or self-protective in the context of the session (keeping coat on, purse over chest, umbrella in hands, or moving one's seat away from the group), this item can be checked.

Client refuses or is reluctant to respond when directly addressed by another family member.

This item is checked when, either verbally or nonverbally, a client fails to respond to a direct request (question or remark) from another client. A lengthy silence in response to a question is one example, if the silence indicates either a negative reaction to the other family member's request. Silence that occurs because the client is thinking hard about what to say should *not* be checked. If verbal, the response must clearly indicate a reluctance or refusal to engage when invited to do so. Verbal expressions of reluctance include "I'd rather not talk about it," or "It's none of your business" or "That's personal." If the client is clearly reluctant but later relents and does respond hesitatingly, the item can be checked if the reluctance is notable. Reluctance can be signalled when a client avoids answering a question by turning to a third person, as in: Husband (to wife): "Tell me why you don't want to go out with my sister." Wife (to therapist): "You should just MEET his sister, wow! She is so obnoxious to me!"

Client responds defensively to another family member.

Defensiveness is indicated when, in a non-hostile manner, the client uses clearly complaining or criticism in response to other family member who is demanding explanations or justifications for his/her behavior. Often, defensive responses are part of a communication pattern called "cross-complaining": one family member complains about the behavior of another, and the target of the complaint responds by complaining about any behavior of the first one. If the defensiveness is directed toward the therapist, this item should not be checked. If the client's tone is angry or hostile, the item *Family members blame each other* should be checked instead, and if the comment is not hostile but is devaluing or disrespecting of the other person, the item *Family members devalue each other's opinions or perspectives* should be checked. In other words, defensiveness is indicated when the client has been put on the spot by another family member to explain or justify his or her own attitude, behavior, or choices and answers back by complaining defensively about any behavior of the other (instead of explaining his/her own behaviors). Examples include (without overt hostility): "You are asking me about my behavior with your son but you do not say anything about your behavior with YOUR sister" or "You are

saying you do not understand my hostility but last week YOU were very aggressive with me too, you yelled me three times.”

Client makes an uneasy or anxious reference to the camera, observation, supervisor, or research procedures

This item is indicated if the client spontaneously mentions these extra-therapy procedures in a way that suggests uneasiness. Examples might be, “Do you tell your supervisor everything we say?” or “I wish we could turn the camera off sometimes” or “How do I know that you won’t send the tape to Child Protective Services?” A nonverbal indicator might be looking warily at the camera and then deliberately leaning forward and speaking much more softly.

SHARED SENSE OF PURPOSE WITHIN THE FAMILY

Family members offer to compromise.

The offer may or may not be in response to the therapist’s request for a compromise. Sometimes the client’s offer to another is clear, as in “Well, if I do [this], will you do [that]?” A client might only make one part of the offer, such as “I could [do this]” or “I’m willing to....” Typically people compromise on something behavioral, but the compromise could also be cognitive, such as “I’ll try to stop looking for the negative in everything, if you do.” The therapist might ask each member of the family to think of something positive to do in relation to other family members, and if the client comes up with something, that could be considered a compromise, such as, “I’ll help Mom with the dishes.” These statements need to be considered in a context of *quid pro quo*. That is, if a client merely offers to do something different without an implicit or explicit expectation that another family member will also do something in return, the item “Client offers a plan for improving the situation” (Engagement) should be considered instead.

Family members share a joke or a lighthearted moment with each other.

This item is checked only if the humor is evoked during the session, not before it gets started or as people are leaving. The humorous moment may or may not involve the therapist, but for this item to be checked, there needs to be some connection among the family members, i.e., joking *with* each other, or making eye contact while laughing together. One exception is when a joke reflects negatively on another member, or when family members joke together at another’s expense (see the item “*client makes hostile or sarcastic comments to family members*”).

Family members ask each other for their perspective.

This item is often a precursor to an offer to compromise. For the item to be checked, family members must explicitly speak with one another, and one person needs to ask

another what he/she thinks, feels, or wants to do. Examples include “How do you see it?” or “What do you think is causing this problem?” or “How would you suggest we solve it?” However, simple questions about agreement regarding information or something prosaic (“Was it Wednesday or Thursday that you...?” or “Who said that, Mom?”), this item should *not* be checked. Also, if spoken sarcastically, however, this item should *not* be checked. This behavior is also *not* checked when it was prompted by the therapist, asking, for example, “Why don’t you ask your dad and mom how they see your plan?” (see “complies with therapist’s requests for enactment”).

Family members validate each other’s perspective.

Although validation tends to be thought of as positive (e.g., “I can see where you’re coming from” or “That makes a lot of sense”), positive content is *not* required for this item to be checked. A couple might agree in the session with each other, for example, that their marriage is over and that they need to separate. The validation might be mixed with other messages, such as, “Although as your mother, I’m hurt by this decision, I recognize your right to do what you want.” This item requires some verbalization, *not* merely head nods or “mhmm.”

Family members mirror each other’s body posture.

Doing so is generally unconscious rather than deliberate. For this item to be checked, at least two family members must be positioned similarly with respect to both arms and legs. It is important to pay attention to specific moments in which somebody changes his/her body position in response to what is being discussed and another family member mirrors that shift.

Family members avoid eye contact with each other.

Eye contact is a personal and cultural experience. Some people maintain good eye contact with everyone, so that doing so does not necessarily mean there’s a connection. However, the avoidance of eye contact with other family members throughout the session, such as when everyone looks at the therapist and never at each other, is notable. Thus, for this item to be checked, the avoidance needs to be notable, consistent, or prolonged. Avoidance of eye contact among family members is particularly notable when one family members is speaking and others do not look at him/her.

Family members blame each other

In determining whether or not blame is present, a distinction needs to be made between expressing blame *vs.* simple responsibility for an action or problem. Blame is usually carried in tone of voice and implies fault. Further, blame tends to be indicated when the client describes a specific event or problem as clearly avoidable, intentionally caused, or due to another client’s negative attitude. Terms like “blame,” “fault,” “if only you had[n’t]...” may or may not be present. Blame may also be expressed through a highly

negative, accusatory, or pejorative manner. For this item to be distinguished from the items “devalue each other’s point of view” and “makes hostile or sarcastic comments,” the client must be blaming another client *for something*, typically for the problem under discussion, or for having done or not done something, for having made a poor decision, and so forth. Examples include, “Your drinking caused all our problems!” or “My son lost his job because he seems to think he can come in late and the boss won’t mind!” or “You screwed up as much as I did when it came to parenting.”

Family members devalue each other’s opinions or perspectives.

This item is checked if the client verbally says something to contradict another client’s point of view in a way that suggests disrespect. The item can be checked if the statement is made angrily, but *not* if it is made sarcastically or in a mean-spirited way (see item “makes hostile or sarcastic comments”). Examples include, “You don’t have the right to ask me that!” or “That may be *your* point of view, but that’s just because you don’t give a damn!” or “Who gives you the right to talk to me that way?” The essential point of this item is that clients are not listening to each other in an accepting way. The key feature is disrespect rather than hostility. Note that if blame (i.e., ascribing fault for having done or said something) is expressed, consider the item “family members blame each other.” Note that devaluing is different from simple disagreement (“That may be *your* point of view, but I think you’re wrong!”).

Family members try to align with the therapist against each other.

Verbal expressions of this item include a client asking the therapist for an opinion in the midst of an argument with another family member or directly asking the therapist to choose sides, to decide who is right, or to intervene in a specific way with someone else, or joking with the therapist at another client’s expense. The meaning of “against” is not necessarily a disagreement, however. It may simply be that one family member accentuates a controversy by including the therapist on his/her side. Examples of these less overt behaviors include saying to the therapist, “Can you tell him again what you told him last week?” or “My father needs to be told that he has to see a doctor for his heart.” As another example, one adolescent may tell another in his mother’s presence, “You need to listen to [therapist], not to mom!”

Client makes hostile or sarcastic comments to family members.

For this item to be checked, there needs to be a mean-spirited exchange, not merely an argument. Name calling, cursing, or threats are examples. The interchange must suggest not only disrespect (see item “devalue each other’s opinions”) but also rage, condescension, contempt, or disgust. If blame (i.e., fault for having done or said something) is expressed, consider the item “family members blame each other.” Joking with one family member at another’s expense could be also an example of this behavior when the joke implies hostility.

Family members disagree with each other about the value, purpose, goals, or tasks of therapy, or about who should be included in the sessions.

The argument or disagreement needs to be clear, *not* implicit or simply nonverbal. Further, this item is only checked if the disagreement or argument is among the clients, *not* between one client and the therapist (see item “questions the value of therapy” under Engagement). This item should be checked rather than the item “*family members try to align with the therapist*” when the disagreement or argument is about the goals, tasks, or value of therapy, as in, “You heard what [therapist] said! We need to be here!” Other common examples include, “If you don’t take this seriously, it doesn’t make sense to come here” and “Why is HE coming? He NEVER does his part in anything!”

THERAPIST ITEM DESCRIPTIONS

THERAPIST’S CONTRIBUTIONS TO ENGAGEMENT IN THE THERAPEUTIC PROCESS:

Therapist explains how therapy works.

This behavior includes all types of explanations about the therapy process: time (duration of sessions, length of treatment, intervals between sessions), activities, theoretical models or methods, formats (individual, group, family), team work, consent forms, legal/institutional obligations, use of recording or observation by others, etc. The item should only be checked when an explanation is given in some detail and actively, although it may be in response to a client’s question. Incomplete or hesitant descriptions of therapy should *not* be checked, nor should the item be checked if the therapist makes a vague response to the client’s question, as in:

Client: Do my parents always have to come?

Therapist: We’ll see. Therapy can be with parents or not.

If, however, the therapist were to respond as follows, the behavior would be checked: “It may be that it’s not always necessary. In the course of therapy, we can all decide together which people can contribute something in a session depending on what we all consider useful. In that case no one feels obliged if they decide they shouldn’t or don’t want to come” *or* “Our kind of work implies that these decisions are made with everyone’s agreement. Your participation is very important in how we work here.” **Note:** If consent forms or the use of recording/observation is simply mentioned in explaining how therapy is done in the setting, this item should be checked. If privacy or confidentiality is specifically discussed, stressed, or explained in response to a client’s question, check instead the Safety item, “Therapist provides structure and guidelines for safety and confidentiality.”

***Therapist ask client(s) what they want to talk about in the session.**

With this behavior, the therapist helps clients see that they have a role in deciding what to work on in session. The behavior can either be an open question (“What would you like to work on today?”) or an invitation to comment on the therapist’s plan for the session, i.e., offering clients the option of modifying the agenda or introducing new topics for discussion (“I had thought that today’s session would be devoted to talking over John’s change in schools, but I’d like to ask if you think that’s enough, or is there something else you think we should do today?”).

Therapist encourages client(s) to articulate their goals for therapy.

The therapist can accomplish this goal in the initial phase of treatment, e.g., by asking family members what they’d like to achieve in therapy or what needs to change for them to consider therapy useful, e.g., “What would you have to see taking place in order to feel that it’s worthwhile to come here?” In more advanced stages of treatment, the therapist may ask clients for their participation in defining, re-defining, or simply recording the goals, e.g., “Now that you’ve ruled out the possibility that your son is using heroin, what would you like us to focus on in therapy?” The difference between this behavior and the previous one is that here the therapist is encouraging articulation of a treatment goal, objective, or outcome, not merely a topic of discussion in the session at hand.

Therapist asks client(s) whether they are willing to do a specific in-session task (e.g., enactment).

By asking clients if they are ready to do something specific in the session before doing proceeding, the therapist is implying that the final decision is the clients’. Examples include, “I’d like you to recreate here and now the same conversation that you had at home. What do you think? Do you think you can do this?” *and* “There’s something I think would be helpful, if you’re willing to go along? It’s something different that...” The item should *not* be marked if the therapist is simply asking a question rhetorically or for courtesy when, in reality, the client is not being given the option to refuse, e.g., “We’re going to recreate your discussion at home right now. Maria, please sit in the chair next to your husband and....” *or* “What would you say to trying it again, but this time more forcefully? Go on, try it again.”

Note: Mark this item *only once* if the therapist asks the same question repeatedly, i.e., about the same task. If, however, the therapist proposes the task again later on in the session, the item *could* be marked again.

***Therapist asks client(s) whether they are willing to follow a specific suggestion or do a specific homework assignment.**

With this behavior, the therapist asks or implies a clear interest in the client’s opinions about his/her suggestion for something new to be thought about or done *between sessions* or about a specific homework assignment that s/he is proposing. (If the suggestion is about something to do in the session itself, the previous item should be checked instead.) This comment usually takes place after the therapist has offered a concrete assignment or suggestion (“We’re considering your going together to pick your daughter up as a way to show interest

in her. How do you feel about that suggestion?”). On occasion, the therapist may accomplish this objective while defining or describing the homework task (“The team suggested a specific task for this week, but it requires both of you to be together on it. Are you prepared to come together to do something? Would you like to hear what the team suggested to me?”).

Note: Mark this item *only once* if the therapist asks the same question repeatedly, i.e., about the same homework assignment. If, however, the therapist proposes the assignment again later on in the session, the item *could* be marked again.

***Therapist asks client(s) about the impact or value of a prior homework assignment.**

Examples: “Last session we talked about a task to do during the week. How did it go? *or* What happened?” “Last time it seemed to me that you found my suggestion to plan a trip with your son interesting. Did you follow through with that idea?” “How helpful was the homework?” Occasionally, clients may indicate that they did not do the specific assignment or suggestion that was made in the previous session. The item should be checked nonetheless if the therapist asks about the impact or value of the task, as in: “Although you didn’t do it, did you think or talk about it together?” “You didn’t find it useful, or maybe you thought it was overly complicated or stressful?” “Could it be that this was somewhat scary for one of you?”

***Therapist expresses optimism or notes that a positive change has taken place or can take place.**

Optimism about change can take many forms, e.g., “Incredible! You’re saying that [*the problem*] hasn’t happened again?” “It’s a small change, but I’ve no doubt that it’s a clear sign of improvement.” “What you say suggests an improvement. This week it’s only happened twice but, earlier, it always happened three or four times in a week.” “That makes me certain that you’re going to get there.” Sometimes the therapist may offer hope explicitly, e.g., “Even though things are really rough right now, I can see a spark between you, and that means there is still something growing in your relationship. I’m hopeful that we can make a difference for you in our work together.”

Therapist pulls in quiet client(s) (e.g., by deliberately leaning forward, calling them by name, addressing them specifically).

For this item to be checked, the client or clients who are addressed must have been silent or withdrawn for a noticeable period of time or clients who are only superficially responding, e.g., one-word answers. However, if the therapist leans forward or addresses a client who has been talking (or crying), this item should *not* be checked. The behavior is meant explicitly to involve someone or some group of clients who have been silent or uninvolved. If the therapist’s behavior is nonverbal, it must be a discrete change in body posture. By leaning forward, the therapist clearly communicates attention and concentration, an interest in what the client(s) is saying or experiencing in the moment, highlighting the relevance of this communication. The behavior should *not* be checked if the change in posture suggests tiredness or motives other than drawing in someone who has been quiet, as when the therapist leans forward to write something down, pick up an object, etc.

Therapist asks if the client(s) have any questions.

This behavior refers to all kinds of clear and direct offers to the client to ask questions related to the content or process of therapy, e.g., “Before we go any further, do you have any questions or concerns we should discuss?” This item should *not* be marked if the therapist simply asks for general reactions (e.g., “How’s that plan for you?” “Are you okay with what we’ve been talking about?”). Even when the therapist asks if there are questions *right after* having done one of the other engagement behaviors (i.e., in the same speaking turn), this item should be checked, as in: “Therapy works when..... Do you have any questions about what I’ve just explained?” *or* “So, are you willing to try this at home? Is there anything you want to ask about this before we stop today?” As in this last example, because the therapist first asks about the client’s willingness to do a homework assignment and *then* asks if the client has any questions, both items should be checked.

Therapist praises client motivation for engagement or change.

With this behavior, the therapist praises all direct or indirect expressions of motivation to get involved in the therapy or to work toward a change. The client’s motivation can be expressed explicitly (“We’re really excited about what we’re doing here”) or implicitly (“We’re willing to come more often if that will help things along”). The therapist’s praise must be patently clear in order for this item to be checked, e.g., “Excellent! This is essential for our work to get done,” “Very good! Your participation and willingness to compromise is the most important thing,” “It makes me happy to see *you* happy and so ready to work.”

Therapist defines therapeutic goals or imposes tasks or procedures without asking the client(s) for their collaboration.

For this item to be checked, there must *not* be a direct question from the therapist asking for the client’s input. The essence of this item is that in giving instructions for an assignment at home, for an enactment in session, or for some other proceeding in the treatment, the therapist imposes his/her will without considering the opinion or well being of the client. For this item to be checked, the therapist must not explain his/her reasoning, not ask if clients understand, and not use a questioning tone of voice. Examples: “Next session I’ll see you separately. I want one of you to come in the morning and one in the afternoon” would be marked, but “Next session, could I see each of you separately?” would *not* be marked. Other examples: “Good, after consulting with the team, here is the assignment for you this week: You go pick up John every day at work and after...”; “In what remains of this session you’ll take turns answering me, and I don’t want you to speak to one another.” An important precaution to keep in mind: the failure to ask for collaboration may be based on a prior agreement with the clients that allows the therapist to use his/her discretion in imposing tasks and procedures. In these cases, the item should *not* be marked. That is, on occasion, a previous conversation or some understanding established earlier in the session (or in a prior session) has given the therapist permission to offer directives or instructions without consulting the clients. As an example, working with a highly conflictual, troubled couple a therapist and couple agreed that

if the level of conflict seemed untenable to the therapist, s/he would see them individually. Thus, when s/he informs the clients that they will be seen separately in the next session, there is no need to consult them because a previous agreement to do so was already in force.

Essentially, this descriptor refers to moments or episodes in which the therapist references the goals of therapy in a unilateral or highly assertive (or even aggressive) manner. As an example, a therapist working with an adolescent and his parents says, “What we have to achieve in therapy is increase your ability to discipline John around his study habits, so he doesn’t fail in school.” In this case, the therapist asserted the goal of treatment without asking for the opinion or for confirmation from the clients. When, however, the therapist has already actively negotiated the goals of therapy with the clients and finally asserts a summary of what will be accomplished, this item is *not* marked, as in “Okay, I understand that you all want this therapy to eliminate the conflicts you’re having over John’s education.”

**Therapist argues with the client(s) about the nature, purpose, or value of therapy.*

This item requires subjectivity. Naturally a therapist’s opinion can differ from the client’s about the nature, purpose of value of therapy. Typically, the item is marked when one client devalues what is occurring or the need for therapy, and the therapist tells the client s/he is wrong or that therapy is the only way changes can be made, and so forth. The point is that client participation is negatively affected when there is an open confrontation (even if not particularly hostile) with the client about the process of treatment, as in:

Client: I don’t see how therapy can change what someone does. That depends on a person’s personality, and I think people’s basic personalities never change.

Therapist: Therapy works to change people. As a professional, I know that’s what’s needed here.

Client: I don’t think that can occur through therapy.

Therapist: Without trying it, you can’t know what therapy does.

There are situations in which the therapist paints a different picture of the treatment process but avoids getting into a confrontation with the client. In cases like these, the item should *not* be marked:

Client: I don’t see how therapy can change what someone does. That depends on a person’s personality, and I think people’s basic personalities never change.

Therapist: Yes, change is complex, but we can talk about what you think should change and how you see personality. What changes have you experienced since the problem started?

Therapist shames or criticizes how clients did (or did not do) a prior homework assignment.

Even if the therapist does not clearly criticize the clients for failing to do the homework (as in, “You should have done this. It’s for your own good.”), the blame can be subtle but nonetheless harmful. Examples include, “Well, I know that you had a busy week, but isn’t

that an excuse?"; "We're not going to get anywhere without your full cooperation"; "I'm going to insist that you do the assignment for the next week." There may even be a threat that therapy will be terminated without the client's cooperation, as in: "There is no point in your coming here if you're not going to follow through at home." When the client has attempted the homework and either not completed it or did it incorrectly, the item should be checked if there is implied criticism, as in: "That's not what was expected. Next time, be sure you understand the assignment before you start" *or* "Well, you got it partially right. Try harder next week."

THERAPIST'S CONTRIBUTIONS TO EMOTIONAL CONNECTIONS:

***Therapist shares a lighthearted moment or joke with the client(s).**

This item refers to a the therapist's rapport with client(s) through humor or good will, typically signally by laughter. The comment could be initiated by the therapist or the client, but both parties need to be simultaneously amused for this item to be checked. Typically the markers are smiling, giggling, or laughter.

***Therapist expresses confidence, trust, or belief in the client(s).**

The therapist verbally encourages the client(s) with comments that express general confidence in the family members' ability to achieve a goal or try a new behavior. Examples: "I know you can do it" *or* "This is hard, but I have faith in you" *or* "I've seen you do this in the past" *or* "One aspect of your family that continues to impress me is your strength. With that strength, I have no doubt that you will be able to make these changes for each other."

Therapist expresses interest in the client(s) apart from the therapeutic discussion at hand.

Sometimes this occurs when a therapist recalls a detail that that client shared in a previous session. Example: "I remember your father was going in for surgery. How did it go?" *or* "You vacationed there before, didn't you?" The item should *not* be checked when during casual conversation the therapist is engaged but s/he does not specifically express interest in the client(s). For example, if the clients report that they went to a new restaurant for dinner and therapist asks about the restaurant, the item would not be endorsed. If the therapist asks about the clients' reaction to the evening (e.g., "What was your experience like there? Did you enjoy the restaurant?"), the item would be marked. If the therapist initiates or changes the topic to something non-therapy related in an attempt to alleviate anxiety, mark instead the item "Therapist changes the topic to something pleasurable or nonanxiety-arousing" under Safety.

***Therapist expresses caring or touches client(s) affectionately yet appropriately (e.g., handshake, pat on head).**

In addition to hand shakes and pats, this item includes other affectionate expressions by the therapist, such as reaching out to take or touch something (e.g., a picture, photograph,

journal, hat) that a client brings into a session. This item would also be marked if the therapist uses terms of endearment (e.g., “sweetie” or “honey”) with children. If the therapist makes the same gesture (e.g. handshake) with more than one family member at the beginning or end of the session, the item is marked only once. If there are separate gestures with different family members (e.g. pats child on the head at beginning of session and shaking the parent’s hand to celebrate an accomplishment during the session), the item can be marked for each behavior.

Therapist discloses his or her personal reactions or feelings toward the client(s) or the situation.

This item reflects the therapist’s self-involvement in the session. The therapist reveals something about his or her inner experience during the family session. Examples: “I felt close to you while you were crying” *or* “As we talk about this I feel sadder and sadder” *or* “I’m excited by what I hear. You all seem to have a lot of energy to work together to get more of what you want for your family life.” Other examples include, “I’m confused by your silence this week. I’m wondering if you are upset with me” *or* “I’m concerned that you have cancelled several sessions in the last few weeks. What’s happening?” This item should be distinguished from the one below, which has to do with disclosure about something personal in the therapist’s life.

***Therapist discloses some fact about his or her personal life.**

For this item to be marked, the therapist must disclose some personal information that would not have been known to the client(s) otherwise. The self-disclosure can be spontaneous or in response to a question from the client(s). For example: “I grew up in a large family. I had seven siblings” *or* “I grew up in the south” *or* “I have two children” *or* “I going to _____ for vacation.” *or* “We went to see the fireworks last evening.” If the disclosure includes similarity to the client’s experience, even something nontherapy related, check instead the item below.

Note: This item should *not* be marked when the therapist gives information about his/her orientation to therapy unless it includes personal data, such as where s/he went to graduate school, etc.

Therapist remarks on or describes how his or her values or experiences are similar to the clients’.

When the therapist shares some personal experience or personal values and comments on how he or she is similar to the client, this item would be marked. This item takes precedent over the previous item (“discloses some fact”) if the disclosure includes some connection to the clients’ experience. Examples: “When I was in college, I got pretty nervous and upset about tests too” *or* “I wanted some privacy when I was your age” *or* “I agree, I think it is important that the parents are in charge of the household rules” *or* “I remember when my own children were toddlers, like you, I sometimes felt overwhelmed by the need to constantly watch them. I really valued conversation with and support from other adults in my life at that time.” When

the therapist's comment is nontherapy related but does express a similarity with the client (e.g., "I've eaten there before, too. What a restaurant!"), check the previous item instead ("discloses some fact about his/her personal life").

***Therapist (verbally or nonverbally) expresses empathy for the clients' struggle (e.g., "I know this is hard," "I feel your pain," crying with client).**

Empathy is generally an expression of understanding of the experience of another person. The critical element in this item is the therapist conveying the message that he or she understands the experience of the client. In addition to the examples above (e.g., crying with client), the therapist could make any statement that reflects understanding of the clients' struggle.

Examples: "It's humiliating for you to have to go to court about these private family matters" *or* "You really didn't have any support from your parents when you were growing up, and you don't want it to be that way for your children" *or* "It's scary when your mom yells like that." Nonverbal expressions that are clear and discrete can also be marked, as leaning forward or crying when a client relates painful material, patting a shoulder. If the nonverbal behavior is ambiguous (not clearly related to the clients' struggle or pain), the item should *not* be marked. *Note:* If the therapist's message in a single speaking turn includes reassurance or normalization, a decision should be made about whether to check this item or the following one, depending on which aspect of the speaking turn seems most salient. (However, both items could be checked if empathy and normalization occurred in different speaking turns.)

Therapist reassures or normalizes a client's emotional vulnerability (e.g., crying, hurt feelings).

Reassuring or normalizing a client's emotional vulnerability differs from empathy in that the therapist's statements explicitly affirm that the client's reaction is understandable, expected, or "normal" considering the circumstances. The therapist may talk, in general terms, about how other families have expressed similar emotions. Some examples: "[*to a single mother*] I've worked with many single mothers over the years and a common theme has been their desire to have more time for themselves. It is understandable that you would wish for a break from the constant responsibility of parenting." *or* "[*To a new stepparent*] Becoming a stepparent when the children are adolescents has unique challenges. It's understandable that you are feeling confused and frustrated about what your role should be" *or* "[*To one or both members in a couple*] I see these disagreements about discipline bring tears to your eyes. That's okay--I hear that this is really painful for you. It seems important to give those feelings expression" *or* "Often individuals in a couple will feel more angry with each other than with their children when there are disagreements about discipline. Many parents have expressed those feelings in here" *or* "[*To a teenager*] You feel like you don't have any power or influence in your family. You want your parents to notice that you are growing up and can handle more. I can understand that you are frustrated. It's hard to figure out how to convince your parents to trust you." *Note:* When the reassurance is nonverbal, consider instead the above item. If the therapist's message in a single speaking turn includes empathy, a decision should be made about whether to check this item or the preceding one, depending on which aspect of the

speaking turn seems most salient. (However, both items could be checked if normalization and empathy occurred in different speaking turns.)

****Therapist has hostile, sarcastic, or critical interactions with the client(s).***

Essentially, this item connotes disrespect or devaluing of the client(s) by the therapist. For this item to be checked, the therapist's communication needs to be mean-spirited, bitter, or contemptuous. For example, a therapist might sarcastically ask a family that has attended therapy irregularly if they planned to skip the next meeting: "Now, I'm not going to be sitting here alone again next week, am I?" The therapist's communication might be directed at one family member, but if his/tone is hostile, critical, or sarcastic, the item should be marked. An example: "[*in an exasperated tone*] "I wonder if ____ [child] will every stay in [his/her] seat for the whole session without having to be reminded repeatedly." This behavior should *not* be checked if the therapist is sarcastic in a playful way, smiling, for example. If the therapist criticizes the client's not doing homework, the Engagement item, *Therapist shames or criticizes how clients did (or did not do) a prior homework assignment*, is checked instead.

Therapist does not respond to clients' expressions of personal interest or caring for him or her.

This item is checked when the therapist fails to respond to a direct question or statement connoting personal interest or caring for the therapist, such as questions and comments by the client about the therapist's health, wellbeing, work, etc. Endorse this item when the therapist either ignores or shuts down the client's comment. Alternately, the therapist may react with silence or with a statement of reluctance to respond to the client(s). Statements of reluctance to respond include, "It's none of your business" *or* "That's personal" *or* "We're talking about you right now." This item would *not* be indicated if the therapist initially asks the client(s) to expand on his/her question or statement before the therapist replies. As long as the therapist acknowledges the client's interest e.g., implying "I recognize or appreciate that you care about me", the item would *not* be marked, even if the therapist's response does not include a significant personal self-disclosure.

Note: Even if the client's expression of personal interest is not appropriate (e.g., asking the therapist for a date, asking the therapist about something highly personal), ignoring the client's comment should be marked. However, if the therapist gives a polite or didactic response ("Although I appreciate your interest, as a professional I am going to decline to answer your question about my private life"), the item would *not* be marked.

THERAPIST CONTRIBUTIONS TO SAFETY WITHIN THE THERAPEUTIC SYSTEM:

****Therapist acknowledges that therapy involves taking risks or discussing private matters.***

The therapist may make this statement at the outset of treatment when explaining the therapeutic approach and discussing how therapy works or do so whenever clients are reluctant to discuss upsetting issues or concerns. Ex.: "I know it's hard to expose your private life to a stranger" *or* "I know that talking about private matters can be difficult" *or* "I

may ask you to try to talk with each other in different ways, ways that you may not talk with each other at home, and that may feel difficult and even risky at times. I want to encourage you to talk about how you are experiencing these challenges in therapy.” To a couple, “I know this is really personal, but can we talk about your sex life?” In essence, the therapist acknowledges that addressing personal feelings and problems in therapy may result in feelings of vulnerability and exposure. Normalization may also be intended, as when the therapist explains that concerns about exposing one’s private life are common. Ex: “Sometimes families end up fighting with each other before finding new ways to talk with each other” *or* “Sometimes the going can be rough. You may find that conflicts and problems can seem to get worse before getting better.”

Therapist provides structure and guidelines for safety and confidentiality.

If the therapist discusses how the therapy sessions are to be structured in order to keep the clients safe (e.g., no name calling, yelling, physical contact), this item should be marked. The item is also checked when the therapist explains confidentiality, its limits, and privacy issues related to informed consent for release of information, recording sessions, research, and/or observing teams. Sometimes the therapist delineates and explains what type of information will be shared with third parties (e.g., Child Protective Services or other court-affiliated agencies). If the therapist *also* encourages the family to express reactions to these elements, also mark the next item, “Therapist invites discussion about the intimidating elements in the therapeutic context.” *Note:* For this item to be checked, the therapist needs to discuss or explain confidentiality or privacy. If the use of consent forms, recording or observation is simply mentioned in the context of what is done in therapy or in this setting, check instead the Engagement item, “Therapist explains how therapy works.”

***Therapist invites discussion about intimidating elements in the therapeutic context (e.g., recording equipment, reports to third parties, treatment team observation, one-way mirror, research, etc.).**

Simply reporting these extra-therapy procedures (e.g., “We’re using the camera today”) is not sufficient. The therapist must *invite discussion* about the intimidating elements in the therapeutic context. At a minimum, the therapist must offer the clients an opportunity to talk about their reactions to these conditions. Ex.: “Most people feel a little uncomfortable with the camera [or observers] initially. We can talk about your concerns” *or* “Tell me more about what makes you uncomfortable. Can I answer any questions about it?” The client may ask a specific question about reports to third parties, but in order to mark this item, the therapist must do more than simply respond to the question; s/he must invite *further discussion*.

***Therapist helps clients to talk truthfully and non-defensively with each other.**

This behavior can occur when one family member demands explanations or justifications from another. Rather than simply witnessing demands and defensive reactions, the therapist intervenes to ask family members to talk about their *own* upset and hurt feelings. The therapist may intervene in a number of ways to discourage defensive communications or to

promote open, honest, and truthful self-disclosures. Ex.: “Speak from your heart” or “Say what’s true for you.” Speaking to one person about another, “She’s not looking at you right now. Talk to her in a way that she’ll want to look at you” or “Tell it like it is. Be open with him.” The therapist may encourage family members to communicate differently in therapy than they might typically do at home. “Can you for just this moment be real and genuine with your parents?” or “Don’t hold back. He needs to hear what you are saying.” “Let her show you that she can handle what you’re thinking.” *Note:* This item can be marked *even if* the client was speaking directly to the therapist (i.e., not specifically addressing another family member) because the other clients overhear the therapist’s intervention.

Therapist attempts to contain, control, or manage overt hostility between clients.

Overt hostility may include name calling, verbal abuse, and threatening remarks. The therapist does not necessarily have to be successful at controlling or managing the hostility, but this item is marked if s/he at least makes an attempt to do so. Sometimes therapists tell families that in order to help create a safe environment for everyone, s/he will stop the session if hostility or aggression emerges. Later, the therapist may remind the family of the no aggression contract or intervene directly when hostility surfaces. Ex.: “Is this how it goes at home? Let’s see if we can do it differently in here” or “I don’t want to make therapy a place for you just to hurt each other” or “If you just keep rehashing this fight, it will go to another fight. It’s unlikely that it will go problem solving.” “This isn’t going anywhere -- can we try something different?”

Note: This item should be endorsed only once for interventions during a single hostile episode. If there are repeated hostile episodes separated by calm discussion, the item should be marked each time it occurs. If the therapist explicitly intervenes on behalf of one family member (e.g. mentions one family member by name, age, or other specific identification) to protect him or her from another family member, consider marking instead the item, “Therapist actively protects one family member from another (e.g., from blame, hostility, or emotional intrusiveness)”. Both items could be indicated during the same session.

If there is hostility and there is no therapist attempt to control it, consider whether the therapist allowed the conflict to escalate unchecked during the session. If so, mark the negative indicator (“*Therapist allows family conflict to escalate to verbal abuse, threats, or intimidation*”).

Therapist actively protects one family member from another (e.g., from blame, hostility, or emotional intrusiveness).

For this item to be endorsed, the therapist must intervene directly and specifically to “rescue” one or more family members who is “under attack.” The therapist must mention the client(s) by name or in other way (e.g., by age or nonverbally, as by pointing). Ex.: “Your wife needs a break” or “It’s too hard for a 10-year-old to say who he wants to live with” or “I can see she’s not ready to talk about this” or “I’m not sure it’s safe for him to answer while you’re so angry.” The therapist can also intervene by proposing separate meetings (e.g., parents alone

and child alone). If one client is clearly under attack during the session (rather than at some future date), check this item *rather than* the item “Therapist asks one or more clients to leave the room in order to see one client alone for a portion of the session.”

Note: This item should be endorsed only once for repeated interventions in the same episode. For repeated episodes, separated by periods of calm communication, the item may be marked each time it occurs. Also, if the therapist stops the blaming or aggressive communication *without specifying one or more clients*, mark the above item instead (“Therapist contains, controls, or manages overt hostility between clients”).

Therapist changes the topic to something pleasurable or non-anxiety arousing (e.g., small talk about the weather, room decor, TV shows, etc.) when there seems to be tension or anxiety.

This item should only be checked when the therapist initiates or changes the topic of conversation to a more casual, pleasurable, or relaxing one in order to reduce tension or anxiety.

Father [to son]: You’re failing all your major courses!

Son: [lengthy, uncomfortable silence]

Therapist: Well, before going into all the school problems, Johnny, I wanted to show you my new fish tank, that one over in the corner....Do you like fish tanks? Have you ever had one.

Note that it is *not* necessary for anxiety to actually be reduced in order for this item to be marked.

Note: The item is *not* marked if the therapist uses these kinds of interventions at the very beginning or very end of the session simply as a bridge, e.g., “Is it still raining outside?” Moreover, if the small talk does not seem to be in response to tension or anxiety yet does refer to the clients’ likes, dislikes, hobbies, etc., mark instead the Emotional Connection item, “Therapist expresses interest in the client(s) apart from the therapeutic discussion at hand.” When both therapist and client(s) laugh at a joke or funny incident in the absence of tension/anxiety, mark instead the Emotional Connection item, “Therapist shares a lighthearted moment or joke with client(s).”

Therapist asks one client (or a subgroup of clients) to leave the room in order to see one client alone for a portion of the session.

This item is marked when the therapist asks to see one client or one subgroup of clients (e.g., parents, children) alone, even if requested by the client. By providing this private opportunity, the therapist allows discussion of personal matters that the client(s) may not wish to discuss in the presence of other family members. For example, the therapist notices that answering questions about sex or other intimate or private matters may be hard for an adolescent in the presence of her mother, the therapist decides to ask the mother to leave the room. This behavior essentially promotes safety by drawing boundaries and giving client(s) the space to

speak freely. The item is *not* marked, however, when a client simply walks out of the session or when the therapist asks someone to leave in order to control hostility or to protect one client from others (consider instead the items, “Therapist contains, controls, or manages overt hostility between clients” *or* “Therapist actively protects one family member from another”).

Therapist allows family conflict to escalate to verbal abuse, threats, or intimidation.

Some expressions of anger and blaming communication are likely to occur during the course of therapy as problems are aired and addressed appropriately and with measured control. This item should only be marked in situations where the therapist is lax or negligent about the ongoing hostility. As an example, a family member threatens, “You will do this or I will make you wish you had,” and the therapist says nothing about the implied threat. Similarly, a family member uses extremely pejorative language toward another family member, and the therapist does not intervene. Moreover, this item is marked if any aggression (verbal or physical) ends of its own accord, that is, without the intervention of the therapist (e.g., someone walks out, family members shut down, the session is over).

Note: This item should *not* be marked when a therapist makes a direct intervention to control or manage hostility but is not successful at doing so. (In this case, mark instead “Therapist attempts to contain, control, or manage overt hostility between clients.”)

Therapist does not attend to overt expressions of client vulnerability (e.g., crying, defensiveness).

For this item to be marked, client vulnerability expressed through crying or overt defensiveness is not acknowledged by the therapist. If the therapist does acknowledge the client’s difficulty (e.g., by a softening tone of voice, leaning forward, offering tissues, or reassuring comments like, “I know this is tough to talk about”), mark instead the item “Therapist explicitly expresses empathy for the clients’ struggle” (Emotional Connection). To mark this item, the therapist must essentially ignore noticeable client vulnerability.

THERAPIST CONTRIBUTIONS TO SHARED SENSE OF PURPOSE WITHIN THE FAMILY:

***Therapist encourages clients to compromise with each other.**

Compromise involves some contribution by each party to reach an agreement about the relationship or about specific course of action. The therapist may explicitly ask family members if a compromise is possible and what each person would be willing to do to reach a compromise. An example is, “Is there one small step that each of you could take to move closer to a compromise?” The therapist may also refer to compromise indirectly, as in, “Is there anything that each of you is willing to do to move closer to an agreement, something that each of you would feel better about?” The therapist could also suggest a specific compromise to a problem that is being discussed. In other words, the therapist encourages compromise through a suggested solution where each individual is asked to give something for the other, implying “If you do _____ for him, maybe he’d do _____ for you.” Compromise should be distinguished from a concession when only one person is asked to give in to the

other person. Asking one person, “Would you do this for her?” is asking for a concession not a compromise, and in this case the item should *not* be marked.

***Therapist encourages clients to ask each other for their perspective.**

This item is often a precursor to the discussion of a compromise. The therapist may encourage any family member to check with one or more other family members about their perception of the problem or their perspective on possible solutions. In other words, the therapist’s intervention involves family members in seeking to find out how everyone views a situation or problem. Examples: “[*Child*], would you be willing to ask your parents to share their ideas about when things started becoming a problem at school? Mom and Dad, have you asked [*child*] what is going well in school? Why don’t you see if you can help him say those things now, in here?” *Note*: The item should *not* be checked when the therapist directly asks another family member for input (e.g., “Mom, what do you think about [*child*’s] difficulties at school?”).

***Therapist praises clients for respecting each other’s point of view.**

Family members do not necessarily have to be in agreement for the therapist to acknowledge and recognize their show of respect for each other’s views. For example, the therapist might say, “Even though you two have different opinions about this, you each listened carefully to each other and seemed to show that you appreciate that the other person may have a reason for differing with your opinion” *or* “Wow, even though there are still differences in how each person sees things, I can’t help but notice how you were willing to listen to each other. There seems to be some openness and respect for each other that I’m sure is going to be helpful in solving this problem” *or* “It’s important that you understand and acknowledge that you both have valid reasons for what you think. Even though you don’t agree, I see there is some basic respect for each person’s point of view in this family.”

Therapist emphasizes commonalities among clients’ perspectives on the problem or solution.

This item focuses more on the cognitive aspect of the clients’ perspectives, the way people are looking at the problem as opposed to their underlying values, needs, or feelings (which are referred to in the item below). In order to check this item, the therapist must do more than summarize various perspectives. Rather, the therapist must make explicit statements about connections and common themes among the various family members’ perspectives. For example, “Mom and [*child*], you both agree that the problem seemed to start with the change to a new school” *or* “It’s clear that ultimately you both want [*child*] to have more responsibility. She wants to be trusted to do some things on her own and Mom wants her to act in a way, by making good choices and considering the family’s rules, that she can trust her to handle this responsibility with maturity” *or* “So, you all want Child Protective Services out of your lives. It seems that you agree that part of the solution will be to figure out how to make that happen.”

Note: A therapist might simultaneously address commonalities among perspectives and point out shared experiences among family members, i.e., in one intervention: “You both agree that [child] is not showing respect {*point of view, perspective*} and both of you feel scared that you’ve lost control with him {*shared experience, feelings*}.” In this example, this item as well as the following item, “Therapist draws attention to shared values, experiences, needs, or feelings,” would be marked.

Therapist draws attention to clients’ shared values, experiences, needs, or feelings.

This item differs from the above item by its focus on values, experiences, needs or feelings; the previous item focuses on similarities in perspectives on the problem or solution. In other words, to mark this item the therapist must be discussing the clients’ affective experience, needs, or values, *not* their views on a situation. An example of a shared value is family loyalty, as in: “Each of you has described your family as a family that sticks together through tough times” *or* “Both of you want the best for your children, although you go about getting it in different ways.” The therapist may point out a specific instance in the session when two or more family members expressed similar feelings (e.g., wish for change, frustration, anger, distrust, loneliness). When discussing a specific problem, the therapist may point out how family members experience the situation in a similar way (even though they may not see the problem similarly), as in: “You both feel like victims of the other,” *or* “You’re both hurting a lot,” *or* “Both of you feel trapped.”

Therapist encourages clients to show caring, concern, or support for each other.

The therapist may encourage expression of caring, concern, or support among family members by suggesting a specific action that the clients do for each other. For example, the therapist could request that a family member pass the tissues to another family member who is crying. The therapist may say, “Can you reach out your hand to him, while he’s saying that?” *or* “It looks like your child needs a hug” *or* “Could you let her know that you care about her, even though you are upset with the trouble that she’s in at school” *or* “Say more about why you are concerned for her” *or* “What are you willing to do to support your child as he tries to change?” *Note:* When emotions are running high, the therapist may propose an in-session task, like “give him a hug” without asking if the clients are willing. If the purpose of the therapist’s intervention is for support, do *not* mark the negative Engagement item, “*Therapist defines therapeutic goals or imposes tasks or procedures without asking the client(s) for their collaboration.*”

***Therapist encourages client(s) to ask each other for feedback.**

To distinguish this item from the item, *Encourages family members to ask each other for their perspectives*, mark this behavior only when the therapist explicitly encourages family members to ask each other for feedback in the session. The therapist might encourage all family members to ask each other how they feel about talking about the problems and possible solutions, for example. Other examples: “You want to convince your parents that they should

consider your request. Why don't you ask your mom and dad how you came across" *or* "Find out if your parents have other concerns about you?" In couples therapy, a therapist may ask, "Are you willing to ask each other how your partner sees you at home? Does your partner see you as trying to do things differently?" The item should only be marked if the therapist wants the clients to ask each other in the session, *not* if this is an assignment to do at home between sessions.

****Therapist fails to intervene when family members argue with each other about the goals, value, or need for therapy.***

In contrast to the Safety items related to conflict or hostility between clients, the conflict in this item refers to conflict *about coming to therapy*. To mark this item, the family argument or disagreement about the value of treatment needs to be clear, *not* implicit or simply nonverbal. The clients might say, "You heard what [*therapist*] said! We need to be here!" *or* "This is useless, we don't want the same thing. He's not willing to take this seriously." If the therapist fails to address the conflict, this item should be marked. This item should *not* be checked if the therapist acknowledges the disagreement and points out that some family members are uncertain about the benefits of therapy. Also, if the therapist invites discussion of the client's doubts and searches for possible points of agreement among family members, this item would *not* be marked.

Therapist fails to address one client's stated concerns by only discussing another client's concerns.

Essentially, this item is marked at the end of the session when it is clear that although more than one client stated a concern, the therapist only addresses one concern, not the other(s). For example, at some point in the session a parent raises a concern about an adolescent child's failure to complete homework and repeated disciplinary referrals in school for disrupting class, while the adolescent complains that the parent never gives him/her credit for helping out at home. This item would be marked if the therapist focuses the conversation on the school behavior problems but ignores or fails to address the adolescent child's complaint about lack of recognition for contributing at home. However, if the therapist comments at the end of the session, "We never got to your [*one family member*] concern, so we'll pick it up next time," the item should *not* be checked. *Note:* The client must specifically request a discussion on a topic, not just bring something up in cross-blaming. In the following example, this item would *not* be checked because the son is trying to deflect his mother rather than initiate a new topic:

Mother: Let's talk about your refusing to do anything I ask you to do!

Son: Well, you don't give me an allowance like other kids get!

If the conversation were to go as follows, the item should be marked:

Mother: Let's talk about your refusing to do anything I ask you to do!

Son: Can we also talk about why you don't give me an allowance like other kids get?

* Indicates that there is a parallel item under client behaviors

REFERENCES

- Bachelor, A. (1991). Comparison and relationship to outcome of diverse dimensions of the helping alliance as seen by client and therapist. *Psychotherapy, 28*, 534-549.
- Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research, and Practice, 16*, 252-260.
- Bourgeois, L., Sabourin, S., & Wright, J. (1990). Predictive validity of therapeutic alliance in group marital therapy. *Journal of Consulting and Clinical Psychology, 58*, 608-613.
- Friedlander, M. L., Escudero, V., & Heatherington, L. (in press). *Therapeutic alliances in couple and family therapy. An empirically informed guide to practice*. Washington, DC: American Psychological Association Books.
- Friedlander, M. L., & Tuason, M. T. (2000). Processes and outcomes in couples and family therapy. In S. Brown & R. Lent (Eds.), *Handbook of counseling psychology* (3rd ed; pp. 797-824). New York: Wiley.
- Heatherington, L., & Friedlander, M. L. (1990). Couple and family psychotherapy alliance scales: Empirical considerations. *Journal of Marital and Family Therapy, 16*, 299-306.
- Horvath, A.O. & Greenberg, L.S. (1989). The development and validation of the Working Alliance Inventory. *Journal of Counseling Psychology, 36*, 223-233.
- Horvath, A. O., & Symonds, B. D. (1991). Relation between the working alliance and outcome in psychotherapy: A meta-analysis. *Journal of Counseling Psychology, 38*, 139-149.
- Johnson, S. M., & Talitman, E. (1997). Predictors of success in Emotionally Focused Marital Therapy. *Journal of Marital and Family Therapy, 23*, 135-152.
- Pinsof, W. M. (1994). An integrative systems perspective on the therapeutic alliance: Theoretical, clinical, and research implications. In A. O. Horvath and L. S. Greenberg. (Eds.), *The working alliance: Theory, research, and practice*. (pp. 173-195). New York: Wiley.
- Pinsof, W. M., & Catherall, D. R. (1986). The integrative psychotherapy alliance: Family, couple and individual therapy scales. *Journal of Marital and Family Therapy, 12*, 137-151.
- Quinn, W. H., Dotson, D., & Jordan, K. (1997). Dimensions of therapeutic alliance and their associations with outcome in family therapy. *Psychotherapy Research, 7*, 429-438.
- Tichenor, V., & Hill, C. E. (1989). A comparison of six measures of working alliance. *Psychotherapy, 26*, 195-199.