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## The History of Family Therapy: Conceptual and Clinical Influences

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# Karl Tomm: His Changing Views on Family Therapy Over 35 Years

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*Karl Tomm has been the director of the Family Therapy Program in Calgary for more than 35 years. He has developed an international reputation not only as a family therapist, major innovator, theoretician, and trainer of family therapists but also as a leader in facilitating dialogues among many of the world's family therapists. He started his career applying the problem-solving approach to family therapy developed by Nathan Epstein (Part I). In the 1980s, Karl championed the work of the Milan Group (Part II). More recently, Karl has promoted the work of Michael White and David Epston in narrative therapy (Part III). Don Collins recently had the opportunity and pleasure to interview Karl about the evolution of his thinking and practice over the span of his career.*

**Keywords:** *Karl Tomm; family therapy; history of family therapy; postmodern family therapy*

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## **PART I (1969–1979): A PROBLEM-CENTERED FOCUS**

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**Collins:** What influenced you to become a family therapist?

**Tomm:** Well, there were many personal influences from my family of origin, but I will talk specifically about professional influences. The professional influences started in my 1st year of psychiatry residency at the University of British Columbia in 1969.

One of my patients was a 14-year-old girl who was admitted because she kept running away from home. I asked her family to come in so I could see what she was running away from. She lived with her two parents and a younger brother, and I was struck by how nice they were, really nice people, all of them. Her brother cared for her a lot and was very worried about her, and both her father and mother were devoted to her; I was bewildered. Why was this happening? Why did she keep running away? I asked my supervisors and they did their best to answer my questions, but I was not satisfied. Around that time, Nathan Epstein from McMaster University visited Vancouver and gave a lecture on family therapy. He seemed to know a lot about families. I talked to him after his lecture and discussed the possibility of learning from him and he was very receptive. So I decided to transfer to McMaster, in Hamilton, Ontario.

After moving to McMaster, I got deeply into family work. My main family therapy supervisor was Sol Levin. He was an early riser and started supervision at 7 in the morning. It was a wonderful experience. Around that time Nate and his colleagues were developing the Family Assessment Measure, the FAM, and the FAD, the Family Assessment Device. Previously, Nate had done a lot of work generating the Family Categories Schema at McGill in Montreal where he had worked with Norm Westley and published the book *The Silent Majority* (Wesley & Epstein, 1969). Nate Epstein had previously been influenced by Nathan Ackerman who founded the Ackerman Institute in New York. Nathan Epstein, Nathan Ackerman, and Sol Levin were all psychiatrists and psychoanalysts as well as systems family therapists.

**Collins:** What were some of the early concepts influencing your thinking?

**Tomm:** At that time, the main theoretical concepts that were being used to understand families were Von Bertalanffy's ideas about systems, notions of feedback loops and homeostasis, the whole as greater than the sum of the parts, and change in one part triggering change in all other parts. Those kinds of basic systems ideas were talked about a lot.

Yet it was another client experience at McMaster that influenced me most deeply. She was not my patient, but I got to know about her through discussions in medical rounds while I was working on an adjoining ward at the Hamilton Psychiatric Hospital. She had been admitted after an overdose and she had been in and out of hospital with depression for several years. Her husband was a kind man who was very helpful in the home. So when she was depressed, he would manage the kids and do all the housework and stuff. And of course the more he did, the less she did. Then, an interesting thing happened: The husband was involved in a serious car accident. Because two people were killed in the other car, he was charged with manslaughter. That really sent him for a loop. He got down and began having trouble coping. Interestingly, when he was struggling, his wife seemed to get better. He was heavily preoccupied with the legal issue hanging over his head, and started doing less at home. So she did more. And the more she did, the better she felt about herself, so she could do even more, and he did even less. She became fully functional. Indeed, after a while, it appeared that she had fully recovered from her depression. However, a couple of years later, when the court proceedings about the accident came to a conclusion, he was found “not guilty” because it was a genuine accident. When he received that ruling, he was relieved, became energized, and started doing things again. The more he did, the less she did, and the less she did, the more he did, etc. She became depressed again, felt hopeless, and eventually committed suicide by drinking carbon tetrachloride.

That whole process stuck with me. At the time it was happening, I didn't recognize the pattern of overadequate/inadequate reciprocity between the couple. It became apparent to me in retrospect. I came to recognize the pervasive power of such problematic patterns in family systems. People could get caught in difficult positions in their relationships and sometimes could not get out of them. These interpersonal patterns struck me as having a significant influence on mental health and solidified my commitment to work with families. I thought “if this is happening to some people with mental illness, I want to be able to work with them and their relationship systems” as a way to help them recover.

**Collins:** Was there a theoretical approach or model you were operating under at McMaster?

**Tomm:** The approach was very problem centered then. We used the medical model where the therapist would assess the family, determine what the problem was, and then treat it through confrontation. Nathan Epstein was well known for his strength of character and confrontational style. He was a very skilled clinician. He would confront

people vigorously and very effectively. His approach was based in part on research he did with a sociologist, Norman Westley, at McGill University where they studied some students at McGill. They made the assumption that students who get into McGill must come from well functioning families because their children were doing so well academically. They examined these families to see what made them tick and found that they were “father-led families.” This led Epstein and Westley to believe that families do better when fathers are in charge. In retrospect, what they were studying and reproducing was the dominant culture of patriarchal patterns in families, which they assumed was the basis of good mental health. Epstein took their findings to McMaster and when he saw mothers of problematic children with too much influence, he would “knock down” the mothers and “build up” the fathers to take charge. This approach used lots of confrontation and to get away with it you had to package it with support in what we called “the sandwich technique.” You give a bit of support and then you hit them with the “meat” of the intervention and then you give them a bit of support again. For example, “You seem to be an intelligent man, why don’t you just stand up to your wife? I know you can do it!” Basically that was the way we would try to treat families at the time.

**Collins:** Was Epstein influenced by Minuchin at all?

**Tomm:** No, there was not much influence on each other as far as I am aware. Epstein was more influenced by Ackerman. Nathan Ackerman was very direct and confrontational as well. In retrospect their approach could be seen as “put-the-pants-back-on-father family therapy.” While at McMaster, I learned how to confront as well and became quite good at it. However, in retrospect, I am ashamed of the way in which I was so confrontational with families. But that was what we believed in at that time.

After residency I continued on at McMaster for another year as a teaching fellow. During that year I came out to Calgary to visit my father who was ill at the Foothills Hospital. I met Dr. Pearce in the Department of Psychiatry and was promptly offered a job at the University of Calgary. I proposed starting a Family Therapy Program if I moved, and eventually did so in 1972.

Once I left McMaster I was freer to explore other models. I traveled around to see what other people were doing in family therapy. I went to visit Minuchin in Philadelphia, to the MRI (Mental Research Institute) in Palo Alto, and also to the Ackerman Institute in New York. I picked up lots of other ideas and put them together to develop my own blend of family therapy. My understanding was summarized in the “circular pattern diagramming model” that I developed where I tried to integrate psychodynamic ideas, cognitive

ideas, and behavioral ideas, by connecting them through a cybernetic feedback loop. My perspective at that time was problem oriented and the therapy focused on solving problems. I was not as aware of alternatives then. I just assumed that was the way you should work with families.

**Collins:** What ideas did you find particularly useful from visiting Minuchin, the MRI, and Ackerman?

**Tomm:** I found Minuchin's concepts about boundaries and subsystems very useful. Nate Epstein used those ideas too but not as rigorously as Minuchin did in terms of defining clear intergenerational boundaries and having an executive subsystem and a sibling subsystem. I found that Minuchin was clearer about those ideas and he had specific interventions that he used to push families toward what he felt were healthy or more appropriate boundaries.

At the MRI, I became aware of Bateson's work in cybernetics and the importance of positive feed-back loops and negative feedback loops in family systems. I actually used the cybernetic feedback loop as an organizing principle in my circular pattern diagramming.

The main influence of the Ackerman Institute was in the psychodynamic/psychoanalytic approach to family therapy where one pays attention to the emotional dynamics within family members. Within my circular pattern diagramming I placed emotions within the individual enclosures along with cognitions. But my focus shifted from individual problems toward relationship problems or patterns of interaction that were problematic.

**Collins:** Could you explain the shift from the McMaster focus on the individual in the family to the patterns of relationships?

**Tomm:** That was a significant shift; it set me up for further developments. If you think of a family who has a member with a problem and say there are family relationship influences that aggravate or ameliorate the problem, it is still an individual problem. I was moving toward a view where individual family members were quite incidental and the problem was in the pattern of interaction like the overadequate/inadequate reciprocity between the couple mentioned earlier. It could be that the problem was not within either one of them. The problem was in the organization of their relationship as one of overadequate/inadequate reciprocity. That possibility became more apparent through the "natural experiment" of the car accident, when the positions in the reciprocity reversed but the pattern stayed the same. The husband and wife temporarily occupied different positions in the pattern. It became more apparent to me that the problem was not in either the wife or the husband. It was in the

pattern of interaction between the two of them. That is why I was attracted to the cybernetic metaphor of patterns of interaction that was highlighted by the MRI group. However, what I could not get a handle on in those years was the MRI's use of paradoxes. They did not make sense to me at that time, so I did not use paradoxes then.

**Collins:** How did you see influencing change of the patterns then?

**Tomm:** The circular diagramming model helped me clarify the problematic pattern, and I could use interventions at different points in the pattern. Depending on the nuances of the family situation and their relationship patterns, I could intervene with the behaviors on the feedback arrows, I could intervene on the emotional dynamics, or I could intervene on the cognitions in terms of how the participants were interpreting the behavior of the others. In other words, I had multiple points of entry to break up the pattern that was problematic. I was less clear about what pattern the family could or should enact, than I was focused on the problematic pattern that I was trying to break up.

**Collins:** How did you decide which nuances to focus on, whether the feelings, behaviors, or cognition? How did you decide one over the other?

**Tomm:** I usually decided on the basis of intensity and what emerged most strongly. If there was a particular behavior that was obviously problematic, for example pervasive criticism and persistent dumping on one person, repeated behaviors like that, I would probably focus on that. If the intensity emerged in the emotions like anger, outrage, bitterness, or resentment, I would focus there. If kids were unable to sleep at night because they thought they saw ghosts or monsters, I would focus on that. Or if the pattern was subtle and had to do with ways of thinking or believing, for instance the parents seeing the kids as defiant rather than afraid, I would try to work with the cognitions. It was what jumped out to me as most "obviously out of line."

**Collins:** When did the concept of first-order and second-order change occur in your thinking?

**Tomm:** First-order change and second-order change are different than first-order approaches and second-order approaches. First-order change and second-order change are ideas that the MRI developed. By first-order change they meant change analogous to driving in one particular gear and you can speed up or slow down. Second-order change occurs when you change from one gear to another gear: you move into a different frame of reference. Within that new frame of reference, change is again possible, but it is first-order change within that frame. The MRI notion of reframing, where the meaning of a certain behavior is changed, reflects a second-order change.



First-order and second-order approaches refer to a comparison at a different level, namely, the relationships between therapists and families in the therapeutic system. First-order family therapy approaches employ concepts from systems theory and first-order cybernetics, which refers to the cybernetics of control systems or regulation and control in observed relationship systems. If one is engaged in first-order approaches to therapy, then one is interested in these regulatory patterns of control. As an observer, I am outside of the pattern and I am just observing it, analyzing it, and operating upon it.

The second-order approaches include an ongoing awareness and assessment of the therapist's relationship with the family in the therapeutic system and how this is simultaneously influencing interactions within the family system. Second-order approaches are more complex. For instance, they entail a "cybernetics of cybernetics" and imply the domain of understanding in observing systems. The distinction between first-order approaches and second-order approaches didn't come to me until there was a shift in the field, which could be marked around the time the Milan approach emerged in the mid-to late 70s. I think their work had a very significant impact on the understanding and doing of family therapy.

## **PART II (1979–1989): MILAN WORK: A MOVE AWAY FROM PROBLEM-CENTERED FOCUS**

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**Collins:** In the late 1970s you seemed to move away from the problem-centered focus?

**Tomm:** A major change for me occurred on my first sabbatical of 1978-1979. What led up to that change was very significant. Just before I went on sabbatical I had an experience of a major therapeutic failure. The husband/father in a family I had worked with intensively for 9 months eventually committed suicide. It was a very complex situation (which I wrote about for the book *Failures in Family Therapy*, edited by Sandra Coleman). This failure experience set me up to be more receptive to new ideas because my "good idea" of circular pattern diagramming didn't help. I had worked systematically and thoroughly with a clear problematic pattern between the couple, yet the outcome was tragic. After the suicide I came to realize that, without intending to, I was actually aggravating the problem. In this family there was a recurrent pattern of criticism coupled with distancing between the parents. Each spouse would criticize the other while the other would distance him or herself and vice versa. However,

I ended up criticizing them for criticizing each other, for instance by drawing the pattern on a blackboard and pointing out what they were doing to each other that was problematic. I tried to do so in a supportive and respectful manner but nonetheless it was the same dynamic. I was criticizing them for criticizing each other in a continuing problematic pattern. Without realizing it, I was adding to the problem. This only became apparent to me in retrospect.

I heard about his suicide just before I left on sabbatical to Europe where I encountered the Milan approach through their book *Paradox and Counterparadox* (Selvini, Boscolo, Cecchin, & Prata, 1988). When I first read the book, I could not understand it. This upset me a bit because I thought I was up to date with the family therapy literature. I read it a second time, and a third time. Finally I got up enough courage to write Selvini a letter and ask her whether there was an implicit negative connotation within the positive connotation that accounted for the therapeutic changes. She wrote back saying “very interesting question” and suggested we get together to talk. This was the beginning of my connection with the Milan team and led to a collaborative relationship with Luigi Boscolo and Gianfranco Cecchin that remained quite close for over 10 years. During my work with them a huge shift occurred in me, absolutely huge, it was the biggest single shift I made in my professional thinking and patterns of practice.

**Collins:** When did the Milan Group influence you?

**Tomm:** I first met Selvini in Wales in 1979. It was a very exciting meeting for me because I found our discussions very enlivening and energetic. She was a very dynamic woman. One of the things I remember about that conversation was her statement about Bateson claiming that “the mind is social!” That idea really took hold of me and I pondered it for a long time. I made a concerted effort to connect more with her and her colleagues. That year John Burnham and I cosponsored a conference with Boscolo and Cecchin in Birmingham which was the beginning of our clinical collaboration.

I could see that they were onto something quite unique, very different. The possibility of doing something paradoxical had been something I had entertained but never used. For instance, with the family I “failed” by virtue of the father committing suicide, I had considered some paradoxical interventions but had never tried them. I did not have the confidence to do so before connecting with the Milan team. My understanding of the Milan approach at that time was that symptomatic families were regarded as stuck in

patterns of interaction that they couldn't get out of. Part of the reason they could not get out of them was because they had certain rigid beliefs and ideas that constrained them. If you use a paradoxical intervention which generated confusion around those firmly held ideas and beliefs, then you loosen the grip of the ideas on the people who hold them. This made it possible for spontaneous change; for family members to entertain different ideas and consequently different patterns of behavior. If these differences made a difference, in allowing the family to move forward, then the paradoxes could be seen as very therapeutic. Thus, I became increasingly interested in what I was doing in the therapeutic relationship to influence the beliefs in the family. I kept asking myself, "What kinds of interventions could I use in terms of ideas and beliefs that could alter the family's ideas and beliefs and secondarily enable change in their behavior patterns with each other?" In retrospect, one of the most useful aspects of the Milan approach was to harness the power of the distinction between good and bad in the so-called "positive connotation" intervention which was highly paradoxical.

A related change occurred in my personal belief system about the nature of knowledge and of therapy. Prior to Milan work, I was trained in a paradigm of empiricism and objectivity, but now I was doing something outside that framework. The domain of constructing alternative knowledges, that are not based on objectivity, led me to explore constructivism, social constructionism, and eventually bringforthism. A whole different way of thinking about reality or "realities" and about myself as a participant in conversations to co-construct realities opened up to me. Indeed, the single most significant change that occurred in my professional development was being able to liberate myself from the empirical paradigm so I could move into a social constructionist or a bringforthist paradigm when I am doing clinical work.

Nowadays, I live and work in both domains. For example, if I am preparing to go flying, I live in the domain of empiricism; I believe the airplane has the objective capability of flying, otherwise I would not board the aircraft. When I am doing therapy, I prefer to live in the domain of social constructionism; I want to be thinking of realities co-constructed in our therapeutic conversation. If you believe in objectivity during therapy and you distinguish something as objectively true, then you are stuck with it and the possibilities for change are reduced. Most schools of family therapy still employ predominantly first-order approaches grounded in empiricism, while the second-order approach of the Milan team was grounded in constructivism. To work in second-order approaches you need to

liberate yourself from being stuck in objectivity, and instead entertain alternative ways of thinking, believing, and seeing the world. For me, that was a huge, huge change.

**Collins:** You also made a shift from circular pattern diagramming to HIPs (healing interaction patterns) and PIPs (pathologizing interaction patterns) in 1991.

**Tomm:** HIPs and PIPs are components of interpersonal relationships and exist, in my view, in the interpersonal space between people: They are patterns of interaction that are external to the people who engage in them. A circular pattern diagram, on the other hand, incorporates the persons who are interacting; the HIPs and PIPs don't. The PIPs perspective has certain advantages in supporting a social constructionist understanding and in enabling certain initiatives in therapy. If I describe a PIP of criticism coupled with defensiveness, you and I can engage in those behaviors, yet the pattern remains between us, not within us. This view enables therapeutic conversation along the lines of Michael White's way of working and thinking in terms of externalizing problems. HIPs like apologizing coupled with forgiving, on the other hand, begin external to the persons involved, but become more therapeutic as they are internalized. Michael did not talk about internalizing. He mainly talked about externalizing constraints. I suppose you could say that by bringing forth unique outcomes and restorying people's lives, he is engaged in an internalizing process. I have not heard him describe it that way—maybe he does but I never heard it from him.

I talk about both internalizing and externalizing. I sometimes use the metaphor of the immune system of the body as analogous to the work we do in therapy. The immune system of the physical body works at the interface of self and nonself in the physical domain. If some poisons, bacteria, or viruses enter the body, or early cancer cells develop, the immune system identifies these threats as nonself and mounts a response to defend the body and destroy those things, to get rid of them. At the same time the immune system allows nutrients into the body to nourish us and become part of our body, of our self. In other words the immune system operates at the interface of the self and nonself and monitors what comes in and can stay in, and what gets excreted or sent out. Similarly, a good therapeutic conversation operates at the interface of self and nonself, but in the social/psychological domain. If in the course of an argument someone calls you names and says you are arrogant, or you are bossy or inadequate, those descriptions could stick to your identity and if they are "poisonous" you have to do something to get rid of them. A therapeutic conversation could externalize such noxious descriptions of self and get rid of them and instead

allow nurturing descriptions about one's identity back in, in other words, about being competent, being capable, being resilient, or being able to survive hardship. Therapeutic conversation, in that sense, also operates at that interface between self and nonself, by monitoring one's psychological self and identity, and by trying to "clean up" the self and get rid of noxious descriptions, which have become stuck to oneself from the words of others.

### **PART III (1985–PRESENT): SOCIAL CONSTRUCTIONISM AND NARRATIVE FAMILY THERAPY**

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**Collins:** The last time we were together, we ended with the influence that the Milan group had on you, and then you introduced meeting Michael White for the first time. Where I'm most interested in starting today is if you could talk about how Michael White influenced your thinking, your theory, and your practice and as well how you think you influenced his theory and practice of family therapy. It was about 20 years ago that you met Michael?

**Tomm:** I think it was about 1985 or 1986 that we met. Michael influenced my work a lot! I could certainly say that. I'm not sure how much I influenced him; he'd have to speak to that. We did collaborate quite closely for a number of years. One of the first things that attracted me to his work was his process of externalizing and how he engaged in elegant externalizing conversations. That, to me, seemed extremely useful and I think it has been a major contribution to the field. It's a method whereby one can actually implement, in a concrete way, some of the contemporary theory of social constructionism. You can take one conversation about yourself and can separate that conversation out from other conversations about your self, and give priority to one over another to select a preferred identity. The distinctions between self and nonself became highly relevant in the context of therapeutic interviews. So one could bring forth an identity of being a survivor rather than a victim, of having competencies rather than limitations, and move forward in one's life despite past difficulties. One develops a personal story, a narrative of self, and lives out one's story. Through selective conversation and reflection, you bring stories about yourself into focus, carve out parts of the self story that don't fit or you don't want to belong to you anymore and want to get rid of, and start deconstructing them. If it's a certain quality that you don't like, such as being lazy, you might transform the adjective *lazy* into the noun *laziness* and separate it from yourself. For instance, I could shift from thinking "Karl is lazy" to thinking "Karl is under the influence of laziness" and

that “laziness has a grip on him” at times. Then you could engage in a conversation or reflection about laziness being a habit or a phenomenon separate from me, and doesn’t have to be part of my identity. That way of talking and thinking was such a useful contribution to the field and in developing ideas around therapeutic conversation. So I incorporate it into my practice.

**Collins:** This is quite a big shift from where the Milan [group] wielded the problem. What was the function of [the] problem, and now you are really shifting into the influence the problem had on you. I think that’s a fairly radical shift.

**Tomm:** Oh yeah. I felt that what Michael was doing in practice, was more compatible with Humberto Maturana’s theory of knowledge than what the Milan team were doing (even though I first got involved with Maturana because of my interest in explaining the work of the Milan team). I think I mentioned last time that I abandoned Milan systemic work once I realized that Maturana was challenging functional thinking and used the notion of structure determinism instead. He helped me see how relationship patterns could more usefully be described as mutual invitations.

**Collins:** Did Maturana influence Michael White’s thinking?

**Tomm:** Well, I don’t think Maturana had a lot of influence on Michael, except indirectly through me. Michael and Maturana never really connected, I don’t think. I think Michael may have heard him present a few times. I don’t know. But Michael would often ask me about Maturana’s theory and I did my best to explain it to him several times. Because I felt there was compatibility in the practices that he was developing in his clinical work and the theory that Maturana was espousing, I could see a significant connection there. I still see Maturana as offering the best theoretical foundation that I’ve come across so far, for the kind of work that I do.

**Collins:** How do you put Maturana and Michael White’s work into that whole circular patterning way of thinking that you have to operate?

**Tomm:** Well, both helped me shift away from circular pattern diagramming to highlight the mutual invitations of the HIPs and PIPs model which are complementarities that exist in the interpersonal space. With the circular pattern diagramming model, the persons interacting remain part of the description. You represent two people with internal thoughts and feelings in the enclosures, plus the behaviors linking them. With a description using the HIPs and PIPs model, all of the components of the pattern, in my view, remain in the interpersonal space and are external to the people engaged in the pattern.

**Collins:** Who else has influenced you do you think over the last 15 to 20 years? Were there other major influences in your life, in your family work?

**Tomm:** Well, there were many, many influences. David Epston clearly was a major influence along with Michael. They're pretty much together in their way of thinking, in narrative therapy. I don't know if I mentioned this to you before or not but at one point they actually invited me to join them in coauthoring their first book on *Narrative Means to Therapeutic Ends* (White & Epston, 1990), for which I wrote a foreword. I didn't join in then because I didn't feel like I was sufficiently into their frame of reference at the time.

Some of the ways in which David has influenced me has been to create unique activities for families, and especially for kids, to enact a process for narrative change. One example could be work with a child who has had a problem with lying and stealing. After we go through an externalizing process, of externalizing "sticky fingers," we set up some "honesty tests" and create conditions for a child to succeed in passing the tests as a counterpoint to being dishonest. The issue of one's "reputation" would also be brought up. Kids who have been lying and stealing often get into trouble in the community and at school because their reputation precedes them. Sometimes these kids are no longer allowed into the stores where they have been caught stealing. Eventually, whenever something goes missing, they get accused, even if they didn't do it. Such accusations are of course problematic for the child because they run them down and they actually become more vulnerable to slip back into old problematic habits of lying and stealing.

One of the things that David might do in situations like that, is to externalize the stealing habit and bring forth the child's desire to be honest and to escape the bad reputation. David might raise questions like, "Can you see how your reputation gets you into trouble? . . . Would you like to change your reputation?" "Yeah, yeah, I'd like to change that." "How would you go about changing it, if you wanted to?" "Don't know." "Well, say you were to pass some honesty tests, and the store knew you were doing that. Do you think that would help?" "Maybe." "What if I asked your mom or your dad to go to the store, before you go to buy some groceries. They could talk to the clerk in advance, and give her an extra dollar and tell her that when you come to buy something, she should give you an extra dollar in change. Now what would you do with that dollar if she give you too much change? If you wanted to develop a reputation for honesty, instead of a reputation for being a thief, what would you do? What would be the smart thing to do?" Well, the kid struggles a bit with this because if one gets too much change

back, the child usually thinks the smart thing to do would be to keep it. However, if you want to change your reputation, the new smart thing to do would be to give it back. “If you gave it back to the clerk, what would that do to your reputation in the clerk’s mind?” The child really starts thinking about this. David advises the parents (in front of the child) to do this sometime when the child doesn’t know it is happening. You don’t want him to know when you’re doing this. And then the kid is always wondering when this might happen. The kid checks the change and learns to give the extra change back. It’s a way to construct real life situations for behavioral change.

David Epston was really good at that. He was really good at developing these kinds of strategies and methods for change, for instance developing fear busting skills, night watching routines, etc. Of course another thing that David did was “therapeutic letter writing.” I did a bit of that too.

**Collins:** So where are you at today? What would you say, if you were to describe your theory and practice today? I’m actually also interested in what you brought from your original family practice, your family-centered practice from Epstein and then of course your Milan influence on you and the narrative influence. If you were to describe your practice today, what did you keep and what has changed?

**Tomm:** One of the major things that I’ve retained from the beginning is the very strong focus and commitment to the family as an entity, as a relationship system itself. That has been consistent even though my theoretical frames and patterns of practice have changed. I have continued to focus on the family as a unit. And part of the reason for this is that the intensity of interaction in family relationships is so rich and the conversations are so significant in constructing realities for the members of that family system. There is a phrase that someone wrote about “the family being an epistemological crucible,” that is, it is the base out of which epistemology arises, where kids come to know about “reality,” and to “know about knowing”—that happens in a family system. Our knowing/knowledge becomes extended of course in school systems and other social systems that we become part of. But the family unit per se remains so crucial because of the richness of interaction that occurs among the members of that system. That focus has been consistent.

At the beginning of my career, I would often insist on seeing the whole family. I was overly rigid about that then and would insist that if they didn’t all come, I wouldn’t work with them. I’ve abandoned that practice many years ago because I learned to think



in terms of relationship systems. I don't need to see the whole family system in front of me to think in terms of family systems anymore. I'm more grounded now in thinking systemically about relationship and I can hold that perspective even when I'm working with individuals, whereas at the beginning I wasn't able to do that as easily. So while I do work with individuals now or with parts of family systems, such as a parent-child subsystem, a parental subsystem, or sibling subsystem, I still think in terms of whole family system dynamics. This overall systemic commitment informs me in terms of my local therapeutic initiatives, so that has been constant. I think that over time the degree to which I've focused on the co-construction of knowledge and competencies has grown. At the beginning that was very limited. But it's now become more and more part of my way of thinking and practicing. And so I would say that has been a change, but not a complete change, it's a matter of degree.

**Collins:** So you're much more active with all family members to get them to look at different ways of dealing with things and developing competencies as compared to you pointing them out to people, which was more of an Epstein kind of a model.

**Tomm:** Yes.

**Collins:** What about from the Milan group? What have you kind of kept from them that you still use in your practice, some of their thinking or practice?

**Tomm:** Oh for sure, the notion of circular interviewing and how it is possible through your questions to understand systemic patterns of interaction and relationships so well. That has been a big part of their work that has stayed with me. I still use those kinds of questions a lot. I've extended my thinking to distinguish between circular questions and reflexive questions. But that definitely has its roots in the Milan work. However, I've pretty much abandoned functional hypothesizing, although I employ it somewhat sometimes, but not when I'm thinking clearly. I prefer Maturana's way of conceptualizing. Another thing I still use from the Milan team is the process of creating family rituals.

Actually, I'm working with a family right now where I'm co-constructing a ritual with them that I hope is going to be therapeutic. And it's a family where this couple has three sons, all of whom have autistic spectrum disorder and the boys are all very significantly disabled. This has been a huge trauma, especially for the mother, because her identity as a person is heavily rooted in her

motherhood. She feels like she is a profound failure as a mother in bearing these three boys. Every time she sees their limitations, she feels inadequate and struggles with depression. She has been chronically depressed for years. Now, their third son is old enough to go through his bar mitzvah. The mother was dreading this, because for her it's another reminder of how she had failed as a mother. In a conversation with them, I've wondered whether we could modify the bar mitzvah ritual to not only acknowledge the coming of age of the son, but to acknowledge the extraordinary amount of parenting that the mother had provided for him, despite his limitations, to make possible what development he has achieved. I wanted to be sure it was consistent with their culture, and because I'm not Jewish I asked them if they would like me to work with them and their Rabbi to discuss how to do this. The mother's enormous contributions, of putting in far more time and effort than most mothers ever do in helping their children grow, could be acknowledged by the son somehow in the ceremony or by the people that are witness to it. The acknowledgement could be made compatible with the cultural ceremony yet make it a significantly healing event that the mother could remember; that she was indeed "a good mother" by virtue of her incredible contributions. This idea of creating family rituals comes from the Milan team where they have a number of rituals that they often used with different families. I still occasionally use their standard rituals, such as the "odd days and even days" or the "invariant prescription" (of carefully arranged parental "disappearances") but in a more flexible manner. I prefer if possible, to create a specific ritual together with the family that fits their specific situation.

Just recently, I got an e-mail message asking me what I knew about pseudocyesis. It's a subject I actually know next to nothing about. I assumed the person must have read an article that I had written about a family I had worked with many years ago. A female client kept having symptoms of being pregnant when she actually wasn't pregnant. What became apparent was that this might be related to an earlier stillbirth. She had had a couple of daughters who were healthy, and then a son who died in utero. Some time after she delivered the dead fetus she developed pseudocyesis. And so I worked with them as a family to create a ritual where they could symbolically bring the boy into their family, give him a name, and then give him a proper burial. This could then be an opportunity for them to acknowledge the significance of this event as part of their family life and so forth. They actually followed through on this; they went out into the forest and had a private ceremony. The mother made up a little doll to represent the boy, and together the

whole family buried it. Immediately afterward the symptoms of pseudocyesis disappeared. It was marvelous.

**Collins:** I have a tougher question for you. I'm interested in some of the criticisms people have of that systemic form of family therapy. I know you have heard some of them, particularly the people concerned about family violence and people not taking self responsibility for their behaviors. I know you've responded to this in other areas, but I am curious with how you put the whole concept of family violence within your thinking.

**Tomm:** That's a tough issue. There's a lot of disagreement in the field about how to deal with situations of violence. The systemic approach, generally speaking, is more accepting of what happens, and is less judgmental and less impositional than traditional approaches. For instance, in traditional child welfare, a worker comes in and determines the child is at risk and therefore feels justified in taking the child out of the home or forcing an abusive parent out of the home. If it's spousal abuse, a traditional therapist might insist that the wife go to a shelter, the spouses must separate, or whatever, and refuses to see them together as a couple. In some states there is actual legislation prohibiting marital therapy, or at least it's not funded, when there is spousal violence. The theory is that if conjoint work occurs, there is the implication that somehow "the woman was asking for it" when male to female violence occurs, and therefore men need to be treated alone to take full responsibility for their behavior.

Impositional therapeutic strategies run counter to the systemic position, which is to see the violence as part of the system. That's not to say that the people with less power who were violated are contributing to the violence. But it does imply that there's something that they are doing that is a part of the pattern that includes the violence. I prefer to still work systemically in situations of violence, but there are times when I have to break from that and move into a role of a social control agent. So I've had to certify people at times, or call social welfare. However, I tend to do so in a different way because of my systemic orientation.

Just to give you an example: With an Asian family I was working with, a while back, the father was violent with his daughter, physically violent with her. And from his point of view, it was culturally appropriate: "That's the way things are done in Korea." He believed that she ought to be completely obedient and submit to his authority. When she didn't, he felt justified in beating her. The mother had compassion on the girl and didn't agree with his view and hence the mother insisted on therapy. Now when I heard

the story, I said to the father, “Well, this may be compatible with your culture in Korea, I don’t know because I’m not knowledgeable about that, but in Canadian culture it is not acceptable. And given that you live in Canada, I need to let you know that I am required by law to inform the authorities. What I’m prepared to do though, is to try to help you to be seen more positively by them and give you an opportunity to report yourself, because if you reported yourself, the authorities are much less likely to be as severe in their intervention with your family than if I had to report you. If I have to report you and you don’t want to be reported, then they’re going to look at it as a much more dangerous situation. So I’m suggesting that maybe it would be good for you and your family to report yourself.” The father retorted, “No God damn way!” So I said to him, “That’s fine, I understand that you don’t want to do it but I want you to know that I will still give you this opportunity. So I’m not going to call for the next 24 hours. If you change your mind during that time and you want me to help you make the phone call, I am willing to do that.” And sure enough, he did call back within 24 hours and he reported himself. In effect, I used the threat of coercive external control as a way to strongly “invite” him into taking some responsibility, which would be quite different from what I would have done before getting into the Milan approach.

- Collins:** Now if you were to work with that family further, and he’s coming back and he’s trying to be vigilant to keep family violence out of his life, how would you then look at it with a systemic perspective, further on when you’re working with them?
- Tomm:** Now, after that, what I would do is invite him to learn to “live above suspicion.” What he would need to know, given that he now has a record with child protection, is how he can organize his way of being in relation to his daughter such that he is never going to be held suspect with respect to being violent with her, or abusing her again. I asked him, “What would you have to do to live above suspicion? To avoid being held suspect as abusive in the future?” This is particularly useful in situations of sexual abuse or in situations where there are allegations of sexual abuse where you don’t know whether it’s happened or not. If the person who is considered abusive is invited to recognize how there is now talk in the community and their reputation has been tainted because of the allegations, it would be wise for them to be very careful not to do anything that could feed those suspicions. Therefore they need to live above any suspicions in such a way that they can never be held suspect again. When they really understand that, they usually want to do so because they want to avoid being charged. So I ask, “But

how? How could you be sure that this would never arise again, that you'd never be held suspect again?" He might respond, "Well, if somebody else was always there when my daughter and I are together, the other person could vouch for me, even if my daughter did make an accusation. So if there is always a third party present, there would be less risk." "Yeah exactly!" I encourage him to make a personal rule of nonviolence that he lives by and which is supported by "a community of concern," in other words, other people in his social network, both inside and outside the family. That would be one way to work a bit more systemically with violence. I also use their systems of understandings to build new distinctions and behaviors, and work with them to facilitate movement in a preferred direction.

**Collins:** Let me ask you about another case example, and it was with alcoholism. I remember the old systemic way of sometimes thinking, is to say a person would say that my wife nags me, so I drink. There's at least a subtle part of blaming the other partner for some other behavior and yet we are trying to move very much away from that. What would your thinking be on that and your approach?

**Tomm:** Well, I like some of the recent work on motivational interviewing which is used with addictions and alcoholism in particular. An effort is made to focus on the internal system of a person and how they organize themselves and their own ideas about themselves and what they want for themselves. Motivational interviewing, in my view, is still in an empirical paradigm in terms of their thinking. They are not in a postmodernist, social constructionist paradigm, at least from what I've seen of Miller's work so far. I like what they do because it's so respectful of clients. They bring forth what they call ambivalence in terms of the person's feelings about themselves drinking; why it's good to drink, why it's not good to drink, and juxtapose the contradictions without putting pressure on them. To me, this is such a useful way to do therapy because you are working with their intrapersonal relationship with their internal systems of meaning, which of course ultimately came from interpersonal relationship dynamics. So I try to do that when I am working with situations of addiction, while at the same time, attending to the interpersonal dynamics that are operating. I try to deconstruct the process that you described of projecting responsibility on the other for the drinking, so it is a combination of bringing forth their internal system of motivation in a direction to be less abusive with drugs and alcohol and live consistently with their preferred way of being, at the same time as creating relationships or interpersonal interactions that are more supportive of that, rather than blocking it. So say there is a partner that is enabling in terms of buying the alcohol, making sure

there is a supply of alcohol available, I would certainly work with that person to help them abandon their component of the systemic addiction process.

**Collins:** Final question on that area, severe mental health issues. Individual ones, what's your thinking on that? I think go back to the old classic issues of schizophrenia, remember the whole original work of the family, schizophrenia, they've changed the thinking out of the individual to the schizophrenic family, and yet there seems to be a shift back to the schizophrenic individual.

**Tomm:** There's a really interesting story there . . . and it does a disservice to the field of family therapy in a way. After the double bind hypothesis was created at the Mental Research Institute through Bateson's work in distinguishing different levels of meaning and stuff, it was postulated as a psychotogenic dynamic that contributed to schizophrenia. This led to notions of a schizophrenogenic mother, and then a schizophrenogenic father, a schizophrenogenic sister and brother, and so on. Everybody in the family system got painted with the same pejorative stigmatizing brush of mental disorder. The families of persons who were diagnosed as having schizophrenia really got up in arms about this. And they took collective action through NAMI—the National Association for the Mentally Ill in the United States. For a while, NAMI took a very strong stand against family therapy, and gave family therapy a bad name because of the tendency of some therapists to blame families for the mental illness of one of their members.

We've come a long way since then, and NAMI has backed off, partly because of some of the research findings in the expressed emotion (EE) studies. The EE studies came out of England where it was demonstrated empirically that the person diagnosed with schizophrenia was much more likely to require rehospitalization if they lived in families where there were high levels of expressed emotion, high levels of criticism, etc. Those families who participated in psychoeducation and learned to respond to their member with schizophrenia in less emotional ways and more supportively instead, the prognosis was better in terms of staying out of hospital longer. There is more acceptance now about family work even by organizations like NAMI but there is still a sort of hint that family therapy is to blame. What I think is not yet adequately acknowledged is the significance of social dynamics in contributing to psychotic patterns of thought and in ameliorating them as well. The best genetic studies that we have so far, in terms of identical twins, show a 50% concordance rate, i.e., if one identical twin has schizophrenia, 50% of the time the other twin will have it too. How do you account for the other 50% who have the same genetic makeup but do not develop the psychosis? That

raises questions about the adequacy of the genetic hypothesis which of course unfolds into brain structures and neurotransmitters, etc. I think there is eventually going to be a drift back to examine what it is in life experiences or relationship patterns that may be psychotogenic, which promotes psychosis. Murray Bowen came up with a theory for how schizophrenia arises through a series of successive generations of decreasing differentiation of self, which results in people living patterns of weakened “reality testing” in the face of strong demands for familial consensus.

**Collins:** . . . Includes things like alcoholism passing on from generation to generation too? There’s some kind of transmission process there.

**Tomm:** For sure. Murray Bowen has passed away. But one person carrying forward his ideas and connecting them to the biological domain is David Reese. David has been doing a lot of work in genetics as well as family systems, and has made a distinction between consensus sensitive families and environment sensitive families. Consensus sensitivity is used to describe families in which there is a high need to appear to agree because of the associated emotional dynamics. Thus, people tend to give up their distinctions of their environment or “reality,” in favor of a “safer” emotional relationship with the other. Of course in extreme situations a “folie a deux” may arise where people live within the same psychotic belief system. I’ve had some experience working with families with a member who has been diagnosed with schizophrenia. And I’ve been able to recognize clear patterns of interaction that appear to be psychotogenic, maybe genic is not the right word, they seem to be psychoto-promoting patterns, they tend to aggravate psychotic process. For instance, patterns of disqualification seem quite pervasive in those family systems and the disqualification can be overt in terms of saying “there are no voices here,” that idea is “crazy,” or that belief is “stupid” when they suffer from delusion, to quite subtle things of not paying attention to, or ignoring, what the person is saying. One can imply through lack of response that what someone is saying is wrong or irrelevant and is therefore “crazy.” I’ve found that working with these families can be gratifying because you can help family members become more affirming, and less disqualifying, and the family interactions become less psychotogenic. There is a man I worked with off and on for 25 years, who I still see from time to time. I’ve seen his family for a long time. I still remember one point in the therapy where he abandoned his delusional belief about being a Roman emperor, or being a famous drummer. He developed these beliefs almost as a way to compensate for his profound sense of inadequacy compared to other family members. But at one point in the therapy he said to me,

“I just want to be an ordinary man.” It was music to my ears—to hear him say that, when he had been hanging on to these grandiose delusions for so long. It was such a wonderful thing. He’s still limited, he’s still not working, but he’s able to function and help out doing chores for his parents and stuff. Although he’s getting into some social relationships, he’s still limited in what he can do. He’s on medication as well. It’s not an either–or, it’s a both–and situation. I assume there may be a genetic predisposition and certain life experiences that aggravate one’s vulnerability. However, I still see a major role for family therapy in families with members who have serious mental illness.

**Collins:** I have a final question. I’m interested where you see yourself headed in terms of family therapy, or even like your prediction of where the future of family therapy is, what it may look like, or at least where you’re proceeding with it?

**Tomm:** Well, a number of years ago, I imagined a periodic table of “healing elements of mind,” where we as clinicians could understand how we engage in conversations to co-construct certain mental phenomena like hope, responsibility, motivation, acceptance, apology, forgiveness, etc. As we develop more understanding about the kinds of interactions and conversations that allow those phenomena to arise in relationship, and then could be internalized to become part of the self, maybe we can develop the corresponding conversational skills. If we as clinicians could develop a way of outlining an overall structure of meaning systems, and of beliefs and values, and of behaviors that are interconnected, just like the periodic table of elements, then we might see how there are certain patterns of interaction/conversation that create certain phenomena. We could learn to meet people where they are at, tune in to their patterns of interaction and their recurrent conversations, and then open space for them to co-construct with us, and each other, what they need to realize to enact selective conversations for “healthy minds.”

**Collins:** It would be interesting for you to figure that out in the family therapy context of how to help influence hope for people, what do conversations look like to help that happen.

**Tomm:** I see that as one future possibility. I mean that’s a wild fantasy in a way. I also see that there is a lot of potential for using the method that I enjoy in terms of interviewing the “internalized other.” When I interview “a significant other” as “part of the self,” I bring forth their relationship as it is lived by the person I am speaking to. If this happens in the presence of the actual other, that other person gets to meet their “distributed self,” i.e., how they exist in the person I am speaking to. These practices are very rich with possibilities I think.



I also see a future possibility where families will go in to see their “friendly therapist” for an annual family system checkup, to discuss their family relationships and unique patterns and what directions they are evolving or drifting in, and possibly realign their directions. I can see such a tradition as one way toward maximizing mental health and wellness for the future. Every 6 months or year, a family would meet with their friendly therapist, who might not be called a therapist at all; a family coach might be a better term for it, or a family consultant. I do see lots of merit still in the HIPs and PIPs model being extended and elaborated. For instance, I see that the DSM, if it could be expanded, so that every individual diagnosis was sort of connected with a clarifying section to elaborate on common patterns of interaction that contribute to and/or generate the individual phenomenology. For instance, in various types of depression, there could be typical interpersonal patterns that generate such depression which then clinicians can use as ways to understand a particular client’s situation more richly and use the knowledge of relationship dynamics to foster change and not just depend on pharmacotherapy. I could see that potentially happening. The DSM is still deeply immersed in assumptions about separate skin-bounded selves; there is lip service to looking at the situation, the context, or stressors, but it’s not really incorporated into the theorizing and understanding of the mental phenomena that they are trying to diagnose and treat. So those are some of the things that I see possibly happening in the future.

**Collins:** Before we end, are there any other questions that you’d like me to ask you?

**Tomm:** Not really. I enjoyed talking to you; there are many places we still could go.

**Collins:** Well, we may still. But at the moment this is just a pleasure for me. I’m looking forward to listening to all this. Thank you.

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