Family Relational Assessment and Intervention Training Program
(1_24_23)

Beatrice Wood, PhD, ABPP & Sourav Sengupta, MD, MPH
bwood@buffalo.edu souravse@buffalo.edu

This FRAI program included 6 hours of didactics and 20 hours of group supervision plus individual supervision of family assessment and intervention. The program meets in the **fall** for 6 one-hour introductory didactic sessions (outlined below). Both first and second year fellows attend. The second year students continue supervised family intervention and participate in the didactics by illustrating the teaching points using family video recordings they have made during their assessments and interventions. In the **spring** the first year fellows conduct **Family Relationship (observed interaction) Assessment Protocols** (described below), and the second year fellows continue their (live and video recorded) interventions with at least one family at a time for which they are responsible. Family assessment and intervention cases are discussed in group supervision.

Session 1. Welcome to the Family Systems Theory and Practice Didactic Seminar

Child mental health depends upon healthy family function.

Before this session: Read Josephson's *From Family Therapy to Family Intervention.* Child Adolesc Psychiatric Clin N Am 24 (2015) 457–470

This As a child and adolescent psychiatrist, every child that you see will be an integral part of a family. Understanding how a child's family works is critical in helping both him/her AND the family better manage emotional/psychological/behavioral/cognitive challenges they are struggling with. Furthermore, child and adolescent psychiatrists often need to find ways to constructively intervene with family systems that have gotten "stuck." Over the next few weeks, we will review basics of family systems theory and core ideas and interventions often engaged by child and adolescent psychiatrists to assess and help families function better.

Goals and Objectives

Learners will be able to:

- Understand and apply core principles foundational to the family systems assessment and intervention
    - Systems Theory
    - Communication and Feedback Systems
- Characterize a child's family and describe its functioning, including:
    - Who is in the family?
    - How do family members relate/interact with each other, esp. in terms of:
        - **Family Vital Signs** model defined below
    - How is the family functioning well? How is it struggling?
    - How do they approach developmental, life and interpersonal challenges?
    - What are their beliefs regarding the patient, parenting and family relationships
- Understand the centrality of relationships in family function
- Identify communication patterns as they shape relationships in families

- Understand how child and family developmental changes influence family functioning
- Recognize how socio-cultural-economic factors influence family function

Key Tools:

- **Family Relationship Assessment Protocol (instructions attached)**. Families participate in a structured set of emotionally relevant family interaction discussions and activities, while observed (usually from behind a one way mirror or through zoom with video recording) by residents/fellows, and supervisors. Specifically, the family engages in 6 discussions or activities designed to evoke a range of emotionally relevant interactions. *The purpose is to be able to see first-hand how a family interacts without the resident/fellow needing to be central in an interview process. This both helps the resident/fellow learn to observe family patterns of interaction (the foundation of relationships), and for more experienced clinicians to assess family relationships unbiased by self-report.*

- **The Biobehavioral Family Model** is an evidence-based model of key dimensions of family relationship which we call "**Family Vital Signs"(presented below).** Applied to the observations obtained in the Family Relationship Assessment Protocol, the Family Vital Signs guide the resident/fellow in systematic evaluation with an evidence-informed set of dimensions for each family. While it does not include all aspects of family function, it addresses essential features.

Session 2. Child Development Drives Family Development

Before this session:
Read Josephson's *Family Intervention as a Developmental Psychodynamic Therapy*. Child Adolesc Psychiatric Clin N Am 22 (2013) 241–260

I. Review: Eight Stages of Man (Erik Erikson). Each stage shapes family relational patterns.

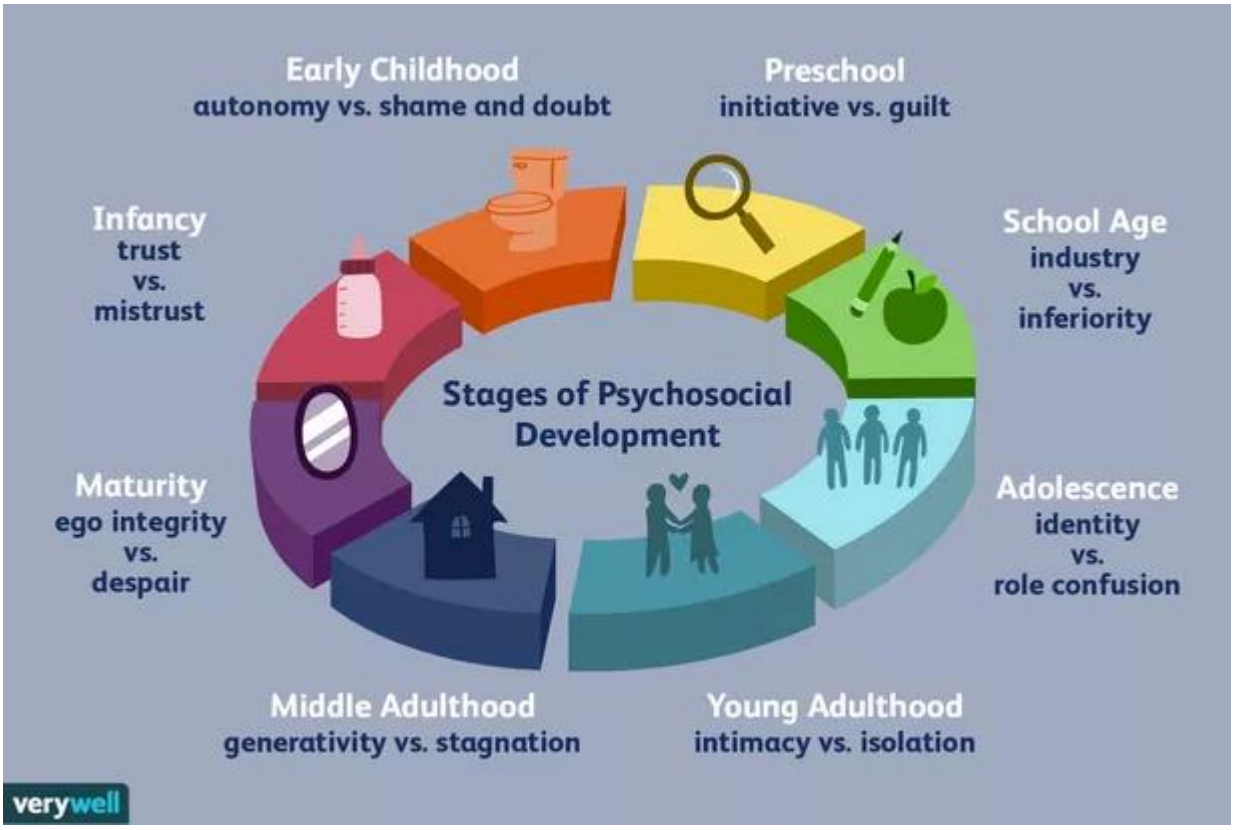
II. Review Family Development progresses from formation of couple to child rearing How can/do families develop over the course of a child's development?

Exercise:
1. Using Family #538 and #617 to compare and contrast family developmental stages and how they shape family relations.

Do the same for each family for whom the residents/fellows conduct a Family Process Assessment Protocol

2. Identify family developmental stages and incorporate family principles into ongoing treatment planning for one/more clinical example cases. Invite second year fellow to present appropriate case.

Erik Erikson's
Eight Stages of Man from "Identity and the Life Cycle" 1994



Age	Conflict	Important Events	Outcome
Infancy (birth to 18 months)	Trust vs. Mistrust	Feeding	Hope
Early Childhood (2 to 3 years)	Autonomy vs. Shame and Doubt	Toilet Training	Will
Preschool (3 to 5 years)	Initiative vs. Guilt	Exploration	Purpose
School Age (6 to 11 years)	Industry vs. Inferiority	School	Confidence
Adolescence (12 to 18 years)	Identity vs. Role Confusion	Social Relationships	Fidelity
Young Adulthood (19 to 40 years)	Intimacy vs. Isolation	Relationships	Love
Middle Adulthood (40 to 65 years)	Generativity vs. Stagnation	Work and Parenthood	Care
Maturity (65 to death)	Ego Integrity vs. Despair	Reflection on Life	

Session 3. FAMILY RELATIONAL ASSESSMENT

Every child psychiatry case is a "family case"

I. How to define "family"

A. Family is a social system which evolved to support the survival and welfare of its members, and impart the values and beliefs of their given culture.

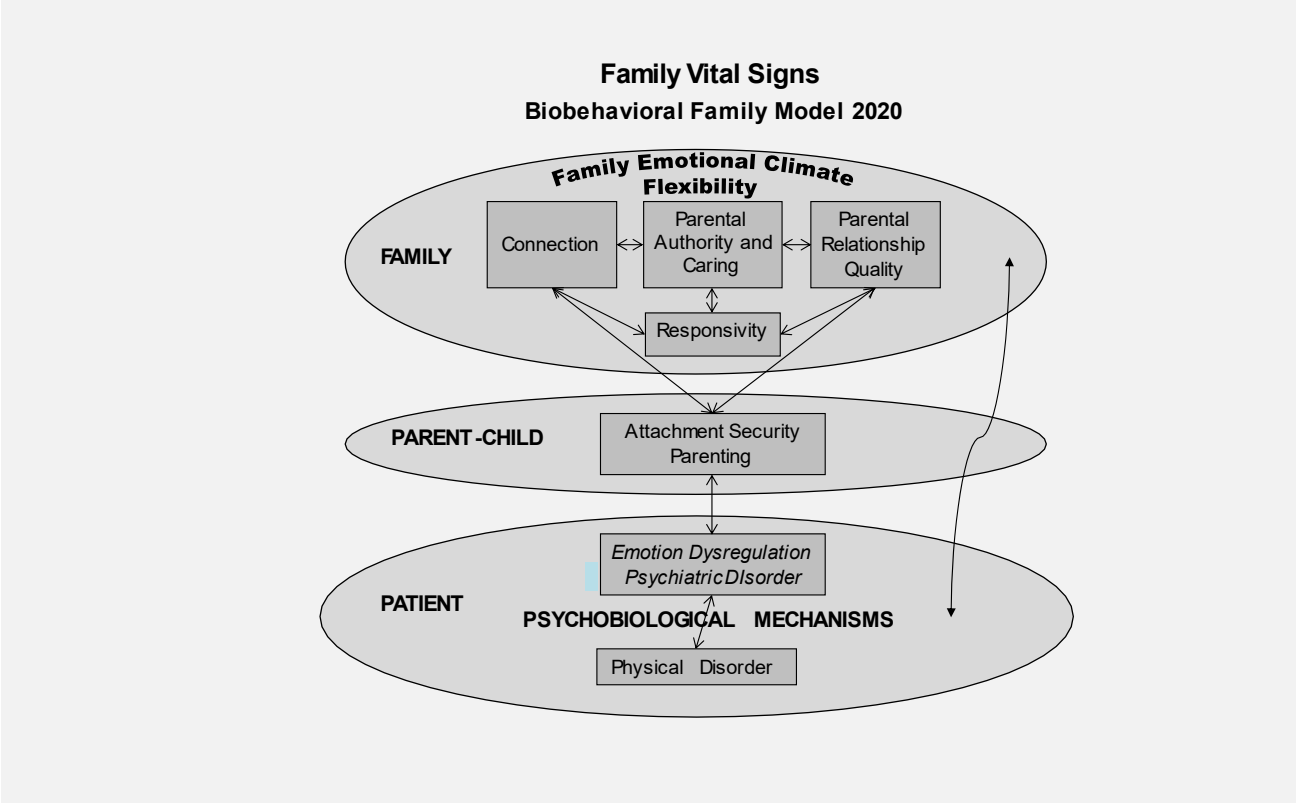
B. The "operative" family, from the point of view of clinical intervention, is the system of individuals who are most closely tied and who have the most influence on the individual who is identified as having a "problem."

C. "Household" is a place to start while beginning to identify "operative" family, but significant others not living in the household may be important to consider as part of assessment and intervention.

II. Family Vital Signs from the Biobehavioral Family Model (BBFM)

A. The Biobehavioral Family Model (Wood, BL,2017) in "*Encyclopedia of Couple and Family Therapy,"* Jay Lebow, Anthony Chambers, Doug Breunlin, (Eds.), Springer Publishing Company, NY. This model is derived from Minuchin's Structural Family Therapy concepts.

B. The BBFM is a *systemic* theory of "vital signs" of family function. These specific dimensions of family interaction are potential targets for intervention. (Families #528 and #617 as contrasting illustrations.)



Emotional Climate: the overall intensity and valence of family emotional exchange (e.g. warm, calm and accepting, tense, angry, anxious, depressed, disengaged/flat emotional tone

Interaction indicators- body and facial language; tone and volume of voices; content of things said (nasty vs nice)

Family flexibility- - extent to which the family interactions are patterned; ranges from rigidly patterned (and resistant to change), to patterns adaptive according to content, to chaotic lack of patterning in interactions

Interaction indicators-same people say the say types of things, or show the same emotions over and over, patterns of exchange do not vary; vs. variability in exchanges, but staying on topic; vs exchanges are not completed, others interrupt or topic changes, no "turn-taking" in conversations, relentless interruptions

Connectedness: who is close to whom and how; family wide connectedness is often referred to as "family cohesion"

Interaction indicators -eye contact; sharing emotions, private information; interactive facial expressions others?_____

Parental authority: the extent to which caregivers are in charge of children by offering guidance, and limit setting;
effective parental alliance and absence of cross-generational coalitions

Interaction indicators-parent(s) provide developmentally appropriate respectful guidance and limit-setting; child listens (eye contact, respectful response;
-parents respectfully collaborate in relating to their children, and don't undermine one another;
-child and one parent do not join together against the other parent, e.g. with criticism or disrespect or stonewalling
Others?_____

Parental caring: providing nurturance, warmth, respect, validation

Interaction indicators: parental eye contact and listening when child expressing negative affect; parent expressing sympathy and empathy when called for; parent listening attentively to child's experience, opinions, disagreement and respectfully considers them
Others?_____

Parental relationship quality: mutual support, understanding, and adaptive disagreement (respectful and resolving) versus
hostility, rejection, and unresolved conflict. (*Note: Parent-parent relationship quality is key in determining family-level emotional climate. It also helps or hinders parental alliance.*)

Interaction indicators-parent looks at other parent when he/she is speaking, tone of voice in verbal interaction, body language, verbal content nasty, nice, or remote.
Others?_____

Responsivity: refers to the extent to which family members are behaviorally, emotionally, and physiologically responsive to one another. Moderate levels of responsivity allow for empathic response among family members. Extremely high levels of responsivity (i.e., reactivity) can exacerbate maladaptive emotional/physiological resonance and emotional escalations,
Low levels of responsivity (i.e detachment) may result in neglect or avoidance, leaving family members unbuffered from internal, familial, or environmental stressors.

Interaction indicators-speed and intensity of emotional response (verbal content, tone, body language) in interactions.
Others?_____

Parent-child attachment (for each caregiver): Attunement (informed observation) and appropriate response to child's signal of emotional or physical suffering; child tendency to reach out for soothing or support from parent, parent offering it, child accepting it. It is a reverberating system. Types of attachment: secure, anxious, avoidant, confused. (Parent- parent attachment, and sibling attachment security vs insecurity may be relevant to an individual child's wellbeing.)

Interaction indicators- child shares feelings comfortably (if awkwardly) with parent; parent makes eye contact with child when child expresses emotion or emotionally relevant content, parent listens, parent responds in way that connects with child and helps the child with the emotionally difficult moment
Others?_____
Emotion regulation/dysregulation in child: Ability or inability of child to modulate stress and emotions adaptively; dysregulation can express itself in anxiety, depression, behavioral disruption *and is always accompanied by physiological dysregulation which may impact physical systems to make physical disorders worse, e.g. child asthma through physiological stress pathways.*
Interaction indicators- extremely high OR low levels of emotional or verbal or behavioral reactivity or distress.
IMPOTANT NOTE: These dimensions are interactive with one another in a systemic fashion. For example, in secure life circumstances, a very reactive and connected family patterns would likely enhance positive emotional climate, which supports positive parenting and supportive attachment. However the same very reactive and connected family pattern in a setting of insecure and stressful life circumstances may lead to an intensely negative emotional climate which in turn, undermines parenting, increases interpersonal reactivity and impairs secure attachment, which undermines individual emotion regulation which contributes to psychiatric and physical dysfunction in individuals. Recursively, the individual dysfunction would negatively impact patterns of relational function the family.
Exercise: View Family Process Assessment Protocols from Families #538 and 617. Compare and contrast patterns of interactions in these families according to the BBFM Family Vital Signs.

Session 4. Developing BBFM Formulation and Initial Treatment Plan

Exercises: Develop formulation and Treatment Plan for Family #617. Continue this practice for each family for which the residents/fellows conduct a Family Process (Interaction)Assessment Protocol. (**See BBFM Formulation Template Attached**)

I. Consider BBFM targets for intervention and whom to include in initial sessions (With adolescents usually best to have individual sessions with the adolescent plus family sessions to address the relational processes that need redirecting or adjusting)

II. Consider strategy
   A. Consider what family relational changes would likely have greatest positive effect on patient
   B. Consider most feasible relational target to begin the intervention
   C. Factor in developmental stage of child/adolescent

Fundamental treatment process: combine individual, dyadic and family-wide interventions with relational approaches to achieve treatment goal. Remember that everything you do or say has an impact on the patient and the family system, directly or indirectly, whether you are working with individuals or whole family or subsystems. So be intentional. Strive to intentionally address both levels at the same time.

John Sargent's Approach Initial Family Therapy Session (either before or after or instead of Wood's Family Relational Assessment Protocol): [NEED REFERENCE FOR THIS APPROACH, IF ONE IS WRITTEN]

I. Use **John Sargent's Initial Session Approach** Essential Goal: to engage the family's participation in the process of therapeutic change.

II. Collaborate with the family to develop consensus regarding what needs changing, and how bring about change.

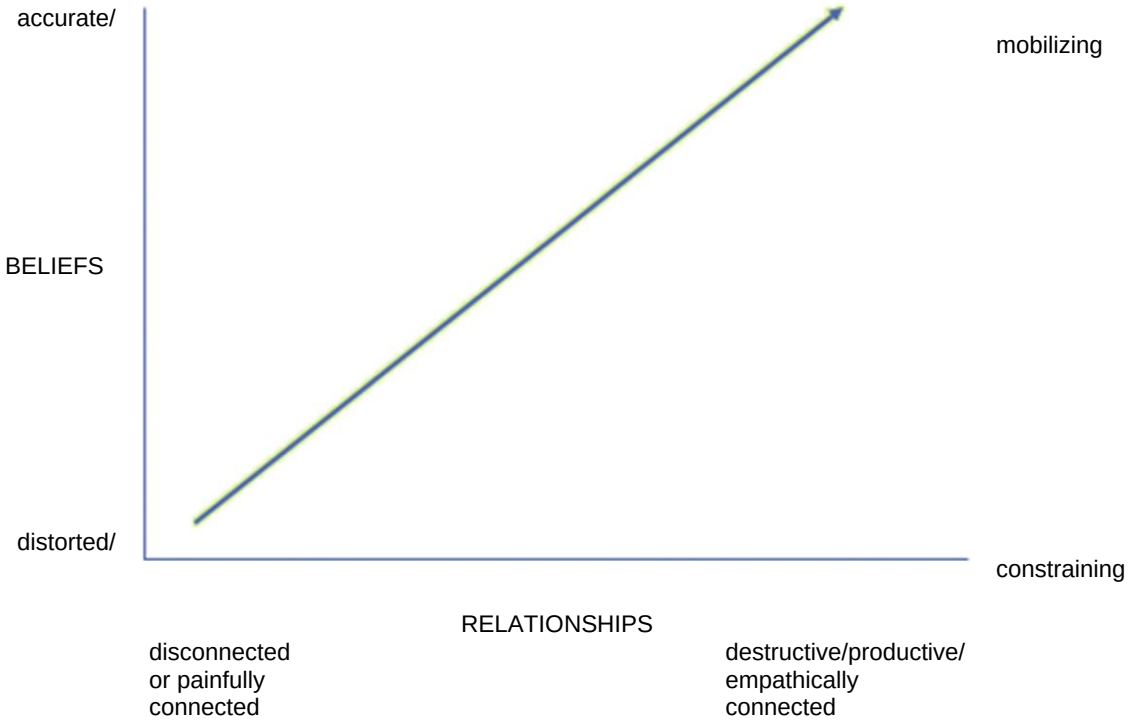
III. Ask family members to discuss what might need changing. If the FRAP (Family Relational Assessment Protocol) was used, apply the knowledge gained to help guide family members in discussing and arriving at a consensus about what might need changing.

IV. Ask family members to discuss and come to agreement about what things to try first in order to bring about change. Use the knowledge gained from FRAP (if used) to help the family to consider what things to try first.

If initial therapy session comes before the FRAP, then, if helpful, you can introduce a FRAP session in order to assist in learning more about how the family communicates in order to help things to change.

Rickerby and Roessler Beliefs and Relationships Model

Training Child Psychiatrists in Family-Based Integrated Care **Michelle L. Rickerby, MDa, *, Thomas A. Roesler, MD Child Adolesc Psychiatric Clin N Am 24 (2015) 501–515** (note overlap of "relationships" in this theory with the BBFM Model of family relationships)



Session 5: FAMILY SYSTEMS INTERVENTION

Family relational intervention occurs every time you intervene with an individual patient (even with medication) or family, so sustain awareness of this in order to optimally intervene on multiple levels.

I. Family Systems Intervention is a framework to understand, assess and intervene therapeutically.

   A. Family Psychoeducation provides information to the family but does not intentionally seek to change relationship process in the family. However, it may do so. Therefore, it is best to conduct psychoeducation in an intentional manner that supports positive relational functioning.

   B. Family Relational Intervention seeks to change patterns of family interactions that are not helpful to the patient to those that are. Altered patterns of interaction change relationships.

   C. Family Systems Intervention is contextual and includes social and cultural systems in which the family and individual is embedded.

II "Structural Family Therapy (SFT)," developed by Salvador Minuchin, MD, Child Psychiatrist, is a theory of assessment / intervention. **("Structure" does <u>not</u> refer to who is in the family. It refers to the repeated patterns of interactions, or "process" in families which define the relationships.)**

   A. Process refers to the quality and sequence of interactions/communications among family members (including those who are silent during an interaction).
      a. All interactions have both verbal and non-verbal aspects of communication.
      b. Therefore, interaction process is always occurring at two levels at the same time. (Clinicians must pay attention to both.)
      c. It is impossible NOT to communicate. NOT communicating is conveying something, and therefore is communicating

   B. SFT includes strategies to redirect problematic patterns of family interactions to functional ones (ones that support the "identified patient's" improvement)

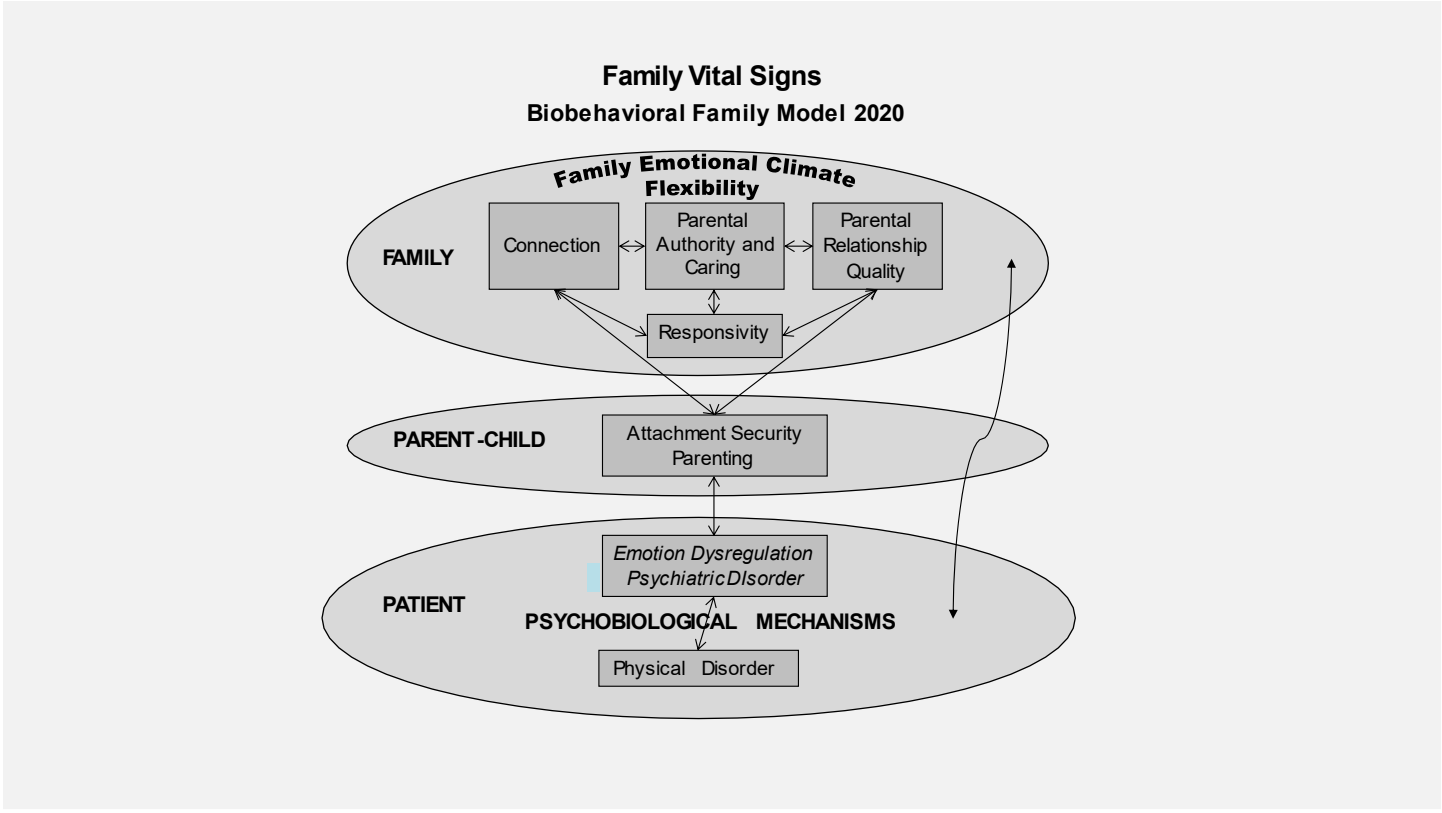
   C. Family Systems Intervention (specifically SFT) privileges cultural factors

      a. the family's cultural "ecological niche" will be factored into the understanding and interventions with families

D. Family Systems Intervention privileges social justice

b. Families of any minority status have additional vulnerabilities.
c. Therefore, cultural or social disadvantage conferred upon a given minority status, and factoring that into the understanding and interventions with families is prioritized.

III The Family Vital Signs Model guides process interventions (PI) to redirect maladaptive aspects of family vital signs to adaptive function. Many interventions take the form of an "enactment" where you engage the family members in interaction with one another, so as to be able to redirect unhealthy process in to healthy process. Having successful healthy process in session will naturally carry over to home because it WORKS for the family. But healthy process has to be practiced many times until it replaces unhealthy "habits" of interacting. Healthy patterns of family process improve relationships and assists the family in functioning in ways that work well for everyone and makes everyone feel fulfilled.



A. Negative Family Emotional Climate: tense, negative climate:

PI- clinician take charge of the process and convey and model warmth, acceptance, appreciation and optimism;

TIPs (Tip to Improve Negative Emotional Climate Process)-

i. If you expect conflict/negativity, **set the tone at the beginning**. After touching base with each family member to connect with them, start session by asking each person to identify one thing they like best (or value or a strength) about each other; and/or ask the same about the family as a whole.

ii. **Reframe negative interactions**. Acknowledge negative statements (interrupt if necessary) and comment on how well the family members speak honestly with (or about) one another because it helps you see how you can be of use to them and their child. Do so with a warm confident tone.

iii. **Dyadic respectful listening enactment**. Interrupt angry interactions, ("hold on just a minute"), and <u>reframe</u> the process. ("You all are clearly in a lot of pain about this situation;" "I can see how difficult it is to work this out because you both/all feel so strongly. Let's slow down a bit and see if we can get a better understanding." Then create an enactment, "Mom can you tell your daughter how it makes you feel, underneath the anger, when she does/says….." and then to daughter "listen carefully to mom, then when she is finished, do your best to tell her what you understand her to be saying"

UNTIPs

1. DON'T start a session by asking: "how was your week." You can easily lose control of the emotional climate in session. Instead ask what went well or what would you like to work on, or figure out, today.
2. DON'T let pattern of negativity go uninterrupted. Help transform it into respectful exchange.
3. DON'T let anyone else interrupt a dyadic listening enactment.

B. <u>Weak connectivity</u>

PI-Enactments that will help family members disclose their feelings, thoughts, opinions ton one another.

TIPs

1. <u>Respectful listening enactment</u> about any event, experience, opinion. (whole family respectful listening enactment) "daughter, tell your family what it was like when… [choose something important to her]" Encourage family members to listen attentively, and ask questions to learn more about how she thinks and feels.

2. Variations of the FRAP Cohesion task ("like, value, strength") for dyads or whole family
3. Be on the look out for opportunities to **draw out as long as possible** the warm, emotional, disclosing, opinion exchanges. "Ask her more about that," "why not ask her what she means by that," "why not tell her how you would feel in her shoes"

UNTIPS

1. DON'T let someone speak for someone else. Instead say, "please let them talk to each other,"or " it's ok, let them figure it out"
2. DON'T allow the exchanges to become negative, "hold on, can we dial it back a bit and speak in a way that we will be able to hear what you are saying, instead of getting upset and responding angrily"

C. Parental authority

PI- support warm authority, redirect cold/angry or controlling authority (authoritarian) to respectful authoritative interactions

TIPs-

1. if warm connection missing between parent(s) and patient, **reframe** parental authority. To Parent(s) with child present "you know, it is totally understandable for you to be angry and frustrated with ____. However, if a trusting/caring parent-child relationship is compromised, it is next to impossible to exercise effective authority. So lets start by rebuilding trust and caring between you both (all). To Child, "if you want to be taken seriously by your parent(s) we have to help you find a better way to relate to them. To both parent(s) and child … "Lets start by developing a mutually respectful way of talking about important things." Then use the **respectful listing enactment.**
2. If parents persist in engaging negatively with the child in an attempt to assert authority, ask the child (and any siblings if present) to leave, and explore parental relationship quality to examine whether the parents able to be in alliance in their parenting.
3. If the parents do not seem to be on the same page re parenting, or are disrespectful or dismissive or ignoring one another, do the same as above in #2
4. If single parent, meet separately with them an endeavor to understand where they learned their parenting styles. See if perhaps they are carrying forward their parents' approach because it is the only one they know. Be kind not critical, but help them understand and find better ways. There may be need to address their own pain from being treated negatively by parents and/or their child.

UNTIP-

1. DO NOT criticize
2. DO NOT take sides

D. Negative Parental Relationship Quality

PI- Reflect respectfully and acceptingly to the parents that they do not seem to be on the same page about their child. Ask them to talk to you about this without the child(ren).

TIPs-

1. Observe relationship emotional climate as you ask them to talk about their hopes and dreams for their child and their parenting values and approaches.
If respectful and connecting as they discuss this, but they have different opinions about how to handle the child. Tell them "it is ok, and sometimes useful to have quite different approaches, but the challenge is how to integrate those approaches in order to be effective parent figures." I can help with that.
If disrespectful, cold and distant from one another (eye contact, tone, body language and content of speech), note that they do note seem fully comfortable with one another, and ask "am I missing something? Is there some strain in your parenting relationship?" [Best not to ask about their personal relationship with one another. It often feels like a betrayal since they are there for their child.] If they say no, then say "ok, well let's start working on finding a joint strategy that you both can get behind. (The personal relationship will clarify one way or another in this process).

If one, or both, of them mention personal relationship strain, then ask if they are getting help with that or would they want a referral to help with that? Usually parents say no initially. That is ok, because you then say "well ok, then, because parenting is separate from your personal relationship, and let's work on your co-parenting alliance. First it is absolutely necessary to be respectful to one another in front of your child, second you must not countermand one another's parenting, third we will work together to help you find effective common ground as parents. Elicit an agreement to this if possible. Then pick one "they are worried about concerning their child" and help them develop a plan to jointly address their concern. [Best to use "worried about" because it supports their collaboration.]

UNTIP

1. DO NOT attempt to intervene in the parental personal relationship. Reframe and redirect parenting process only to authority and caring for child(ren). (Unless you are specifically trained in couples therapy and they would like you to work with them on their personal relationship.)

E. Responsivity

PI- Aim for moderate responsivity. Intervene to slow down and calm highly reactive interchanges. If low responsivity, assess if it is temperamental (i.e. laid back) or due to depression or stonewalling.

TIPs-

1. Use your tone, body language, and content of conversation to calm or engage more animation.
2. Ask the family "can we please slow down and take a few breaths, it is hard to follow such fast exchanges"

UNTIP- DO NOT tell any of the family members "you are too reactive" or "you aren't responding enough."

F. Parent-child attachment

PI-Aim to improve parent-parent and parent to child/adolescent attunement, soothing, validation and support (support as experienced by the child/adolescent).

TIPS- Engage an enactment in which the child/adolescent discloses or repeats to the parent(s) something that is bothering them. Guide the parent to actively listen. If the parent(s) seems not to be attuned or interrupt to explain away or problem solve for the child, intervene saying, "wait just a moment, lets hear all about it first. Ask questions to draw your son/daughter out and learn more so that you can understand what he/she is feeling. To the son/daughter say, "take your time and really help your parents understand how and why this bothers you." Let them go on as long as there is a positive supportive atmosphere in the discussion. You may need to re-direct the child/adolescent or parent(s) frequently to keep them on track. Once they seem to come to some closure of understanding and feeling understood, then underline this process, saying this is what needs to happen so you can better understand one another. (It is also helping the security of the attachment, but you don't have to be explicit about this.)Do this frequently.

UNTIP- DO NOT let the child choose something about the parents that bothers them, even if there are big issues there. Say "we will get to those later once you all find better ways to listen to and understand one another. **FAMILY RELATIONSHIP ASSESSMENT PROTOCOL [(c)]**

8/2022

Beatrice L. Wood, Ph.D., ABPP

Division of Child and Adolescent Psychiatryip

Jacobs School of Medicine and Biomedical Sciences

Children's Psychiatric Clinic
1028 Main St. Buffalo, NY 14202
Telephone: 716-878-7645
Email:bwood@buffalo.edu

Goals of Wood's Family Relationsh Assessment Protocol (FPAP): to provide clinical family assessment/intervention; aid in training clinicians in family systems assessment and intervention.

The assessment is based in a family systems paradigm that rests upon 2 assumptions:

1) Family relationships and individual wellbeing and development mutually influence one another.

Corollary: maladaptive relationships undermine individual emotional well being and development and adaptive relationships support well being and development;

2) the nature and quality of relationship is eminent in patterns of communication (verbal and non verbal, including behavior);

The FPAP assessment, therefore, focuses on observing patterns of relationship in the family and understanding how they support and undermine the patients' functioning, including 1) how they may help and buffer the child from emotional difficulties; and 2) how they may causally contribute to the presenting psychiatric problem. The FPAP allows assessment of the developmental appropriateness of the patient *and* the family's functioning.

Approach: The FPAP uses specific activity and discussion tasks, designed to evoke a range of emotional family interaction, so that the family may be observed without interviewer constraint.

Invitation to Families:

"I/We would like your family to participate in a family discussion protocol that will help us learn more about how your family solves problems and talk with one another. This information will help us all (you and your clinicians) make decisions about how to best help _____ (patient's name)." [Usually this is all you need to explain before families agree. If they ask questions, answer according to the instructions below. If they agree, ask for everyone living in the home over the age of 5 or so, to come, and any "family" member not living in the home who has current and important ongoing relationship with patient. Ask for guidance from Drs. Sengupta or Wood to determine who should come, if you are uncertain.]

When the family arrives explain the following:

"I/We have asked your family to come here to participate in a family discussion protocol that will help us learn more about how your family solves problems and talk with one another. This information will help us all (you and your clinicians) to better help _____ (patient's name). We will ask you to answer a few questions separately, then come together for a discussion of related topics. While you are discussing these topics, I/we will leave the room, but observe through a one-way mirror so as not to be in the way of your discussion. This will take about an hour or so. After this, I/we will join you for a discussion of the experience and to make plans with you about how to proceed to best help _____.

Do you have any questions"? [After answering questions, ask them to sign a consent form for visual recording, explaining that the purpose of the recording is to "help us to observe and keep track of what goes on."] [REMEMBER, SIMPLE SHORT EXPLANATIONS ARE THE LEAST CONFUSING AND MOST REASSURING.]

FRAP Procedure: [FOR ZOOM APPROACH The clinician will ask the questions to the family members individually some time a week or so before the family discussion meeting. This can be done in one phone call, speaking privately with each person one at a time, or with separate 10 minute calls to each family member.]

1. Before the family discussions, a standard written format is used to have family members independently identify problems, losses, and disagreements.

[See attached PARENT AND PARENT-CHILD questionnaires. Questionnaires can be modified to accommodate a variety of family types.] Each family member has a private place to write. Usually we read the questions to the child/adolescent patient and sibling, and we write down their answers for them (separate rooms). THE INTERVIEWER CHOOSES TOPICS FOR THE DISCUSSION TASKS FROM THE ANSWERS THE FAMILY MEMBERS PROVIDE FOR THE QUESTIONNAIRES. We rarely use the sibling input to chose topics for the following family,

but it is important to have for comparison with the patient, and in understanding the family process.

2. The family is then asked by an interviewer to engage in the family interaction tasks

3. Family debriefing. The clinician meets with the family to debrief and give feedback and receive feedback from the family. Sometimes a clinical therapeutic session continues from this feedback.

FRAP 8/2022

Instructions for Family Interaction Tasks (allow about 5 minutes for each task, except the cohesion task which is allowed to continue until the family completes it, if they can) "We will ask you to take part in a series of activities or discussions. First we will tell you the activity or discussion topic, then leave, so as not to disrupt your conversations. We will observe you, and then return in a few minutes to explain the next task. Please do not discuss the items you identified on your questionnaires until we ask you to do so. Any questions"?

Card Task: "To start out and get things rolling, we would like to have your family build a house using this deck of cards. I will return in a few minutes to introduce the next activity".

(Interviewer leaves)

Problem Task: (interviewer presents problem identified by patient on his/her questionnaire) All people have challenges or difficulties from time to time. _____ (patient's name) identified _____ as his/her greatest challenge right now. _____ (patient's name), tell your family about your difficulty with _____ and see if your family can help you come up with some solutions".(Interviewer leaves)

Loss Task (use a tone of voice appropriate to discussing sad topics): "All families have losses or sad things that happen to them. We asked _____ (patient) to tell us what was the greatest loss or saddest thing that ever happened to him/her. S/he mentioned _____.

_____ (patient's name), take a few minutes now, and tell your family your story about _____. Tell about what happened, and what that was like for you." (Interviewer leaves)

Parents vs. child #1 Disagreement (Identify from the questionnaires the most important disagreement between the parental generation and child # 1). "We asked _____ (parents) and _____ (child#1) to identify some issues that they frequently disagreed about. You all mentioned _____. (Address the parents): _____(child #1) feels _____. But (addressing child #1) your parents feel _____" (interviewer uses family members' own words but attempts to increase the intensity of the disagreement, if necessary). "Take a few minutes and see if you

can resolve this disagreement/difficulty." (Interviewer leaves) [OR for a conflict avoiding family, ask "who is right about this?"]

Parent- Parent Disagreement. (Address parents directly.) "We asked each of you to identify some things that you frequently disagree about. You both mentioned _____. (Address one parent): _____(other parent) feels _____. But (addressing the other parent) ____ feels _____" (interviewer uses family members' own words but attempts to increase the intensity of the disagreement, if necessary). "Take a few minutes and see if you can resolve this disagreement/difficulty." (Interviewer leaves)

Cohesion Task: "For the last discussion, we would like you to go around, one at a time, and each of you say <u>one</u> thing that you like best about each other person in the family and about the family as a whole. I will return in a few minutes." (Interviewer leaves, and returns when family completes task)

Family debriefing: The clinician returns to discuss the experience with the family. The format and content of this can be tailored to the goals of the interviewer and family. However, the family should at least be thanked and told that they have provided a great deal of useful information that will help the interviewer/therapist to be helpful to the patient and the family. Explain that the clinicians involved will discuss the recorded material, and use it to guide treatment recommendations. More complete feedback and recommendations can be provided to the family in a future appointment, but may not be necessary nor indicated. Emphasize that this assessment will help their clinicians, as professionals, to understand their family better and plan with the family's help treatment for _____.

Often it is strategic to use this debriefing to provide the family with some positive observations, and some suggestions about what might be helpful to work on in future sessions in order to best help_____patient. You will be surprised at how often this protocol inspires the family to do some of their own therapeutic interventions.

(If you wish more information about this protocol or have questions or suggestions, please feel free to call, write or E-mail me. I would value your feedback regarding your experience with this protocol.)

PARENT AND PARENT-CHILD DISAGREEMENTS

(Parent form)

8/22

Person completing form_____Date:_____

Relationship to patient _____

Please write down five disagreements you often have with_____.

(patient)

Please write down five disagreements you often have with _____ .

(closest aged sibling)

Please write down five disagreements you often have with your partner that

do not have to do with the children.

Sad things happen to everybody. What is the saddest thing that ever happened to

_____

(patient)

CHILD-PARENT DISAGREEMENTS

(Child form for patient and sibling)

8/22

Person Completing form: _____Date:_____

Relationship to patient (self, brother or sister) _____

PROBLEM:

All kids face problems and difficulties from time to time. What do you think is the greatest difficulty you face these days?

DISAGREEMENTS:

Please write down five disagreements you often have with your parents.

Sad things happen to everybody. What is the saddest thing that ever happened to you?