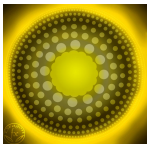

FAMILY-ORIENTED CARE IN ADULT PSYCHIATRIC RESIDENCY

Updated October 2021

GAP Committee on the Family
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Introduction

Utilization of family systems-based techniques in the diagnosis and care of patients is a key evidence-based tool for psychiatric disorders. However, as it is not a current ACGME training requirement, it is possible to complete psychiatry residency without exposure to this key framework. Here, we highlight the importance of considering patients through a 'family systems' lens and the incorporation of multiple individuals from an individual patient's identified system in their care. This is intended to be a guide for programs to teach basic attitudes, knowledge, and skills in family systems-based care as a foundation for residents to build upon.

Current medicine curricula emphasize patient autonomy, one of the core pillars of ethics. Autonomy is the cornerstone of the everyday practice within medicine of communicating all risks, benefits, and alternatives of a proposed treatment to a patient making decisions about desired paths forward. This prevents paternalistic care in which the doctor 'knows best' and makes decisions for the patient. Unfortunately, the emphasis of this pillar has morphed over time into the idea that the individual patient is the *only* person with whom this information should be provided or from whom information should be obtained. There is extensive research (Heru 2006) that proves conclusively that family support, education, and psychoeducation improve both patient and family functioning in medical and psychiatric illness. When a clinician focuses solely on the identified patient, they miss the ability to obtain key information that may influence diagnosis and treatment as well as overlook the opportunity to utilize the structure and support system around a patient to strengthen their care and improve treatment outcomes.

The network and family dynamics around a patient can be critical to providing accurate information on medication adherence and symptoms, supporting recovery, and handling emergencies. Markedly improved patient outcomes occur when family members are seen as allies and offered support, assessment, and psychoeducation (Dixon et al, 2001, Heru 2006). In fact, APA Practice Guidelines for schizophrenia (2020), major depressive disorder (2010), and bipolar disorder (2002) include the expectation that patients' family members will be involved in the assessment and treatment of patients. Yet training in how to incorporate these practices are often minimal or nonexistent during residency.

A family systems orientation is distinguished by its view of the family as a transactional system. Stressful events and problems of an individual member affect the whole family as a functional unit, with ripple effects for all members and their relationships. In turn, the family response—how the family handles problems—contributes significantly to positive adaptation or to individual and relational dysfunction. Thus, individual problems are assessed and addressed in the context of the family, with attention to socioeconomic and other environmental stressors (Rolland & Walsh, in press).

A family systems approach is distinguished less by who is in the room and more by the clinician's attention to relationship systems in assessment and treatment planning. We need to consider how family members may contribute to—and be affected by—problem situations. Most importantly, regardless of the source of difficulties, we involve key family members who can contribute to needed changes. Interventions are aimed at modifying dysfunctional patterns, tapping family resources, and strengthening both individual and family functioning.

A family systemic lens is useful for working with all types of families, e.g. refugee families, thinking through child adoption processes, working with families with specific social disadvantages etc. Incorporating issues of race, gender, sexual orientation, etc is important in this work as is working with larger systems such as schools, workplaces, and healthcare settings. The expertise in each training program will determine the depth of specific areas of family teaching e.g. child psychiatrists have a good grasp of assessing the developing adolescent and the typical family scenarios that might ensue. Some useful references are included below.

A family-oriented approach facilitates periodic consultation over time (e.g. with chronic psychiatric and medical illness; Rolland, 2018), often in relation to transitions in individual, family, and illness development. A family systemic lens allows physicians to incorporate these considerations that can otherwise go under-recognized, into their diagnostic and treatment planning.

As opposed to previous viewpoints that family therapy is the only 'family' skill to be taught during residency, the GAP committee proposes that psychiatric residents should be trained in skills of family inclusion, support, and psychoeducation, and that these skills should be taught throughout the residency (GAP, 2006, GAP, 2008). Our goal is to have residents be able to consider any case through a family systems lens, to understand how patients' illnesses and their family systems have bidirectional effects on each other, to perform a basic assessment of family system functioning, and to utilize this information in diagnostic and treatment planning. The following is a proposal for a set of attitudes, knowledge, and skills to constitute best practice in understanding patients through a family systems lens as well as a curriculum which departments can craft to their own needs.

Training Goals

Systems-based thinking will enable trainees to

1. Ally with family members to work with the patient to comply with goals of care (e.g. take medications, comply with lifestyle changes, maintain sobriety).
Teachers focus on engagement, joining with families

2. Help patients understand the influences of their families in their own lives, such as intergenerational transmission of trauma and resilience.
Teachers focus on the creation of a genogram, and the location of the individual within their family system

3. Understand that mental health includes the creation and maintenance of healthy relationships.
Teachers focus on assessing a willingness to listen to others' points of view and the co-creation of a shared reality and belief system: a belief that relationships can change over time, and how to create new family narratives.

4. Understand the impact of illness on the family unit and the impact of the family unit on illness.
Teachers focus on the concept of a family system, clarifying the roles within the family, including caregiving responsibilities.

5. Assess the family for strengths and weaknesses.
Teachers focus on how families maintain a healthy emotional climate, allocate roles, decide on rules, problem solving abilities etc

6. Gather information from multiple informants in the same room
Teachers focus on utilizing communication techniques to elicit, guide, and redirect information from multiple individuals of a system with varying perspectives in the same room. Teachers help students understand that there are multiple realities in families and learn how to maintain multidirectional partiality.

Knowledge, Skills, and Attitudes Across All Treatment Settings

Family oriented care and systems based thinking achieves the above training goals by cultivating:

Knowledge
Beginning Level
Healthy family functioning at the various phases of the family life cycle. Systems concepts are applicable to families, multidisciplinary teams in clinical settings, and medical/ government organizations. However, family systems are distinguished by deep attachment bonds, specific generational hierarchy, goals of emotional safety and, for many families, child rearing.
Systemic thinking, unlike a linear cause and effect model, examines the feedback loops by which multiple persons or groups arrive at a specific way of functioning. Understanding boundaries, subsystems, and feedback loops is critical to understanding interpersonal connections.
Understand how the family affects and is affected by psychiatric and medical illnesses.
Impact of interpersonal stress on biological systems.

The role of expressed emotion (EE) in psychiatric illness. EE describes the level of criticism, hostility and emotional over-involvement in families. It has been studied extensively across the healthcare spectrum and cultural variance is significant.
The components of family psychoeducation, and its associated research in improving patient and family outcomes.

Advanced Level

Principles of adaptive and maladaptive relational functioning in family life and family organization, communication, problem solving, and emotional regulation.
Role of family strengths, resilience, in reducing vulnerability.
Couple and family development over the life cycle.
Understanding multigenerational patterns.
How age, gender, class, culture, and spirituality affect family life.
The variety of family forms (e.g., single parent, stepfamilies, same-sex parents)
Special issues in couples and families, including loss, divorce and remarriage, immigration, illness, secrets, affairs, violence, alcohol and substance abuse, sexuality, including LGBTQi
Relationship of families to larger systems e.g., schools, work, healthcare systems, government agencies.

Skills

Family interviewing skills, especially managing high levels of emotion and making room for multiple points of view.
Promoting resilience, hope and strength.
Basic psychoeducation techniques, which includes providing a therapeutic space for emotional processing, providing information about the illness, skills such as better communication, problem-solving, and relapse drill and support.
Collaborative treatment planning with family members and other helping professionals.
Treatment planning should include all members of the system: patient, family members, and members of the treatment team. Good planning establishes a role for family members, helps define criteria for managing emergencies, looks for areas of strength and resilience and provides clear and realistic goals for treatment.
Knowledge of, and referral to, local and national resources, both in the community and online.

Attitudes

Appreciate the multiple points of view in a family.
Interest in family members as people with their own needs and history.
Including family members as a resource in recovery.
Understand caregiver burden and rewards and that stress extends to all family members.

Training Techniques

In order to cultivate the appropriate knowledge, skills, and attitudes regarding family and systems based care, teachers may want to consider:

Most learning takes place at the level of patient, supervisor and resident. It is critical that the resident sees faculty members dealing with patients in observed or shared family sessions, and /or sees videos made by faculty or professionally made videos. Attitudes are best learned by modeling.

Family involvement must be seen as routine in all settings. Therefore, residents should be present when a family is interviewed in the emergency room, the inpatient unit and any specialty clinic, beginning in PGY1. While faculty may be most concerned about the acquisition of knowledge, the residents report that their primary concerns in learning to work with families are: fear of the meeting getting out of control, a lack of understanding of system dynamics, and uncertainty about how to deal with multiple people with conflicting concerns. Our first goal is to reduce the residents' anxiety enough to increase their willingness to spend time with families and learn from that experience. Particularly at the beginning of training, a supervisor or experienced staff person should be present in the room to model how to manage a family that is disorganized and frightened. However, competency requires hands-on supervised skill development in addition to a didactic curriculum.

In the outpatient clinic, family interviews should include video or audio supervision, or shared work with a family therapist. Residents are particularly likely to learn how families cope and how they can learn new skills, by attending family psychoeducation groups.

Areas of focus can include time management and addressing the fear that family sessions may get out of control. The influence of the residents' own life experiences and background including potential generational or cultural differences on their assessment and interactions with patient family dynamics. In skill development, our goal is efficient interviewing, history taking, and support in controlling sessions.

It is difficult to specify which techniques are most useful in didactic sessions as each presenter will have a different skill set for engaging the class. The techniques that work best are the ones most comfortable to the presenter. Any technique that gets emotions involved, such as role play, sculpting, discussing movie clips, bringing in family members to discuss their experiences, or self-exploration, will generate the most powerful learning. If time permits, exploration of the resident's own family, including a genogram, is an exceptionally helpful technique, especially if accompanied by asking the residents to interview their own families.

Families are subsystems of culture, community and organizations, therefore we recommend that family and culture be taught concurrently with crossover between classes. Classes in group or

organizational issues can also be taught in collaboration to provide a consistent systems approach.

Milestones: To gauge a resident's performance and guide resident evaluation

Level 1.
Arranges to meet families and establishes an alliance.
Obtains collateral information about the patient's illness.
Is supportive and collaborative in the face of multiple points of view and high levels of emotion.
Includes family in treatment, discharge and follow-up planning.
Encourages family members to seek community resources and provides information.

Level 2.
Obtains a three generation genogram and family timeline.
Provides family with information regarding their developmental stage, and normative family issues.
Inquires appropriately about cultural/racial/ethnic issues impacting illness and treatment.
Understands and supports families of varied structure and composition.
Provides basic psychoeducation.
Recognizes and promotes resilience, hope and strength.
Recognizes when family therapy is indicated and refers appropriately.

Level 3.
Assess a family and develop a systemic formulation.
Intervene in simple problems such as communication difficulties, setting limits and problem solving.
Manages and discusses confidentiality in outpatient settings allowing family inclusion in treatment planning.
Works with other therapists and systems involving the patient (school, child welfare, etc.).
Identifies how systemic issues play out in settings such as healthcare, school and military systems.

Level 4.
Recognizes and treats (or refers appropriately) issues that need specialized intervention e.g. chronic medical illness, sexuality/gender issues, family violence, addiction etc.
Assesses and treats couples and adult families who present with systemic issues rather than psychiatric illness.
Recognizes and manages his/her own feelings and attitudes about families and couples whose structure and attitudes are widely different than their own.

Level 5.
Describes differing schools of family therapy and choose techniques appropriate to the family's needs.
Identify and assess the impact of structural racism and discrimination as it impacts family functioning
Obtains mastery and comfort conducting couples and family therapy in a wide variety of situations.

Site Specific Training

Each training site lends itself to teaching and reinforcing an array of family-oriented systems-based skills.

EMERGENCY PSYCHIATRY

KNOWLEDGE:
Understanding how to include family and friends when patients present with emergencies.

SKILLS:
Patients may be too distressed to give an accurate history. Family members may have critical information to offer, and are usually involved in the emergence of the crisis. Residents can develop skills in history taking and developing a family alliance at moments of stress. Reach out to family members and caregivers, even by phone or virtually (eg Zoom or other tele-health platform).
Assess the family developmental stage because patients often present when the family is in a developmental transition.
Involve family in treatment planning: Can the family ensure the safety of the patient and others at home? Review symptoms that would indicate renewed emergency.
Include family in treatment decision-making. If the family supports the treatment plan, the patient is more likely to follow through.
Educate family about resources outside the hospital.

Supervisor tasks: Be present and model interactions with distraught families. Demonstrate how to develop boundaries and set limits when time is short. Acknowledge difficulties of working in a crisis mode.

ATTITUDES:
Compassion for the difficulties of having a family member admitted to a psychiatric inpatient facility, often against their will, and how this impacts family relationships.

Respect for the struggles of a family living with and supporting a member with chronic mental illness.
Appreciate and validate the emotional reactions of family members, such as anxiety, anger and withdrawal, to the patient's illness and hospitalization.
Take into consideration the family's concerns about too-early discharge or inadequate follow-up plans, caregiving and further emergency care.

Suggested Reading:
Nguyen S.A., Heru A.M., Combrink-Graham L. (2019). The Family in Psychiatric Emergencies: An Across the Lifespan Approach. In Glick RL, Berlin. JS, Fishkind AB, and Zeller SL (Eds.), Emergency Psychiatry: Principles and Practice, 2nd edition. Philadelphia, PA: Lippincott, Williams & Wilkins.
https://www.amazon.com/Emergency-Psychiatry-Rachel-Lipson-Glick/dp/1975113683

PSYCHIATRIC INPATIENT UNIT

KNOWLEDGE:
Be able to explain to families the relationship between family functioning and illness.

SKILLS:
Conduct a family interview with the patient present, regardless of their diagnosis, as well as meeting with the family privately, if indicated.
Provide family psychoeducation during the hospitalization.
Explain how family inclusion in follow-up treatment stabilizes patients.
Answering their questions about caregiving and problem-solve how to manage emergency situations when they arise.
Provide family with resources: discuss social support, respite, and self-care, and about family support organizations such as National Association for the Mentally Ill (NAMI), Depression Bipolar Support Alliance (DBSA), and other online resources.

Supervisor Tasks. Model how to manage a family meeting, including orientation to the purpose of the meeting, management of affect during the meeting, and ending the meeting on time.

ATTITUDES:
Compassion for the difficulties of having a family member admitted to a psychiatric inpatient facility, often against their will and how this affects family relationships.
Respect for the struggles of families living with & supporting a member with chronic mental illness.
Appreciation for and validation of the emotional reactions of family members to the patient's illness and hospitalization.

Listening to the family's concerns and taking them into consideration, particularly around concerns of discharge and transitions back home or next level of care.

Suggested Readings:
Heru A, Drury L. (2007) Working with Families of Psychiatric Inpatients. J. Hopkins Univ. Press.

Heru, A.M., Drury, L. Overcoming Barriers in Working With Families. *Acad Psychiatry* **30,** 379–384 (2006). https://doi.org/10.1176/appi.ap.30.5.379

SUBSTANCE USE DISORDERS (SUD)

SUD treatment, especially medication-assisted treatments (MAT), requires a specialized treatment team and may require multiple types of treatment (individual, group, AlAnon, inpatient detox, etc). Family psychoeducation and perhaps family therapy, are an important part of treatment.

KNOWLEDGE:
Understanding that SUDs are commonly co-occurring conditions with other psychiatric disorders including depression, anxiety, and bipolar disorder.
Parents with SUDs may neglect their children, so assessment of the family is crucial.
Understand how SUDs can affect family functioning and what types of family treatment are most effective.

Supervisor Tasks: Help the resident examine their own feelings about SUDs. Demonstrate collaboration with other team members. Support resident decision-making regarding the choice of psychoeducation, family therapy, or supporting family members in the absence of the person with SUD.

SKILLS:
Taking a 3 or 4 generation genogram for SUDS and other psychiatric disorders. Attention to genetics and vigilance about other types of addiction in family members.
Assessment of family perspective on substance use.
Understanding the role of SUDS in the family.
Psychoeducation. Families need guidelines about how to manage SUDS in the family and strong encouragement to attend Al-Anon, Nar-Anon, etc.

ATTITUDES:
An open and non-blaming approach
Understanding family narratives of SUDS
Willingness for collaboration with all team members

Suggested Readings: Hudak J, Krestan JA, Bepko C. Alcohol problems and the family life cycle, in The Expanded Family Life Cycle, 3rd ed. Edited by Carter B, McGoldrick M. New York, Allyn & Bacon, 1999.

Almanza-Avendaño AM, Romero MM, Gomez-San LAH.I Didn't See It as a Problem, I Thought It Was Going to Be Taken Away: Narratives From Family Members of Users in Rehab. Frontiers in Psychiatry, 2021,12:1404 https://www.frontiersin.org/articles/10.3389/fpsyt.2021.649961/

O'Farrell TJ, Fals-Stewart W. Behavioral couples and family therapy for substance abusers. *Curr Psychiatry Rep*, 2002; 4**:** 371–376 DOI: 10.1007/s11920-002-0085-7

CONSULTATION / LIAISON PSYCHIATRY

KNOWLEDGE:
Understand how acute, chronic, and terminal medical illness can affect family functioning and vice versa.
Understand how patient and family dynamics and needs may result in conflict in care teams, or between families and care teams.

SKILLS:
Use knowledge of systems to manage staff and family conflicts.
Assessment of the impact of chronic illness on the family, including role change, change to family routines, and emotional needs such as guilt, shame, helplessness, and the reactivation of old family conflicts around illness decision-making.
Help the family understand the illness in longitudinal and developmental terms.
Facilitate communication around illness, treatment-related issues, and medical decision-making.
Conflict among family members, or between care teams and family members, around major procedures and death and dying issues, are particularly stressful.
Understand the cultural and spiritual beliefs that guide the family.
Consult with family members near the time of initial diagnosis and at major nodal points during the course of the illness (e.g., re-hospitalization, recurrence, or progression of the illness, transfer to rehabilitation or hospice).
Assess for caregiver burden/depression and manage appropriately. Look for and support resilience.

Supervision tasks: Encourage the resident to meet with patients at times when the family may be present. Model ways to handle issues around death and dying, including family emotions and potential conflict.

ATTITUDES:

Respect the difficulty of a family balancing medical reason for admission and psychiatric cause for consultation
Respect for the struggles of a family navigating consequences of medical crisis in short and long term
Appreciate and validate a variety of emotional and behavioral reactions of family members to these crises and utilize skills to continue communication
Take into account the role of family can play in resilience and caregiving as well as stress
Utilize family members as a resource to better understand a patient's environment outside of the hospital

Suggested Readings: Rolland JS: Families, Illness and Disability: An Integrative Treatment Model. New York, Basic Books, 2020.
Heru AM, Improving Marital Quality in Women with Medical Illness: Integration of Evidence-based Programs into Clinical Practice. J. of Psychiatric Practice, 16:297–305, 2010. DOI: 10.1097/01.pra.0000388625.91039.ea
Heru AM. Working with Families with Medical Illnesses. Routledge, 2013. ISBN 9780415656481 Ebook: https://www.routledge.com/cart

GERIATRIC PSYCHIATRY (Inpatient and Outpatient)

Changes in physical and mental status often necessitate eventual reorganization of living situation, treatment processes and goals. Working with families or caregivers is essential and necessary when working with older adults. Caregivers can be other family members: partners who are often aging themselves; children who are usually grown and have other responsibilities; other caretakers who are hired for the job.

KNOWLEDGE:
Understand changing family relationships: family life cycles and transitions; relational ethics; family stories, life review and attachment.
Apply systemic ideas in everyday work within multidisciplinary teams and systemic consultation to care homes to understand the biomedical approach to family caregiving and systemic perspectives in dementia care.
Acknowledge demographic trends; cultural context; roles and relationships in later life to understand the context of caregiving and service provision for older adults

SKILLS:
Identify multi-generational and cultural differences that influence the current circumstances and presenting problems.
Identify role changes and shifts in relationships as they relate to increased physical needs and physical and cognitive decline.

Provide psychoeducation on life transitions, dementia care, caregiver stress, and end of life care that can include support from organizations such as Alzheimer's Association and other local support groups.

Supervisor Tasks:
Demonstrate collaboration and multi-disciplinary approach to support decision-making for medically and psychiatrically complex older adults. Help residents include family members and caregivers as part of routine assessment and plan of care, including end of life care issues that may arise.

ATTITUDES:
Residents should appreciate multi-generational and cultural differences that may influence approaches to treatment in the care of older adults and their caregivers. Residents should continue to respect patient autonomy and dignity while continuing to include caregivers and their families in treatment planning and appreciate how changes and transitions in roles within the family affect the current circumstances.

Suggested Reading**:**
Rolland, J.S. (2018). *Helping couples and families navigate illness and disability: An integrated approach*. New York: Guilford Press.

Heru AM. Improving Marital Quality in Women with Medical Illness: Integration of Evidence-based Programs into Clinical Practice. J. of Psychiatric Practice, 16:297–305, 2010. DOI: 10.1097/01.pra.0000388625.91039.ea

Heru AM. Working with Families with Medical Illnesses. Routledge, 2013. ISBN 9780415656481 Ebook: https://www.routledge.com/cart

https://www.caregiver.org/resource/caregivers-guide-understanding-dementia-behaviors/

OUTPATIENT AND COMMUNITY PSYCHIATRY (PGY3 and 4 YEARS)

KNOWLEDGE:
Recognize the effect of chronic illness burden on the family and the family on the illness.
Understand what intimacy is and how to discuss the various aspects with patients and families
Be able to use a relational approach even if only one person is present
Understand when to consider an individual needs to set boundaries with family members versus when the family dynamics need to shift to allow relational change.
Understand the difference between family psychoeducation and family therapy and when each is indicated.

Understanding the effects of parental illness on the children, and identify resources for the parents and children.

SKILLS:
Partner with the patient to support family involvement, and determining an agenda
Be able to discuss with the patient the benefits of either an individual shift or a relational shift with family
Develop a treatment plan with the patient and family. This includes education about the course of the illness, the role and side effects of medication, an agreement about what constitutes a relapse or crisis, when the physician or hospital should be contacted, and whether or not the family has a role in medication monitoring. With impaired young adults living at home, reach agreement about family rules (structure of the patient's day, alcohol, or drug use, and finances).
Support families whose ill members refuse treatment.
Understand and normalize life transitions: fallout from divorce, death, chronic illness.
Assess and develop family resilience.
Assess needs of family members of the identified patient, such as children or spouse.
Assess and treat families entering the system as couples or family groups, using an evidence-based model.

Supervisor Tasks: First model, then supervise residents' in a family assessment and treatment model which incorporates a family lens.

ATTITUDES:
Residents should not accept the patient's first "no" to a family meeting as a final decision. In the same way that one would not accept a "no" to medications without continued discussion, the resident with a patient in serious distress or with a relational problem must feel confident in working with the family connection as part of treatment.

CHILD AND ADOLESCENT PSYCHIATRY (Inpatient and Outpatient)
The child and adolescent psychiatry rotation is an excellent site within which to learn family skills. In these settings the work tends to be child-centered, and the resident must be encouraged to think of the parents as individuals in their own right and with their own histories, rather than seeing them only as parents. Parenting issues are heavily determined by the parent's own rearing.

KNOWLEDGE:
How child development and psychopathology is situated within families and family risk and resilience, and the impact of family interactions upon both development and psychopathology.

SKILLS:

Family interviewing is central to learning from a child and family about the presenting problems and should be refined in this rotation. Managing boundaries so that the parent retains authority, while taking the child's concerns seriously, is a major issue in interviewing with minor children. Hearing from all family members, including all the children in the family, and valuing differing perspectives.
Assessing family interactions especially in relation to the child patient.
Dealing with family conflict, recognizing and reconciling diverging goals that a parent and child may have, and creating a frame for family engagement.
Assisting families in navigating normative transitions in their child's and family's life.

Supervisor Tasks: Model the use of systems-based evaluation of strengths and challenges in the assessment of children. This should be modified for developmental stages of the child and family. Include an understanding of the legal requirements of caregiver involvement. Discuss how to create a treatment model that incorporates thse in the child's ecosystem such as the child's family, extended support networks, and school.

ATTITUDES:
Residents should develop respect for and compassion for both children with mental health challenges and also for their parents, and compassion for the parents who are dealing with a struggling and often difficult child. Residents should also develop respect for the diversity of families and normal child-rearing patterns, and the influence of culture and ethnicity on family life.

Suggested Readings:
Sargent, J. (2009). Family Therapy. In Kaplan & Sadock's Comprehensive Textbook of Psychiatry, 9th Edition. Philadelphia: Lippincott Williams and Wilkens.

Josephson, A. (2008). Reinventing family therapy: teaching family intervention as a new treatment modality. Academic Psychiatry 32(5):405-13

ADULT DIDACTIC CURRICULUM

The curriculum is knowledge-based and represents basic concepts. We have vignettes by the authors, if needed, but it is best if the class, including the supervisor, uses vignettes from their own experiences. Material for use in class is in references, but the class is urged to draw on their own experiences as this supports strength-based teaching. The following are key topics and concepts for each of the training years.

BASIC CONCEPTS FOR PGY1 AND 2

1. Where are you in the family and individual life cycles? What are your experiences with psychiatric illness in family / friends? Open discussion about how individual and family life cycles interact. Draw genograms of s/o in the class or the supervisor.

McGoldrick et al. Perspectives on the Evolving Family Life Cycle in The Expanded Family LifeCycle 4th ed., Allyn Bacon, 2011

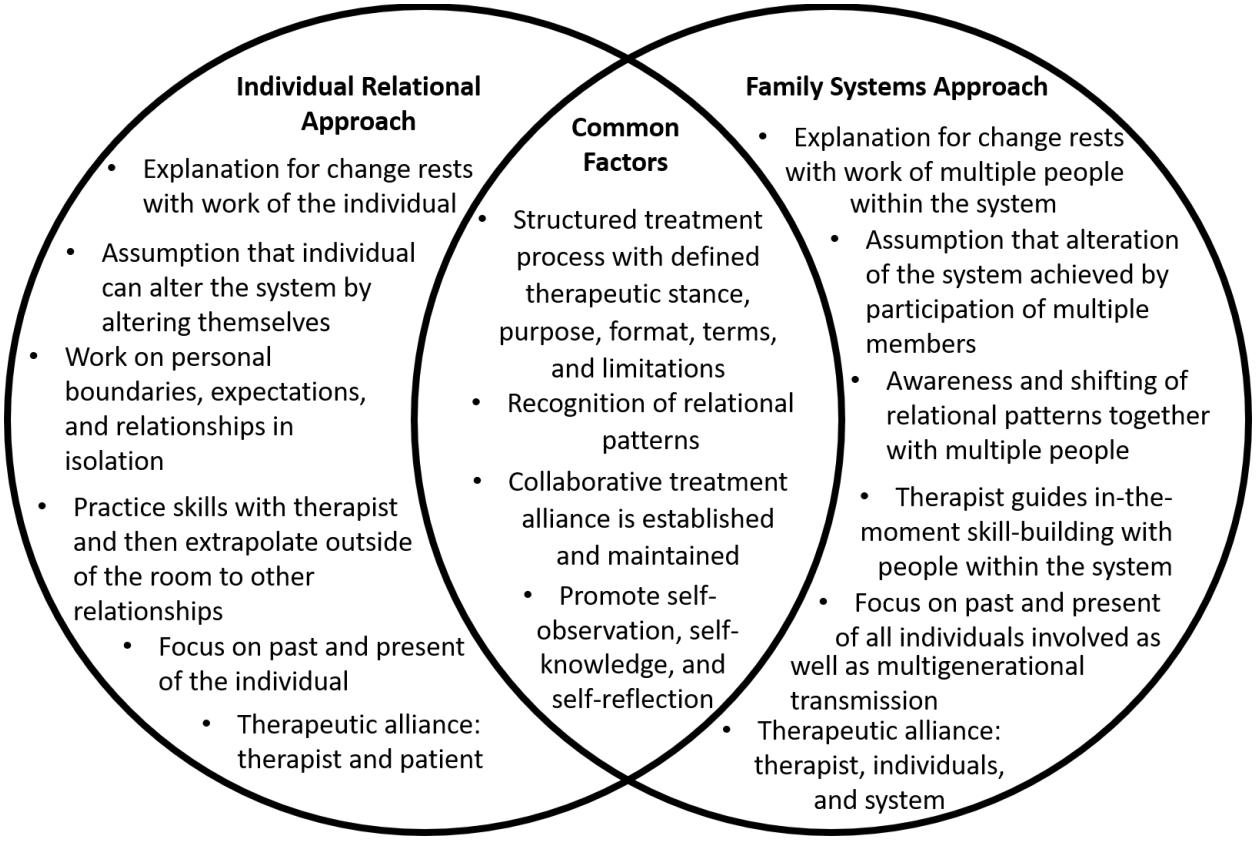
McGoldrick et al. Genograms Assessment and Treatment. 4th ed., Norton, 2020

Libbon R, Triana J, Heru A, Berman E. Family Skills for the Resident Toolbox: the 10-min Genogram, Ecomap, and Prescribing Homework. Acad Psychiatry, 2019;43(4):435-439. doi: 10.1007/s40596-019-01054-6. Epub 2019 Mar 23.

2. Healthy family functioning and family resilience. Recommend asking residents to talk to their parents / elders, about their lives and family life cycle, when they were your age. Open discussion about what makes a healthy resilient family.

3. How do I connect with the family rather than just one person? How do you learn to hold multiple perspectives? How do I try not to take sides / multidirectional partiality? How do I see each person in a positive way? How do I focus on family strengths, rather than focusing on someone behaving badly (which is really hard because it is overlearned in individual therapy).

4. What are the common factors used across all therapies, both individual and family. When to use individual relational approach versus family systemic approach.



Laska, Kevin M; Gurman, Alan S; Wampold, Bruce E (December 2014). "Expanding the lens of evidence-based practice in psychotherapy: a common factors perspective". Psychotherapy: Theory, Research, Practice, Training. 51 (4): 467–481. doi:10.1037/a0034332

Frank, Jerome D; Frank, Julia (1991) [1961]. Persuasion and healing: a comparative study of psychotherapy (3rd ed.). Baltimore: Johns Hopkins University Press.

Weissman MM, Markowitz JC, Klerman GL. *The Guide to Interpersonal Psychotherapy*. Oxford: Oxford University Press; 2018.

5. How do I decide if a family needs support or education or family therapy?

Libbon et al. Colorado Journal of Psychiatry and Psychology (in press)
Heru AM. Family-centered Care in the **Outpatient** General Psychiatry Clinic.
J Psychiatr Pract. 2015 Sep;21(5):381-8. doi: 10.1097/PRA.0000000000000097. PMID: 26352224

6. Psychoeducation: Research, current use and cultural adaptations

McFarlane WR. Family Interventions for Schizophrenia and the Psychoses: A Review. Fam Process. 2016 Sep;55(3):460-82. doi: 10.1111/famp.12235.

López SR, Gamez D, Mejia Y, Calderon V, Lopez D, Ullman JB, Kopelowicz A. Psychosis Literacy Among Latinos With First-Episode Psychosis and Their Caregivers. Psychiatr Serv. 2018 Nov 1;69(11):1153-1159. doi: 10.1176/appi.ps.201700400.

SAFE Program VA: https://www.ouhsc.edu/safeprogram/

NAMI:https://www.nami.org/Support-Education/Mental-Health-Education/NAMI-Family-to-Family

7. Attachment styles and couples therapy: Emotion focused therapy, John Gottman and the evidence base for couples therapy.

Wiebe SA, Johnson, SM. A Review of the Research in Emotionally Focused Therapy for Couples, Family Process 2016; 55,3: 390–407.

8. What is the evidence base behind our work?

Heru AM. Family psychiatry: from research to practice. Am J Psychiatry, 2006; 163 (6): 962-8 doi: 10.1176/ajp.2006.163.6.962.

Sharma N & Sargent J. Overview of the Evidence-Base for Family Interventions in Child Psychiatry. Child Adolesc Psychiatr Clin N Am: Family Based Treatment in Child and Adolescent Psychiatry. 2015;24:3:471-485. https://DOI: 10.1016/j.chc.2015.02.011

SYSTEMIC PRACTICE FOR PGY 3 AND 4

These seminars follow the basic seminars. The focus is on clarification of what systems thinking means. Systems thinking or relational thinking is to be differentiated from systems-based practice. These lectures require knowledge of systemic practice. If there are no local experts, residency programs can reach out to national experts at the Association of Family Psychiatrists, an affiliated APA organization, for help with virtual/remote or in person teaching.

1. Relational Formulation, nested subsystems, boundaries, history of these concepts, contributions to the development of family therapy (see Table on Varieties of Family Therapies).

2. How to define and identify common systems concepts such as circular patterns, feedback loops, triangulation. Teach circular questioning.

3. Framing. This concept is the family systems equivalent of insight. How to intervene to effect communication change and behavior change

4. Working at interfaces: community, legal, government, agencies etc other treaters, consultation. Include systemic and individual racism

5. Understanding the complexity of intimacy

6. Emergency situations. When to report regarding abuse. Dealing with family trauma.

Heru, A. (2007). Intimate partner violence: Treating abuser and abused. Advances in Psychiatric Treatment, 13(5), 376-383. doi:10.1192/apt.bp.107.003749

Varieties of family therapy

Psychodynamic

Assumptions and Major Concepts

- Family relationships are based on previous parent–child relationships of each parent.
- Difficulties arise from developmental arrest, current interactions and projections, and current stressors.
- Improvements develop through the process of family members gaining insight into problematic relationships from the past.
- Therapy consists in shared exploration of past relationships and current distortions and role confusions.
- Therapy also encourages the development of mutual appreciation of the needs and limits of family members.

Major Theoreticians and Practitioners

- Nathan Ackerman
- James Framo
- Ivan Boszamenyi-Nagy

Experiential/Existential

Assumptions and Major Concepts

- The family is a developing organism, and the goal of therapy is to encourage the growth of the family and its members through the process of therapy.
- This process is best supported by encouraging expressiveness, openness, and communication within the family throughout the therapeutic encounter.
- The family is responsible for its solutions; the therapist is a facilitator who encourages growth and confronts stagnation.

Major Theoreticians and Practitioners

- Carl Whitaker
- Virginia Satir

Intergenerational/Bowenian

Assumptions and Major Concepts

- The family is an emotional relationship system, with the goal of relationships to promote engagement, foster differentiation, and avoid fusion.
- In conflictual situations, engaging a third party (triangulation) stabilizes the family system.
- Individuals marry partners at the same level of differentiation, leading, at low levels of differentiation in married couples, to severe personal and relationship difficulties.

Therapy is aimed at clarifying current relationships, promoting individuation, resolving current conflictual interactions, and working through intergenerational and introjected difficulties and patterns of behavior.

Major Theoretician and Practitioner

Murray Bowen

Structural

Assumptions and Major Concepts

Focused on current organization of the family as demonstrated through repeated patterns of interaction.

Particularly attentive to how the family's organization promotes or inhibits task performance, especially child rearing.

Analysis of interactions allows the therapist to determine the nature (distance vs. closeness) and the flexibility of family relationships in relation to task performance.

The therapist promotes interactions in sessions to determine family relationships and then intervenes in those interactions to introduce greater flexibility, alternative patterns and structures, and more effective task performance.

Enmeshment (ineffective closeness) and disengagement (excessive distance), as well as rapid fluctuations between extremes, are manifestations of dysfunctional family relationships when associated with significant symptoms in a family member.

This form of family therapy was developed to respond to child and adolescent emotional and behavioral problems and is particularly effective in those situations.

The therapist is both the director of therapeutic action and participant in the process of therapy.

Major Theoretician and Practitioner

Salvador Minuchin

Systemic/Strategic

Assumptions and Major Concepts

Symptomatic behavior is embedded within the patterns of communication and relationships in a family.

Ineffective attempts at solutions to problematic behavior become part of the pattern also and thus part of the problem.

The therapist is responsible for developing and prescribing tasks and behaviors that disrupt usual patterns of interaction while strengthening other, more productive patterns.

The therapist maintains a stance of neutrality and distance with respect to the family as whole and individual members.

Specific methods of questioning designed to elicit information about family relationships (circular questioning) are used; posing hypotheses, reframing, externalizing blame, and the use of positive connotation are common techniques.

Major Theoreticians and Practitioners

Jay Haley

Cloé Madanes

Mara Selvini-Palazzoli and colleagues (Milan group)

Cognitive-behavioral

Assumptions and Major Concepts

Concepts of learning theory—conditional contingency, reinforcement, extinction—explain problematic behavior and identify therapeutic interventions.

Sessions are entirely problem- and solution-focused in the present.

Skills training is emphasized throughout treatment; homework, record keeping, and between-sessions tasks are used regularly.

Therapy is aimed at changing both cognitions and behavior and uses new cognitions among family members to direct and evaluate behaviors.

Particularly useful for managing mild to moderate disruptive behaviors in children and adolescents, focusing treatment on parent skills training.

Major Theoreticians and Practitioners

Gerald Patterson

James Alexander

References have been cited throughout as they pertain to each section. The following are additional general references:

The American Psychiatric Association Practice Guideline for the Treatment of Patients With Schizophrenia, Third Edition: https://doi.org/10.1176/appi.books.9780890424841

APA Major Depressive Disorder Treatment Guidelines: https://psychiatryonline.org/guidelines

APA Bipolar Disorder Treatment Guidelines: https://psychiatryonline.org/guidelines

Berman EM, Heru AM, Grunebaum H, Rolland J, Wood B, Bruty H; Group for the Advancement of Psychiatry Committee on the Family. Family skills for general psychiatry

residents: meeting ACGME core competency requirements. Acad Psychiatry. 2006 Jan-Feb;30(1):69-78. doi: 10.1176/appi.ap.30.1.69. PMID: 16473998

Keitner GI, Heru AM & Glick ID. Clinical Manual of Couples and Family Therapy, AAPI, Washington, 2009 **(ebook) $8** ISBN-13: 9781585622900 email support@ebooksgift.com.

Heru AM. Working with Families with Medical Illnesses. Routledge, 2013. ISBN 9780415656481 Ebook: https://www.routledge.com/cart

Nguyen S.A., Heru A.M., Combrink-Graham L. (2019). The Family in Psychiatric Emergencies: An Across the Lifespan Approach. In Glick RL, Berlin. JS, Fishkind AB, and Zeller SL (Eds.), Emergency Psychiatry: Principles and Practice, 2nd edition. Philadelphia, PA: Lippincott, Williams & Wilkins.
https://www.amazon.com/Emergency-Psychiatry-Rachel-Lipson-Glick/dp/1975113683

Nguyen S.A. and Heru A.M. Family-Centered Care in Public Sector Settings. In Sowers S., McQuistion H., Feldman JM, Ranz J, Runnels P. (Eds.), Textbook of Community Psychiatry, 2nd edition, in press,

Walsh F. Applying a Family **Resilience** Framework in Training, Practice, and Research: Mastering the Art of the Possible. Fam Process. 2016 Dec;55(4):616-632. doi: 10.1111/famp.12260.

Walsh F. Traumatic loss and major disasters: strengthening family and community **resilience**. Fam Process. 2007 Jun;46(2):207-27. doi: 10.1111/j.1545-5300.2007.00205.x. PMID: 17593886 Review.

APPENDIX
Please use any of these cases for teaching. Permission was granted for publication.

The case examples adopt the McMaster Approach to Family Assessment (Epstein et al 1983). This model uses six dimensions of family functioning to guide assessment and treatment and has a comprehensive, time efficient way to evaluate strengths and weaknesses in family functioning.

1. Problem Solving: ability to resolve problems at a level that maintains effective family functioning.
2. Communication: exchange of information among family members.
3. Roles: established patterns of behavior for handling family functions, including provision of resources, support, personal development.
4. Affective Responsiveness: extent to which individual family members experience appropriate affect and emotions.
5. Affective Involvement: extent to which family members are interested in and place value on each other's activities and concerns. A healthy family has an intermediate level of involvement, neither too little or too much.
6. Behavioral Control: how a family expresses and maintains standards for the behavior of its members. Examples include patterns of control (flexible, rigid, chaotic, etc).

Case Example #1

Ms. Smith is a 23yo single, Caucasian female who presents to establish care after moving to a new area. She has a past medical history of chronic Lyme disease, fibromyalgia, irritable bowel disease, chronic pain previously on high dose opioids and past psychiatric history of many hospitalizations and suicide attempts, depression with chronic suicidal ideation, anxiety, anorexia nervosa, opioid and benzodiazepine dependence in full sustained remission. Her mother completed suicide by overdose two years ago and her father has been absent from her life since her mother's death due to his extensive drug use and inability to cope with his own feelings of grief and loss. Ms. Smith is an only child. She has remained sober from substances for two years after completing nine months of residential treatment and ongoing connection with Alcoholics Anonymous (AA). Since attaining sobriety, her chronic suicidal ideation persisted but she has had no suicide attempts. Her treatment team consists of her primary care doctor (eating disorders specialist), psychiatrist, DBT therapist, eating disorders program therapist, dietician, and support network including AA and her AA sponsor. Each clinician was focusing on a single problem: her PCP, dietician, and eating disorders therapist were focused on her eating disorder; her DBT therapist and psychiatrist were focused on her chronic suicidal ideation and feelings of abandonment as well as maintenance of her sobriety; her AA sponsor was helping her maintain her sobriety.

Family Assessment with Ms. Smith, her psychiatrist, primary care doctor (PCP), DBT therapist, eating disorders program therapist, dietician, and AA sponsor

Her psychiatrist scheduled a one hour meeting with her PCP, therapists, dietician, and sponsor to develop a treatment plan for Ms. Smith. The first step is to clarify each person's understanding of her presenting problems. Each clinician provides appropriate and effective interventions that are incorporated into a unified treatment plan, utilizing the McMaster Model

Problem Solving

Despite the instability in her family life and housing situation, ongoing collaboration with her treatment team and support network becomes her "family" and provides the stability she needs .

Communication

After the meeting, each clinician has a comprehensive understanding of how each of her symptoms is perpetuated and sometimes worsened by her other symptoms. The group makes a plan for all communication to go through her primary care physician.

Roles

The treatment team meeting allows each clinician to understand his or her role in Ms. Smith's care and agree that her symptoms need to be addressed as a whole.

Affective Responsiveness

Ms. Smith is angry that her mother died and her father left her. She used to spend time with her mother and misses her a great deal. This triggers her urges to act impulsively. Her AA sponsor is scared when Ms.Smith is impulsive. Her psychiatrist and PCP feel overwhelmed because she is in constant crisis.

Affective Involvement

Each member of her treatment team is invested in her well-being and care and the need for consistent boundaries.

Behavior Control

Adequate when Ms. Smith is in better control of her feelings.

Case Formulation

Ms. Smith's emotional balance (family stability) was disrupted by the loss of her parents and move to another state (family transitions). Early collaboration of care provided increased

stability and understanding of all of Ms. Smith's needs from multiple perspectives. Everyone agreed that monthly check-in calls together as a cohesive treatment team allowed for identification of triggers and earlier interventions to maintain remission and facilitate relapse prevention. As she continued to experience issues of abandonment and loss, the stability and consistency of her follow ups helped her to avoid acting on her suicidal ideation and impulses. The cohesiveness of her treatment team formed a "family" system that she could rely upon to maintain her sobriety and recovery, and navigate crises.

Learning Points

When patients do not have family who are present or can participate in their treatment, treatment team members and social and community support networks can become an extended "family." However, like any family system, ensuring consistent boundaries and limit-setting within the family, and in this case, the treatment team, is crucial to maintain stability and function.

Case Example #2

> Mrs Nguyen is a 64-year-old, married, Vietnamese-speaking woman with obstructive sleep apnea, bilateral cataracts, recurrent urinary tract infections, and vaginal prolapse. She presents to the outpatient psychiatry clinic with severe anxiety and depression. She was previously a successful business owner but in the past two years she has progressively declined and become bed-ridden, isolative, and unable to work. She lives with her husband, and her family constellation includes a son, and two adult daughters who live nearby and are involved in her care. She has had two prior extended inpatient hospitalizations of 2-3 months each, due to difficulty with discharge planning. When depressed, she is unable to care for herself independently and becomes extremely aggressive, prompting family to bring her to the emergency room (E.R.) for admission. This has been a repeated cycle every 6 months over the last two years. She has had many medication trials of antidepressants, benzodiazepines, antipsychotics and mood stabilizers, and biological trials of transcranial magnetic stimulation (TMS), electroconvulsive therapy (ECT), and ketamine infusions.

Inviting the family into conversation. Since she is accompanied by one of her daughters, the psychiatrist invites her to join the second half of the evaluation. The daughter is grateful to be included. The patient's husband joins by phone using a video conference interpreter service. The family provides information about an extensive trauma history: witnessing extensive violence and the patient herself is a victim of sexual abuse. Her daughter notes her strengths of being a good mother, raising three successful children, and maintaining a business for many years. In this meeting it is revealed that in the last two years, her two daughters recently moved out of the home, married, and had children.

Shared decision-making between professional, patient, and family. Follow up visits focus on collaborating with the family and validating and addressing the patient's extensive trauma history. Consistent calls to both the husband and daughter, as well as connecting the patient with a Vietnamese-speaking therapist, allow the patient to become more engaged. The family members become aware of the patient's triggers and begin to understand how to manage her physical outbursts. They learn how to de-escalate the patient at home, rather than bringing her to the ER. The patient's medication list is reduced, with emphasis on issues of adherence, and trauma-focused psychotherapy to address years of repressed memories and feelings that were triggered by her two adult daughters leaving the home.

Case formulation. The psychiatrist's discussion with Mrs Nguyen's family helped place her symptoms in a larger relational context. The family's emotional balance (family stability) had been disrupted by the numerous changes such as her inability to work, her daughters leaving the home (family transitions) as well as a longstanding trauma history that was never previously discussed or addressed. The psychiatrist acknowledged the family's strengths and caring for one another and invited the family in to sessions to explore how the family's functioning and involvement might play a part in Mrs Nguyen's symptom presentation, her level of engagement, and ultimately symptom alleviation (family as a system).

Learning Points. Including the family as key members of the treatment team allowed both the psychiatrist and the family to identify the family's strengths as well as barriers to treatment: Mrs Nguyen's unaddressed trauma, language and cultural barriers. Use of language interpreters helped Mrs Nguyen feel more comfortable communicating with her entire treatment team and allowed for ongoing psychoeducation and collaboration throughout her hospitalization.

Case Example #3

Mr. Cadie is a single, 50-year-old formerly incarcerated, homeless, Caucasian man living in a halfway house. He has diagnoses of bipolar disorder and alcohol dependence. Neighbors called police because he is outside yelling at midnight. He is admitted to a medical floor with uncontrolled diabetes, alcohol dependence, and metabolic syndrome. He is transferred to a psychiatric inpatient unit where he voices angry feelings towards his mother for betraying the memory of his father who died 4 years ago. A case manager and his 75-year-old mother, Mrs. Zabir, are his only social contacts. His mother is well, works part time and recently remarried. She sees her son periodically but expresses fear about his impulsivity and anger since he threw his phone at her a month ago. The outpatient psychiatrist arranges to meet with Mrs. Zabir and the case manager to develop a treatment plan.

Family Assessment with Mr. Cadie, his mother and stepfather, case manager, and psychiatrist

The meeting, which is scheduled for 1 hour, begins with the stated goal of developing a treatment plan for Mr. Cadie. Each family member is asked to identify problems. Mr. Cadie says

that he does not want any contact with his mother. Mrs. Zabir says that she wants her son to have good medical care. Mr. Zabir says that he wants to be able to help Mr. Cadie in any way that he can. The case manager asks about medical problems and expresses concern about treatment compliance especially with his diabetic medication.

Problem Solving

When sober, Mr. Cadie has good and adequate problem-solving, takes his medication reliably, and stays in the halfway house where he feels comfortable.

Communication

When sober, all agree that he communicates adequately.

Roles

His mother manages all his finances and all are happy with that role. In terms of other roles such as social contact, friendships, and relationships, all agree that Mr. Cadie has become isolated and socially less competent and now frequently abuses alcohol.

Affective Responsiveness

The patient is angry with his mother and sad about the loss of his father. Mr. Cadie used to spend time with his father and misses him a great deal. His mother is afraid of him; her new husband is unsure of the situation.

Affective Involvement

The patient is more isolated since his father died and his mother is more involved with her new husband.

Behavior Control

Adequate when Mr. Cadie is sober.

Case Formulation

All agreed with the assessment and the following problem list was generated.

Mr. Cadie has significant challenges getting his health care needs met.

Alcohol abuse is a result of his social isolation.

Mr. Cadie needs new social contacts.

Mrs. Zabir has a new life and wants to have less involvement with her son. She is afraid of him when he has been drinking.

Mr. Zabir is unsure how much he wants to be involved with Mr. Cadie.

The psychiatrist facilitates a family discussion about problem resolution and psychoeducation. The family decides that a good intervention is to have Mr. Zabir drive Mr. Cadie to AA meetings three times a week. Mrs. Zabir will wait to hear from her son when he next wants to talk with her. She will not visit him at his home. If her son wants to talk to her, they will meet in a neutral place such as Joe's Diner. (This place was chosen by Mr. Cadie as he had fond memories there as a child with his parents.) The case manager suggests that Mr. Cadie call his brother who is out of state to talk on the phone once a week. (The case manager has in mind a possible transfer of medical power of attorney to Mr. Cadie's brother.) A follow up meeting is arranged for 1 month.

Learning Points

The family relationships have to change after Mr. Cadie threw a phone at his mother. A family approach allows the family members to renegotiate their own relationships with the guidance of professionals. This family assessment and intervention is proactive with the goal of preventing future deterioration of the patient, encouraging sobriety, and reducing isolation and allowing, if necessary, for a transition of power of attorney to another family member.

Case Example #4

Ms. Talia is a 37-year-old, Hispanic woman with morbid obesity, obstructive sleep apnea and asthma. She presents with anxiety and panic attacks. She has a past history of substance abuse and has been in prison for drug-related crimes. She is receiving disability. Her family constellation consists of four teenage sons in her mother's custody. Her sons live between her house and her mother's house. A young girl baby, who is the child of her niece, is living with the patient. The niece, who is actively using substances, sometimes stays with the patient and sometimes disappears for weeks. A boyfriend also sometimes stays with her. Ms. Talia wants custody of the baby girl and presents in the clinic asking for help with her psychiatric symptoms so that she can be well enough to go to court to get custody.

Family Assessment with Ms Talia and her mother

The psychiatrist met with the patient and the mother and completed the family assessment over several routine visits. Medication management also occurred in the treatment sessions.

Problem Solving

Ms. Talia relies on her mother to help with all problems. She states that she would like to be more independent but does not know how. The mother supports her goal.

Communication

The mother and the daughter do everything together. Ms. Talia shares all her thoughts and feelings with her mother. The mother does not share her thoughts with the patient and says that she "just wants to help." The mother is not critical and says, "It is my duty as a mother to help."

Roles

The mother and the daughter spend most of their time caring for children, theirs and children of the extended family. The mother, although on a fixed income, provides as much financial support as possible for her daughter. Her daughter is also on a fixed income but gives away food and money to other family members and her boyfriend.

Affective Responsiveness

The patient is anxious most of the time. She experiences pleasure with her baby girl in the house, dressing her and changing her outfits many times a day. The mother thinks she is obsessed with the baby and she treats the baby like a doll. The patient cries and feels overwhelmed a lot and feels guilty because she depends on her mother for money and emotional support. The mother experiences a normal and full range of emotions.

Affective Involvement

There is over-involvement between the patient and her mother, with guilt on the part of the patient for depending on her mother. The mother accompanies her to all appointments, grocery shopping, etc. The mother acknowledges her over-involvement but says, "It is my duty to help."

Behavioral Control

There are no house rules. It is unclear from appointment to appointment who is living in Ms. Talia's house. She is thinking about setting rules about substance abuse and throwing her niece out of her house but is not able to because "there is nowhere for her to go."

Case Formulation

Ms. Talia has generalized anxiety disorder, panic disorder, personality disorder with dependent and histrionic traits and a significant past history of substance abuse. Her family assessment reveals an over-involved relationship with her mother and a chaotic living situation. Family strengths are caring of others and their self-identification as strong good mothers. Ms. Talia and her mother agree with the formulation. The mother and the patient agree that Ms. Talia needs to

set limits with the niece and her boyfriend and tell them they cannot stay there if they are "high" or "crashing." She agrees to tell family members and her sons, that she can no longer give them money, when she herself does not have enough for groceries. She says that although she agrees and knows she needs to do this, she cannot, because she "feels bad for other people." The mother, supported by the psychiatrist, takes the stance that while this is an admirable and valued family trait, she will not get better and thus will not be able to get custody of the baby girl unless she sets limits and controls her home environment. Ms. Talia asks for medications to help her. The psychiatrist agrees that medications are part of the plan but that the patient needs to do her part and set up house rules. The mother and the patient agree.

At each meeting the plan is reviewed. Eventually Ms. Talia puts out the freeloaders and sets family rules for those who remain in her house. Ms. Talia reports that her level of anxiety and panic has not changed but she is feeling better now that she has some control over her life. Monthly visits with the patient and her mother set goals such as the patient taking her citalopram 20 mg, as prescribed and keeping all her medical appointments. She also sets general health goals such as healthier eating and more exercise to try to avoid frequent hospitalizations for asthma attacks.

Learning Points

There are many potential interventions for Ms. Talia. The family assessment approach pinpointed family strengths that can be used in treatment: her relationship with her mother, strong mothering qualities and her desire to care for the girl baby. The patient's relationships have unsettling elements, e.g., dressing up the baby girl and over-involvement with her mother, but focusing on these deficits may result in alienating the patient and her mother. Medication administration is incorporated into a larger contract with the patient and her mother. Without a family assessment, the strengths and weaknesses of the family system would not have been evident. The recommendations are framed in a family context with an emphasis on family strengths.

Case Example # 5

Ms. Sharon is a Black woman who presents with anxiety symptoms and requests benzodiazepines. She is new to the clinic and states that she has been treated in the past for PTSD and has had several hospitalizations. She lives with Ms. Anna whom she describes as her caregiver. You ask her to bring Ms. Anna to the next appointment. At the next few appointments, you find out that Ms. Anna has significant depressive symptoms and is Ms Sharon's significant other but is afraid to acknowledge this out of fear of judgement, stigma, and rejection. Ms. Anna was disowned by her religious and conservative family. Both women express suicidal thoughts and want to figure out how to support each other better.

Family Assessment with Ms Sharon, Ms Anna, the psychiatrist, and the social worker

A one hour family assessment meeting is scheduled.

Problem-Solving

They each identify problems but do not communicate them to each other, nor do they try to solve them together.

Communication

There is poor communication for both due to fears of judgement and rejection, and guilt of burdening each other.

Roles

They each contribute to the household income for rent and food. They are in an intimate and caring relationship that they both find satisfying. However, both are alienated from their families and only have each other to rely on.

Affective Responsiveness

They have warm caring feelings for each other but do not communicate these feelings. They each have intermittent suicidal ideation, but do not want to communicate and burden one another.

Affective Involvement

They spend most of their time together and have few friends. They both feel lonely and isolated.

Behavioral Control

They engage in secretive suicidal and self injurious behaviors from time to time. They would like to change this.

Case Formulation

Both Ms. Anna and Ms. Sharon agree they want to work on improving their relationship. The psychiatrist is most concerned about their suicidal ideation and self injurious behavior and work on developing a mutual safety plan. In following appointments, the treatment team works on establishing rapport and fostering a supportive, accepting environment where they both feel more comfortable sharing with the clinicians as well as each other. They work on spending quality time together, accepting that their relationship is strong, and feeling more comfortable with their sexual identities. They work on improving their communication, problem-solving, and sharing more positive feelings.

Learning Point

Although this couple cannot change the circumstances of their lives, they can reduce acting out behavior and improve the quality of their relationship.

Above five case examples from:
Nguyen S.A. and Heru A.M. Family-Centered Care in Public Sector Settings. In Sowers S., McQuistion H., Feldman JM, Ranz J, Runnels P. (Eds.), Textbook of Community Psychiatry, 2nd edition, *in press*.