

# FAMILY-ORIENTED CARE IN ADULT PSYCHIATRIC RESIDENCY TRAINING

A joint curriculum from:

*GAP Committee on the Family*

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## Introduction

In 2006 and 2008, The GAP Committee on the Family published two papers in Academic Psychiatry (GAP, 2006, GAP, 2008)) which presented a new way of thinking about training in family systems in psychiatric residencies. The committee proposed that for psychiatrists practicing in the new millennium, training in skills of family inclusion, support and psychoeducation should take precedence over training in family therapy, and that these skills should be taught throughout the residency, in the same way that other basic interviewing skills are taught and reinforced throughout residency training. Family therapy, in this model, is an important and useful model of therapy, but family skills are basic to any psychiatric treatment.

As more psychiatrists develop a practice based heavily in medications management, the ability to integrate the family into treatment is critical. While there is extensive research (Heru, 2006) that proves conclusively that family support, education and psychoeducation improves both patient and family functioning in both medical and psychiatric illness, incorporating family training into general psychiatry residency training has been difficult. The lack of emphasis on understanding family systems, in these early years of training, means that residents, even child and adolescent fellows struggle to understand how the family system affects the patient's behavior. It also becomes hard to see family members as having needs of their own, rather than only as "good" or "bad" parents. To improve psychiatric training in families, GAP proposed a set of attitudes, knowledge and skills that constitute best practice. GAP's didactic curriculum is minimal, with the assumption that each program will develop its own.

The University of Penn family curriculum developed by Ellen Berman, (chair of the GAP committee) with Penn family systems faculty members is Penn's effort to put this philosophy into practice--a particular curriculum framed by the needs of a particular residency. While adhering to the principles of the GAP model, the didactic program, in particular, was developed using the particular skills and preferences of available Penn faculty.

Training at Penn is part of the Center for Couples and Adult Families  
<http://www.med.upenn.edu/ccaf/>

In this document we have included both the GAP committee's philosophy and the didactics of Penn's curriculum. There are many programs in which family therapy and family research take a more prominent place at the table. This represents one model of teaching family skills.

## Rationale

Providing *family-oriented patient care* is a necessary skill for psychiatrists. Family-oriented patient care improves patient outcome and reduces family burden. Family-oriented patient care includes allying and communicating with families, helping them understand and cope with mental illness in a loved one, and including them as members of the treatment team. Given both genetics and a potentially chaotic environment, it is likely that several members of a family will have a psychiatric diagnosis, so it is critical that the psychiatrist see, and if possible consider treatment for, other members of the family.

Family-oriented patient care is seen as separate and distinct from family therapy. [Our definition of family therapy is that the family system is seen as the patient, with all members having some responsibility for the outcome. Interventions are directed toward changing the functioning of the system as a whole, rather than focusing on individual pathology.] While family therapy may also be a useful adjunct to psychiatric care of mental illness, it is not the first thing that a psychiatrist needs to think about in family oriented care. Residents must be exposed to family therapy to understand how it works, although only a few residents will learn enough to become experienced family therapists. However, family psychoeducation encompasses many of the building blocks of family therapy, particularly communications and problem solving training, and can easily segue into family therapy.

The need for family involvement in the care of mentally and physically ill patients has been repeatedly demonstrated (Heru 2006). This review of research in both medicine and psychiatry makes it clear that markedly improved patient outcomes occur when family members are seen as allies and offered support, assessment, and psychoeducation. A recent review in *Psychiatric Annals* reviews the biological mechanisms by which family stress is converted to change in the cardiac, pulmonary and immune systems. Hostile and conflictual relationships represent a major stress, produce depression in caregivers and partners, and increase the chances of physical illness (Viamontes and Nemeroff, 2010).

APA Practice Guidelines for most DSM-IV Axis I disorders e.g., schizophrenia, major depression and bipolar disorder (American Psychiatric Association Work Groups 2000, 2002, 2004), include the expectation that patients' family members will be involved in the assessment and treatment of patients. Patient outcomes improve when family members are seen as allies and are offered support, assessment, and psychoeducation (Dixon et al, 2001, Heru 2006). The need for family involvement has also been clearly stated in the community psychiatry recovery movement.

According to the Residency Review Committee for Psychiatry, residents are required to learn how to ally with / communicate with families, provide psychoeducation, and have exposure to family therapy as part of the core competencies. The RRC states

that residents must be able to communicate with families and have some exposure to family therapy. Our goal is considerably broader: that is, to have residents think family at all times, to understand how the patient's illness affects the system as well as how the family affects the patient, and to offer support and guidance to the families who are the primary caretakers of the patients we treat.

### Training Goals

Teach residents to "think family." This includes not only the people that the patient lives with, but those through blood, legal ties or commitment that are involved in his or her care. It may also include professional caregivers.

Teach family skills throughout the residency as an integrated part of patient care. Residents should see families in all treatment settings throughout resident training, using family research to support appropriate interventions for patients and family members.

Teach residents how to form an alliance with family members in all settings, understand the family's needs, provide family psychoeducation, and decrease caregiver burden, as part of biopsychosocial patient care.

Teach residents to work with families according to their level of education.

- PGY1 and 2 residents need to learn to sit with patients and their families and listen to their concerns, assess families and determine what follow-up needs they have, and educate patients and families about the patient's illness.
- PG 3 and 4 residents should develop techniques to intervene when family problems interfere with the recovery process of their patients, including psychoeducation and the basics of family therapy.

## Faculty Guide

### *1. Barriers to family inclusion*

Although family research on psychoeducation has been available for 50 years (Laqueur HP, LaBurt HA, Morong E., 1964; Anderson, Reiss et al, 1980; McFarlane, 2002) its influence has been largely ignored by psychiatrists, diminished by multiple institutional barriers. Because these occur at multiple levels, from the cultural through the financial through the institutional, faculty beginning or attempting to expand a family program must expect a certain amount of frustration.

Barriers include:

- Western cultural insistence on the primacy of individual and individual needs over the family (a position not shared in many other cultures), leading to disinterest in dealing with families when a patient is intellectually competent.
- The philosophical position of medicine and psychiatry that the illness affects the individual only, in spite of extensive research on the effect of relational issues on illness and health.
- The psychoanalytic privileging of the patient-physician relationship over family issues.
- Insurance regulations which mostly deny coverage for family support or therapy.
- Misreading of HIPPA regulations to assume that families should never be included unless the patient specifically asks for them to be.
- Extra time needed to talk to families.
- The need for changes in the procedures such as intake, and information collected on hospital forms, when couples or families are seen.
- Lack of family-oriented physicians in most programs, leading to lack of role models.
- Family avoidance due to concerns that they will be blamed for their loved one's illness.

### *2. Addressing institutional issues and barriers*

Our goal is to find ways to include family care within the department and institutional structure, working to find ways to make use of the evidence-based techniques that give patients and families relief. At the outset, the family program will need to develop the following:

- Buy-in from the department. Someone with significant power (e.g. the chair or the director of training) must believe that family skills training is worth supporting.

- Appointment of family training coordinator. It is best if one faculty person should oversee all family systems training, connecting with faculty in each in each clinical setting to increase family outreach and connection.
- Finding faculty. Psychiatry departments may have difficulty hiring enough faculty members to ensure adequate teaching. Having only one family trained person on faculty gives a negative message that this is a marginalized field. However, several other possibilities should be considered. Since research and good clinical practice suggest that skills with families are needed for general psychiatric practice, a reasonable number of faculty members should be able to teach basic family interview skills and show an attitude of interest and concern for family members. The Penn experience has shown that it is often the case that faculty has previous training in family therapy which they are not currently using, but would be interested in developing. Inviting child and adolescent psychiatrists, who are more apt to see families, to teach in the general adult residency is helpful. In addition, it is worth checking with AFTA ([afta.org](http://afta.org)) and AAMFT ([AAMFT.org](http://AAMFT.org)) to see if there are trained family therapists working in nearby locations who would be interested in teaching. It is important to have some supervisors available who are trained family therapists, and not all of these will be MDs.
- Faculty training and support. In many small programs only one or two faculty are identified as family faculty and they are seen as a voice in the wilderness. Other faculty from different divisions should be included in planning psychoeducation, and meetings should be held periodically which include them. It is important that the director of training be available for some of these meetings if the program is just beginning.
- Presenting family research whenever possible. Having family researchers in a department greatly increases the possibilities for teaching. If they are not available, bringing in researchers for grand rounds, and partnering with departments of psychology, social work, nursing or counseling who are doing family research is likely to yield additional speakers.
- Presenting a consistent model of treatment that works. Nothing replaces successful cases or consultations in the eyes of faculty and residents.
- Helping the residents see that their individual cases have families that need to be involved. Residents typically expect that they will be given family cases, as opposed to individual cases. It is a struggle to demonstrate that a person may come in asking for individual therapy when what is needed is family inclusion (or therapy), or vice versa.

- Developing videotape training materials. In psychiatry residencies, nothing replaces observation. The development of small recording devices has greatly simplified recording sessions, although a group together in a one way mirror is still the most powerful way of reaching residents aside from having them in the room with a patient.
- Using the internet for training materials. A variety of consumer and professionally based organizations have excellent handouts and bibliographies. See the Website at the end of this document.
- Careful reviewing of insurance issues. For example, in many cases, a psychoeducation meeting with both family and patient in the room can be billed to the patient.
- Creating family friendly forms and practices. Working to change forms that are used for recording patient information. For example, at Penn, the general resident evaluation form has been changed so that the form now reads:

#### CONCEPTUALIZATION OF PATIENT

Ability to conceptualize patient's (or family members') history, current symptoms, underlying mental state (thoughts, feelings, fantasies, etc), and use this conceptualization to develop an appropriate treatment plan.

#### THERAPEUTIC EFFECTIVENESS

Ability to help patient (or family) make changes in subjective state, symptoms, behavior or relationships.

This has encouraged the notion that "family" is a normal part of resident training without basically having to change the form.

- Becoming an active part of continuing education. People out in the world are fascinated by family issues. Make yourself visible.
- Involving NAMI or other local consumer groups. Having consumers and families part of meetings, presentations and programs brings home the issues that families face. Many residents and faculty are unfamiliar with resources for families within their city; having those groups speak to residents puts a face on the programs.

### 3. Training techniques

Regardless of the need for intellectual scaffolding, most learning takes place at the level of patient, supervisor and resident. It is critical that the resident see faculty members dealing with patients in observed or shared family sessions, and /or see videos made by faculty or professionally made videos. Attitudes are learned by modeling, so the coordinator needs to be in touch with faculty members across the department.

- It is difficult to specify which techniques are most useful in didactic sessions. Any technique that gets emotions involved, such as role play, sculpting, discussing movie clips, bringing family members to discuss their experiences, or self exploration will generate the most powerful learning. However we have repeatedly found that the techniques that work best are the ones most comfortable to the presenter. In the end, didactic sessions are only useful to the extent that the resident then gets to practice the skills with their patients and their families.
- 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. Residents typically are unmarried or newly married and childless, so helping them understand the effects of a child's mental illness on the parents is a key objective.
- Supervision: Knowledgeable supervisors are vital to resident comfort with families. Supervisors can encourage, demonstrate, or participate in initial family interviewing, and provide planning and post meeting supervision when the resident is able to manage the session alone. Supervisors can support resident efforts to arrange a meeting, even if the patient is reluctant, and to make family meetings a normative part of care. Demonstration interviews are particularly important in PGY1 and 2 where residents first learn basic skills and attitudes. PGY 3 and 4 can use video supervision if available.

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American Psychiatric Association Work Group on Depressive Disorder (revision) *Am J Psychiatry* 2000; 157(Apr Suppl).

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<http://www.acgme.org/>

American Psychiatric Association: Practice Guidelines for the Treatment of Patients with Schizophrenia, 2<sup>nd</sup> ed. *Am J Psychiatry* 2004; 161(Feb Suppl).

Anderson CM, Hogarty GE & Reiss DJ: Family Treatment of Adult Schizophrenic Patients: A Psychoeducational Approach. *Schizophrenia Bulletin* 1980; 65: 490-505

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Laqueur HP, LaBurt HA, Morong E. Multiple family therapy. In Masserman J, ed. *Current Psychiatric Therapies Vol 4*, NY: Grune and Stratton, 1964

McFarlane, W. (2002). *Multifamily Groups in the Treatment of Severe Psychiatric Disorders*. New York: Guilford Press.

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## Teaching Through the Training Cycle

### **Attitudes required in all treatment settings.**

**An attitude of interest, empathy, and an appreciation of multiple points of view.** With the paradigm shift towards teaching family inclusion and psychoeducation, the most critical change required of faculty and residents is an interest in family members as people with their own needs and history. A wider focus on the family will identify people who can be helpful in the patient's care. In addition, residents can develop an understanding of how events in the family can be related to the patient's illness. For example, a grandmother's illness is associated with the decompensation of a young man with schizophrenia, because his mother has been caring for grandmother and has stopped monitoring her son's medications. If such connections are recognized, the need for support for the mother and the family system becomes clear. An effective tool for learning the impact of family events is a three generational genogram. Residents can also learn from examining their own experience in a family, including normal family response to stress, family and cultural norms and how one's own definition of family influences decision making.

## Knowledge required in all treatment settings

### PGY1 & PGYII:

**The resident shall demonstrate knowledge of family factors related to psychiatric and medical illnesses, based on scientific literature.**

- Healthy family functioning, including normal attachment patterns.
- Basic concepts of systems applicable to families, multidisciplinary teams in clinical settings, and medical/government organizations.
- How the family affects and is affected by psychiatric and medical illnesses and changes over time. Impact of family stress on biological systems.

**The resident shall demonstrate knowledge of the current research on family functioning and evidence based treatment and practice. Critical research that all residents should be familiar with:**

- The role of family factors that influence the presentation and course of illness e.g. marital violence is correlated with disorganized attachment disorders in infants.
- Family factors influence the course of psychiatric illness; e.g. patients with major depression who have significant family dysfunction, have a slower rate of recovery. Conversely, good family functioning improves outcome in major depression.
- Depression in a spouse increases depression in the partner.
- The role of expressed emotion (EE) describes the level of criticism, hostility and emotional over-involvement in families. Although initially used with schizophrenic patients and their families, EE is studied extensively across the healthcare spectrum and in many cultures High (EE) is a “significant and robust” predictor of relapse in many illnesses.
- Psychoeducation reduces relapse.

### References:

Butzlaff RL, Hooley JM: Expressed Emotion and Psychiatric Relapse. *Arch Gen Psychiatry* 1998; 55: 547–552.

Keitner GI, Miller IW: Family functioning and major depression: an overview. *Am J Psychiatry* 1990; 147:1128–1137)

Keitner GI, Ryan CE, Miller IW, et al: Recovery and major depression: factors associated with 12 month outcome. *Am J Psychiatry* 1992; 149:93–99.

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Tienari P, Wynne C, Sorri A, et al: Long-term follow-up study of Finnish adoptees. *Br J Psychiatry* 2004;184: 216–222.

McFarlane, W. (2002). *Multifamily Groups in the Treatment of Severe Psychiatric Disorders*. New York: Guilford Press.

Wearden AJ, TARRIER N, Barrowclough C, et al: A review of expressed emotion research in health care. *Clin Psychol Rev* 2000; 20:633–666).

Zeanah CH, Danis B, Hirshberg L, et al: Disorganized attachment associated with partner violence. A research note. *Infant Ment Health* 1999; 20:77

### **PGYIII:**

#### **The resident shall demonstrate knowledge of family development, adaptive and maladaptive patterns.**

- Principles of adaptive and maladaptive relational functioning in family life and family organization, communication, problem solving, and emotional regulation; family strengths, resilience, and vulnerability.
- Couple and family development over the life cycle and multigenerational patterns.
- How age, gender, class, culture, and spirituality affect family life.
- The variety of family forms (e.g., single parent, stepfamily, 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 GLBT issues.
- Relationship of families to larger systems e.g., schools, work, healthcare systems, government agencies.

#### **The resident shall demonstrate knowledge of the current research on evidence based treatment and practice.**

- Family intervention reduces relapse rates and improves quality of life for patients with schizophrenia, bipolar disorder, major depression, alcoholism, borderline personality disorder, obsessive compulsive disorder in children and adolescents, eating disorders etc.

### **References:**

Keitner GI, Heru AM & Glick ID. *Clinical Manual of Couples and Family Therapy*, AAPI, Washington, 2009. Chapter 3, pages 31-55

### **Family skills required in all treatment settings**

- **The ability to think systemically.** The ability to think in terms of boundaries, subsystems, and feedback loops rather than a linear cause and effect model, is critical to understanding interpersonal connections. Systemic thinking is also a critical part of community psychiatry, team building, and administrative work.
- **Family interviewing skills.** Effective family skills training begins by encouraging the resident to be available for brief family contact when the family is available. This is especially true on inpatient medical or psychiatric units. In outpatient clinics the family often brings the patient to the appointment, and a brief greeting or 10 minute meeting can develop an alliance. For assessment, education, or change-oriented interventions the resident needs a specific interview protocol and agenda, discussed beforehand with the patient (if possible) as well as the supervisor. Sample family interview protocols for inpatient, outpatient, and psychosomatic medicine are available (see Keitner, Heru, Glick 2010). Residents should be able to provide psychoeducation and be able to make a distinction between psychoeducational interviews, in which the focus is on helping the patient and family understand and respond to the patient's illness, and family therapy, which is an in-depth assessment and treatment of relational issues. While both may be used in a particular case—for example, a depressed patient may also have marital problems which need direct attention—these are separate interventions and require a different focus of attention.
- **Managing high levels of emotion.** Distressed family members and/or patients can dominate a family meeting. High affective outpouring may be directed at family members or at members of the treatment team. Techniques to de-escalate intense emotional situations and manage hostility and conflict within a family setting can be demonstrated by supervising faculty. The resident can then practice these under supervision.
- **Family assessment.** Assessment techniques will vary somewhat with the instructor. Kietner, Heru and Glick provide several assessment tools.
- **Collaborative treatment planning.** Treatment planning is a process that includes 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 urgent situations, and provides clear and realistic goals for treatment. Collaborative planning helps draw boundaries between family members and identifies specific patient and family responsibilities. While family discharge meetings are common in most inpatient units, in the GAP committee's experience what is most often missed is specific attention to areas where the family can support the patient, such as decreasing high expressed emotion or attention to early warning signs of decompensation. It is also

important to identify the caregiver's needs, such as respite from care and attention to their own psychological wellbeing.

- **Understanding of and the ability to refer to local and national on-line and real time resources such as NAMI, DBA, etc.**

## Teaching Progressively Across the Years

### **PGY1 and 2:**

- **Become comfortable sitting with the family, listen to the family and be able to control a family interview.**
- **Understand what you want from a family meeting.**
- **Be able to understand the struggles of families explain to families the relationship between family functioning and the illness the family is struggling with.**
- **Be able to explain how family treatment can help.**

### **PGY3 and 4:**

- **Understand family systems thinking, family techniques**
- **Be able to carry out a family assessment and basic family intervention including psychoeducation.**

According to Doherty (1995) there are five graded levels of family involvement in training family practice residents, which are quite applicable to psychiatry residents. These range from minimal family contact at Level 1, the provision of family psychoeducation at Level 3, to the assessment, education, and change techniques of Level 4, and skilled family therapist at level 5. Level 4 skills support and manage families who do not require or want major family changes. This includes assessment and psychoeducation. Teaching methods can vary as long as the material is taught, supervised, and reinforced throughout the program. The majority of residents report that they prefer that family skills training begin early in the residency. Residents who are interested in more intensive training in couple/family therapy can be trained up to Level 5. Multiple well-researched models of family therapy have been developed; the choice of family therapy model used in teaching can be made by teaching faculty.

### **References:**

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Slovik LS, Griffith JL, Forsythe L, et al: Redefining the role of family therapy in psychiatric residency education. *Acad Psychiatry* 1997; 21:35–41.

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## ***PGY1 and 2 Years***

### **EMERGENCY PSYCHIATRY**

#### **KNOWLEDGE:**

Understanding when family problems are relevant to the emergency presentation.

#### **SKILLS:**

- **Taking a history under stress.** Patients brought to the ER are often incapable of giving an accurate (or any) history and are frequently brought by family members who have critical information to offer. Family members may have been personally involved in the emergence of the crisis and almost always have a stake in disposition decisions. In these situations, residents can develop skills in rapid history taking and developing a family alliance at moments of stress.
- **Assess family developmental stage.** Patients often present when the family is in a developmental transition.
- **Recognizing the family as a resource.** Provide support, acknowledge and build on family strengths.
- **Treatment Plan:** Can the family ensure the safety of the patient at home? Is there any possibility that the patient will harm family members? Include family in decision-making; educate family about resources outside the ER and the hospital. Review symptoms that would indicate renewed emergency.

**Supervisor tasks:** Be present and model interactions with distraught families, showing how to set limits when time is short. Acknowledge difficulties of working in a crisis mode, both with resident and with families

#### **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 a family living with and supporting a member with chronic mental illness.
- **Appreciating and validating the emotional reactions of family members**, such as anxiety, anger and withdrawal, to the patient's illness and hospitalization
- **Taking seriously the family's concerns** about too-early discharge or inadequate follow-up plans, caregiving and further emergency care.

#### **References:**

Heru AM & Combrinck-Graham L The Family in Psychiatric Emergencies *in Emergency Psychiatry - Principles and Practice* editors: Glick RL, Berlin JS , Fishkind AB,& Scott L. Zeller SI. 2008, Chapter 11 p107-114.

## PSYCHIATRIC INPATIENT UNIT

### KNOWLEDGE:

Be able to understand the struggles of families and explain to families the relationship between family functioning and the illness. Be able to explain how family treatment can help.

### SKILLS:

- **The ability to conduct a family interview** with the patient present, regardless of their diagnosis, as well as meeting with the family privately when indicated.
- **Providing family psychoeducation** related to the illness of the patient, treatment options—both pharmacological and psychosocial—expected treatment, and prognosis.
- **Provide family members with resources:** 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 online resources.

**Supervision tasks:** The resident can observe family interviews which cover the family's history as well as the patient's, adding a genogram form to the chart. Residents can conduct family meetings rather than social workers. This orients residents immediately to family care, which then makes it easier to teach later in the program. Faculty should be available, particularly early in the training year, to supervise inexperienced residents when meeting with contentious families. Otherwise the resident will be overwhelmed and will attempt to avoid future family meetings. If ward faculty are hard pressed for time, volunteer faculty can do family consults on the inpatient unit.

### 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 a family living with and supporting a member with chronic mental illness. Appreciating and validating the emotional reactions of family members, such as anxiety, anger and withdrawal, to the patient's illness and hospitalization. Taking seriously the family's concerns about too-early discharge or inadequate follow up plans, and their questions about caregiving and further emergency care.

### Reference:

Heru AM, Drury L: Working with Families of Psychiatric Inpatients. Baltimore, Johns Hopkins University Press, 2007

## **ADDICTION PSYCHIATRY**

### **KNOWLEDGE:**

Understand how addiction can affect family functioning and what types of family treatment are most effective.

### **SKILLS:**

- **Assessment of family perspective on substance use.**
- **Development of a family-based treatment plan for abstinence.**
- **Understand basic concept and skills for behavioral couples therapy.**
- **Provide education.** Families want clear guidelines about how to treat the recovering patient, education about addiction, and strong encouragement to attend Al-Anon, Nar-Anon, etc.

### **ATTITUDES:**

Addiction may be present in other family members and a genogram can be helpful to assess addiction history in the family. An open non-blaming attitude is important in addiction psychiatry.

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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.

O'Farrell T, Murphy CM, Stephan SH, et al: Partner violence before and after couples based alcoholism treatment for male alcoholic patients: role of treatment involvement & abstinence. *J Consult Clin Psychol* 2004; 72:202-217.

## **PSYCHOSOMATIC MEDICINE**

### **KNOWLEDGE:**

Understand how chronic medical illness can affect family functioning and what types of family treatment are most effective.

### **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 and treatment-related issues and decisions. Conflict among family members, particularly around death and dying, are painful and stunts family growth for years to come.
- Understand the cultural and spiritual beliefs that guide the family
- Consultation 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) can facilitate the treatment process and support the family unit in a time of crisis
- Assess for caregiver burden and manage appropriately.

**Supervision tasks:** Encourage resident to meet with families of inpatients in the late afternoon or early evening or during visiting hours. Dealing with death and dying issues, such as advance directives, is often difficult for residents who have not had much personal experience with seriously ill or dying family members. They may need specific support from supervisors.

**References:**

Rolland JS: *Families, Illness and Disability: An Integrative Treatment Model*. New York, Basic Books, 2004.

Walsh F, McGoldrick M: *Living Beyond Loss*. New York, WW Norton & Co., 1991.

***PGY3 and 4 Years***

**OUTPATIENT CLINIC AND COMMUNITY PSYCHIATRY**

**KNOWLEDGE:**

- Understanding that patients have families and meeting with the families.
- The effect of the illness on the family and the family on the illness.
- Relational aspects of sexual dysfunction.
- Distinguishing relational problems that should be treated in couples / family therapy from problems related to the effects of the illness in which the spouse / family needs education and support. Also understanding the effects of parental illness on the children, and identifying resources for the children.

**SKILLS:**

- A rationale and explanation to allow the patient to bring in the family. Ability to sensitively get consent for a family assessment.
- 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. In terms of confidentiality, the resident can distinguish between individual session content, which can be kept private, and case management issues such as those described above, which can be shared. In addition, particularly with impaired young adults living at home and unable to work, an agreement must be reached about family rules, especially about the structure of the patient's day, alcohol, or drug use, and finances. The resident needs to emphasize that reducing stress in the system, both for patient and caregivers, is important for recovery.

- Supporting families whose members won't accept treatment.
- Understanding and normalizing life transitions: fallout from divorce, death, chronic illness, assess and develop family resilience.
- Assess needs of other family members such as children and spouse.
- Ability to assess and treat couples and families using an evidence-based model.
- 

**Supervision tasks:** Assist resident evaluate the extent to which involving the family will be helpful and to balance concerns about confidentiality and an accurate history or identification of caregiver stresses. Patients often present for individual therapy for relational issues. We recommend supervisors encourage family assessment as part of teaching a biopsychosocial model of health and illness.

#### **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. If residents are allowed to avoid this, their own discomfort remains intact and the patient's reluctance prevails.

#### **References:**

Keitner GI, Heru AM & Glick ID. *Clinical Manual of Couples and Family Therapy*, AAPI, Washington, 2009: chapter 5, p105-108

Walsh F. Family resilience. *Family Process*. 2003;42(1): 1-18.

#### **CHILD AND ADOLESCENT PSYCHIATRY (Inpatient or Outpatient)**

The child and adolescent psychiatry rotation is an excellent situation within which to learn family skills. No matter when it occurs or which setting it occurs within, the resident is expected to interview and work with families to obtain history and to assess parenting.

#### **KNOWLEDGE:**

Programs vary to the degree with which they cover child development and psychopathology in resident seminars. It is essential that this learning be situated within an understanding of families and family risk and resilience and of 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.
- Learning about how several perspectives can be simultaneously true is part of this process.
- Assessing family interactions especially in relation to the child patient is a significant focus of this rotation.
- Dealing with family conflict, recognizing and reconciling diverging goals that a parent and child may have and creating a frame for family engagement in treatment are also important skills to be developed in this rotation.
- Assisting families in navigating normative transitions in their child's and family's life.

**ATTITUDES:**

Residents should develop respect for and compassion for both children with mental health challenges and also for their parents and curiosity about the challenges of parenting for their patients. Skills in communication and listening are essential in this rotation. Residents should also develop respect for the diversity of families and the influence of culture and ethnicity on family life.

**Reference:**

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

**ELECTIVE PROGRAM OFFERINGS**

Enhanced family therapy experiences can be arranged in the third or fourth year for example: in a couple and family therapy clinic, through additional training in child/adolescent psychiatry, or in a woman's mental health treatment program. Training in Geriatric Psychiatry also can lead to the development of enhanced family skills through family meetings, family care planning and assisting family members in their involvement with elderly members with psychiatric difficulties. Residents interested in developing competency in family therapy can then work in these settings with families in a more concentrated fashion.

**A MINIMUM DIDACTIC CURRICULUM**

The following is a minimum curriculum outline with a suggested textbook:  
 Keitner GI, Heru AM & Glick ID. *Clinical Manual of Couples and Family Therapy*, AAPI, Washington, 2009. Appropriate chapters per class are listed below

Other General Teaching Resources:

Carter B, McGoldrick M (eds): *The Expanded Family Life Cycle, 3<sup>rd</sup> ed.* New York, Allyn & Bacon, 1999.

Heru AM, Drury L. Overcoming barriers in working with families. *Acad. Psychiatry.* 2006 Sep-Oct; 30(5):379-84.

### **PGY1 & 2 Curriculum**

- Healthy family functioning: family functions, marital and family life cycle, family resilience: Ch. 2
- Family research: relational factors and biological systems, medical illnesses, psychiatric illnesses: Ch. 3
- Family assessment: connecting with the family, the evaluation process the assessment process, tools for assessment and relational diagnoses: Ch. 4
- Evidence-based treatments: McFarlane's psychoeducation, family focused therapy, problem centered systems therapy of the family models: Ch. 8 and 9
- Integrating family treatment into biopsychosocial care: Ch. 10 and 11

### **PGY3 & 4 Curriculum**

- Out-patient: Involving families in the assessment of risk and in the decision making process: Ch. 7
- Basics of psychoeducation, using a model such as Miklowitz or Anderson.
- Basics of family therapy
- Special situations: gender, race, culture, sexual orientation, affairs, violence divorce, etc: Ch. 12
- Sexual interviewing and exposure to the treatment of sexual dysfunction: *Principles and Practice of Sex Therapy, 4th edition*, ed Sandra Leiblum, Guilford 2007

## **THE UNIVESITY OF PENNSYLVANIA CURRICULUM**

## **THEORETICAL APPROACH**

We assume that family relationships are attachment relationships, and that these bonds are biologically based. Attachment relationships in adults include a belief that one's partner loves and respects you and is willing to "watch your back" ; that is, to privilege the relationship over others in times of stress. It includes a strong biological component of soothing and stress reduction when the partner is present, and anxiety and depression when the partner cannot be found physically or emotionally. When an attachment relationship devolves into chronic conflict or high expressed emotion , it effects the HPA axis as does any high stress situation, with effects on the cardiac, immune and pulmonary systems (Viamontes, G, Nemeroff, C. 2010) and increased vulnerability to depression. In psychiatrically vulnerable individuals this leads to relapse and often rehospitalization. It also leads to depression and often premature aging in caretakers. Therefore our model of treatment stresses decreasing anxiety and increasing safety and aliveness in family members and patients. Attachment-based systems also offer the promise of resilience, strength and safety to their members. (Marsh, D.T. & Lefley, H.P. 1996, Walsh, F. (2006).

Depending on the family's needs, education, community resources, communications and problem solving training and therapy may all be sources of safety. We believe that to understand both psychodynamics and current issues, residents doing either individual or couple and family work should be able to think systems so that the patient is seen as embedded in their family community and cultural context. We encourage use of the genogram which allows a more careful examination of patterns of illness, patterns of maladaptive behavior, and belief systems.

## **INSTRUCTIONAL METHODS**

Our curriculum spans all four years of the residency.

- Didactics: The program includes approximately 35 hours of didactic material over the four years.

In coursework, videos made by faculty and residents are primarily used to demonstrate teaching points, rather than professionally made videos. Given the limited time available, we have chosen to use actual patient videos rather than movies or outside sources for teaching purposes. Role-play is used frequently for skill training. We have experimented with standardized couples for skills training. Our general text for the four years, following the GAP curriculum, is Keitner, G, Heru, A., Glick, I. *Clinical Manual of Couples and Family Therapy* APPI Press, (2010). This text is designed specifically for psychiatrists.

- Observation: Residents observe inpatient interviews conducted by family faculty in PG1 and outpatient assessment interviews in PG3.

- Self of the therapist. Residents are asked to do genograms of their own families, and to consider their own gender, culture and family experience as sources of information and beliefs.
- Supervision: Specific supervision in family assessment, family therapy, and dealing with family systems issues within individual therapy are offered as needed in PG3 and mandatory in PG4.
- Involvement of NAMI and other resources: Because residents are often not familiar with the excellent information available from NAMI and other organizations, we use, and ask the residents to give to patients, handouts from NAMI.org and Support and Family Education (Michele Sherman's program at Oklahoma). [//www.ouhsc.edu/safeprogram/](http://www.ouhsc.edu/safeprogram/) SAFE is probably the best comprehensive on line psychoeducation resource available today.) We also have a NAMI member attend one of our class sessions.

### **GENERAL GOALS FOR RESIDENTS**

Residents will see families in all venues in all four training years. Our goal is to provide a sense that in all patients, attention to family members and other interested persons may be critical towards an accurate history and good ongoing care, and that family issues must at least be explored. The resident should be able to:

- Assess individual patients for family systems issues that need attention
- Assume that in most situations of serious psychiatric illness, including psychotic disorders, substance abuse, PTSD, dementia, depression, anxiety and OCD, that the family is seriously affected by the illness and should be offered support and education.
- Assess families for resilience, strengths, and issues that might contribute to or hinder the patient's recovery.
- Use the genogram and time line to compose a three to four generation family history and event history.
- Be able to conduct education, psychoeducation, communications and problem solving training.
- Assess couples and families who enter with systemic problems and develop a formulation and treatment plan.
- Be familiar with family therapy techniques, including the construction of a genogram and time line, and basic family therapy techniques drawn from insight oriented, structural and cognitive therapy.

## **THE PROGRAM:**

### **PGY 1 AND 2 rotations through inpatient, child, geriatric and substance abuse**

#### **Goals**

While faculty may be most concerned about the acquisition of knowledge, the residents report that in learning to deal with families, their primary problems are fear and ignorance of system dynamics and how to deal with multiple people with conflicting concerns. Our first goal is to reduce their anxiety enough to increase their willingness to spend time with families and learn from that experience. Particularly problematic concerns are time constraints (how do I have time to do a family session on an inpatient unit), and fear that family sessions may get out of control. PG1 residents are predominantly childless, and single, so that their life experience has been from the point of view of the younger rather than the parental generation. They are often prone to seeing parents as perpetrators rather than allies. Without much life experience, they have less to draw from in handling upset families. Therefore, the first year focus is on understanding the feelings of all family members, and grasping the grief of families living with mental illness. In skill development, our goal is rapid interviewing, history taking as well as support in controlling sessions.

#### **PGY1 Didactic**

##### **Class 1 and 2: Interviewing families in time limited situations. Controlling the session**

- Defining family: family is not only the people one lives with but the people one is attached to and depends on.
- The family as a system: linear cause and effect vs. feedback loops
- Dealing with multiple versions of the "truth" in families
- Components of a family history: genogram and timeline
- Family needs vs. confidentiality; review of HIPAA requirements
- Conducting a family session; setting an agenda, keeping the session on track
- Dealing with hostility, grief, silence within the family or toward the therapist

##### *Readings:*

Heru AM & Combrinck-Graham L (2008) The family in psychiatric emergencies, in *Emergency Psychiatry: Principles and Practices*. eds Glick RL., Berlin JS & Zeller SL. NY: Lippincott, Williams & Wilkins.

Heru AM, Drury L: (2007) *Working with Families of Psychiatric Inpatients*. Baltimore, Johns Hopkins University Part III, Part IV

##### **Class 3. Family assessment**

- Boundaries, emotional closeness/distance, power relationships
- Communication and problem solving
- Behavior control
- Role allocation
- Culture, ethnicity and class
- strengths

*Readings:*

Keitner et al Chapters 4 and 5.

**Class 4. The family under stress: grief and anger.**

- The role of expressed emotion.
- How psychiatric illness disrupts normal family development
- Caregiver burden and grief

*Readings:*

MacGregor, P. (1994). Grief: The Unrecognized Parental Response to Mental Illness in a Child. *Social Work* 39 #2.

Miklowitz, D. (2004). The role of family systems in severe and recurrent psychiatric disorders: A developmental psychopathology view. *Development and Psychopathology* 16: 667-688

Heru and Drury, above, 31-36 on expressed emotion

**Class 5. Education and outside resources**

- SAFE website review <http://www.ouhsc.edu/safeprogram/>
- interview with NAMI member who is a consumer or a caregiver

**PGY 1 and 2 Experiential:**

**Residents rotate through multiple inpatient units.**

Emergency Room: residents interview families as part of intake.

Inpatient: Family faculty members conduct a family-patient interview on the floor once a month. Families are seen as part of discharge planning. Residents are asked to do simple psychoeducation by reviewing handouts with families. Some were created by our faculty and others can be found on NAMI or SAFE websites.

VA: Most families on the inpatient units are interviewed

Child Psychiatry. Several family therapists trained in structural family therapy demonstrate family interviews. Children are seen with their parents.

Geriatrics Residents regularly meet with families to obtain a history and plan care.

## **PGY2 Didactic**

### **Class 1 and 2: attachment and systems theory**

- Review of systems theory, open systems as applied to families, feedback loops and homeostasis.
- Neurobiology of attachment and how attachment ruptures produce stress, increasing relapse in vulnerable individuals
- Using attachment bonds to support caregiving
- Introduction to how decreasing expressed emotion and teaching simple communications techniques supports attachment

#### *Readings:*

Hofer, Myron. (2006) Psychobiological roots of early attachment. *Current Directions in Psychological Science*. vol 15 #2.

Johnson, S. & Whiffen, V.(2003). *Attachment Processes in Couple and Family Therapy*. NY: Guilford.

Goldenberg, I, Goldenberberg, G. (2000) *Family Therapy: An Overview* 5th edition. Australia: Brooks/Cole. Chapter 4: The family as a psychosocial system

### **Class 3. normal family developmental cycle**

- how class and ethnicity shape the family life cycle over time
- how recent changes in reproduction and aging have altered the life cycle
- altered family development in psychiatric illness

#### *Readings:*

McGoldrick, M., Carter, B, Garcia-Preto N. (2010) *The Expanded Family Life Cycle: Individual, Family and Social perspectives*. Fourth Edition. Allyn and Bacon . chapter 1: Overview: the life cycle in its changing context: individual, family and social perspective. chapter 26: psychiatric illness and the life cycle.

### **PGY3 Outpatient family care: overall goals**

Goals: Outpatient family care may take several forms. A couple or family may present for treatment; the family of a young adult with a serious mental illness may need support or education; or a patient may present as an individual but come with serious couple or family issues, such as depression clearly related to marital conflict. The resident should know how to engage family members while maintaining appropriate confidentiality, support family members dealing with chronic illness in a loved one, and determine whether a person presenting for individual therapy would be better served by couple or family therapy, or adjunctive family education or brief interventions. The residents should develop a broad sense of how individual and systemic issues are interrelated. In addition the resident should now be able to consider the role of attachment in individual patient dynamics.

Necessary skills:

- Conducting family oriented individual assessments
- Conducting couple and family assessments
- Learning psychoeducation in depth with outpatient families
- The resident should learn how to do communications training and problem solving training with a variety of family systems.

### **PGY3 Didactic**

#### **Class 1:**

- Review differences between inpatient and outpatient assessment.
- The couple/family assessment vs. the family oriented individual interview.

#### **Class 2: common family patterns. understanding family dynamics.**

*Readings:* Keitner, Heru, Glick Chapters 4 and 5

#### **Class 3 and 4: communications and problem solving training**

[These classes are video and role play classes to allow residents the experience of doing this work]

- skills training for communications: mirroring, validating, empathizing.
- skills training for problem solving: define the problem, brainstorm (suggest several possible solutions) discuss pros and cons and agree on trial solution, carry out solution, review effectiveness. .
- communications training and attachment: mirroring and validating as ways of creating a secure attachment bond.

*Readings:*

Miklowitz, D. (2008) *Bipolar Disorder: A family focused treatment approach*. 2nd edition. NY Guilford.

*Bipolar Psychoeducation Manual*, Fetterman and Berman, unpublished (This manual uses some of the techniques of Imago to amplify standard communications training.)

**Class 5: reviewing family research**

- relational factors and biological systems
- relationship between couples therapy and depression
- evidence based interventions for couples

*Readings:*

Keitner et al chapter 3: Family research

Whisman, M.A. & Uebelacker, L.A. (2006). Impairment and distress associated with relationship discord in a national sample of married or cohabiting adults. *Journal of Family Psychology* 20, 369–377.

Snyder, D, Castellani, A Whisman M. 2006. Current Status and future directions in couple therapy . *Ann Rev Psychol* 57:317-44

**Class 6-7: human sexuality**

- assessing sexual issues
- interviewing individuals and couples about sex

*Readings:*

Risen, C. (2007). How to do a sexual health assessment. In Vandecreek, L., Peterson, F. & Bley, J. (Eds). *Innovations in clinical practice: focus on sexual health*. Sarasota Florida, Professional Resource Press.

Berman, E. (1999). Gender, sexuality and romantic love genograms. In DeMaria, R., Weeks, G., & Hof, L. *Focused genograms: Intergenerational assessment of individuals, couples and families*. Philadelphia, PA: Brunner/Mazel.

**PGY3 Experiential**1. Family Assessment Clinic

Six times a year, three-hour family assessment clinic is held in which all PG3 residents observe a family faculty member interviewing couple or family. Family faculty members rotate this assignment so that residents can observe different therapeutic styles.

2. Individual therapy clinic

Residents are encouraged to meet, and evaluate families of their patients early in treatment. Supervision is provided. In addition, all appropriate patients receive a handout for patients and families which the residents discuss with them.

3. The outpatient bipolar clinic has begun a psychoeducation program using a communications and problem solving training based on Miklowitz with an attachment theoretical base. This manual will be available for public distribution in the next year. Residents are required to see at least one case using this manual.

**Supervision:**

Because the residents will see fairly few family cases during this year, we have not assigned them a permanent family supervisor. The Director of Clinical Services of the CCAF is available on an as needed basis. In addition, the faculty members who developed the manual supervise any resident while they are using it.

**PGY4: Overall Goals**

In PG4 the resident should have experience with couple and adult family therapy. For the past two years we have experimented with using Imago techniques, which flow naturally from communications and problem solving to how past experience has affected the couple. Skills include a formulation of couple dynamics, using communications training to increase safety and supporting the couple through an exploration of how the system evolved from their attachment needs. Susan Johnson's emotionally focused therapy is also discussed. Because cognitive therapy was developed at Penn and is a primary individual therapy method, a cognitive model of couples therapy is demonstrated. Issues of gender, class and ethnicity are integrated into the couple discussion.

**Didactics****Class 1-3 Doing couples therapy:**

An experiential, how to do it segment, moving from communications and problem solving training to an attachment based, emotionally focused model of therapy. Using tapes from her practice and role play, the instructor reviews the process of Imago therapy and EFT (Susan Johnson, emotionally focused therapy).

**Class 4: cognitive couples therapy**

- Understanding how cognitive concepts enhance couples work

*Reading:* Beck, A. (1988): *Love is Never Enough*. NY Harper & Row/Perennial

**Class 5: Secrets and affairs.**

The effects of secrets on families. Should secrets be told, and how?

- Affairs: types of affairs, the experience of the couple having the affair and the left out partner
- The aftermath of affairs: dealing with the betrayal, forgiveness and amends.

*Readings:*

Imber-Black, Evan. *The Secret Life of Families*. Chap 2. NY. Bantam 1998.

Spring, Janis. (1996) *After the Affair*. NY: Perennial

### **Class 6: Separation and divorce, Single parent and binuclear families**

Working clinically with the process of separation and divorce

- breaking attachment bonds:
- dealing with mourning, grief and wishes for revenge.
- financial, parenting, community divorce.
- Developing a new life structure
- Patterns of children's response to divorce.

*Readings:* Chapter 19 Divorce: unscheduled family transition. Chapter 20 Single Parent Families: Strengths, vulnerabilities and interventions In McGoldrick, Carter and Garcia-Preto *Expanded Family Life Cycle*. NY: Allyn & Bacon

### **Class 7 Remarriage: Stepfamilies and their Difficulties.**

Remarriage and the remarried couple. Remarriage from a developmental perspective. Common problems in the formation and stabilization of remarried families. Short list of simple interventions.

*Reading:* Chapter 21 Families transformed by the divorce cycle: reconstituted, multinuclear, and remarried. In *Expanded Family Life Cycle*

### **Class 8 Treatment of Sexual Dysfunction**

- Review of sexual dysfunctions
- Review of current research on treatment

Readings:

Gambescia, N. & Weeks, G. (2006) Sexual Dysfunction. In N. Kazantizis & L. L'Abate (Eds.) *Handbook of homework assignments in Psychotherapy: Research, Practice, and Prevention*. Kluwer Academic Publishers. Norwell, MA.

Hertlein, K. M., Weeks, G. R., & Gambescia, N. (Eds.) (2009). *Systemic sex therapy*. New York: Routledge: Taylor & Francis Group, LLC. Chapter 3: Toward a new paradigm in sex therapy.

### **Psychotherapy Roundtable**

This two session clinical case discussion focuses on the integration of individual and couples treatment. Residents present cases which illustrate the diagnostic and technical problems involved in integrating these two models and treatments. Dr Summers, the psychoanalytically trained Associate Director of Training, and Ellen Berman discuss the clinical material from each perspective, illustrating the synergy and pitfalls of combining these modalities. Dr Summers and Dr Berman frequently share cases, so this becomes a visible model of working together.

**PGY4 Experiential**

Residents are required to see two couple and two family cases in outpatient therapy, or to demonstrate multiple two session family assessments and appropriate exposure to further psychoeducation.

**PGY4 Supervision:**

Each resident or pair of residents is assigned a family supervisor with whom they meet bimonthly. Supervision is required. Supervisors review couple and family cases and also review family issues that individual patients present. Resident evaluations are done informally in January and formally in June. Supervisors and other family faculty meet twice yearly to review changes in the program.

**EVALUATION**

Family supervisors evaluate residents in PG4 using the forms in GAP Committee on the Family, Berman, E et al. (2006)

## **RESOURCES**

### **REFERENCES LISTED IN THIS CURRICULUM**

Anderson CM, Hogarty GE & Reiss DJ: Family Treatment of Adult Schizophrenic Patients: A Psychoeducational Approach. *Schizophrenia Bulletin* 1980; 65: 490-505

American Psychiatric Association: Practice Guidelines for the Treatment of Patients with Schizophrenia, 2nd ed. *Am J Psychiatry* 2004; 161(Feb Suppl)

American Psychiatric Association Work Group on Depressive Disorder (revision) *Am J Psychiatry* 2000: 157(Apr Suppl)

American Psychiatric Association: Practice Guidelines for the Treatment of Patients with Bipolar Disorder, revised ed. *Am J Psychiatry* 2002; 159(Apr Suppl)

Berman, E. (1999). Gender, sexuality and romantic love genograms. In DeMaria, R., Weeks, G., & Hof, L. *Focused genograms: Intergenerational assessment of individuals, couples and families*. Philadelphia, PA: Brunner/Mazel.

Dixon, L et al. (2001) Evidence-Based Practices for Services to Families of People With Psychiatric Disabilities. *Psychiatric Services* July 2001 Vol 52 #7

Gambescia, N. & Weeks, G. (2006) Sexual Dysfunction. In N. Kazantizis & L. L'Abate (Eds.) *Handbook of homework assignments in Psychotherapy: Research, Practice, and Prevention*. Kluwer Academic Publishers. Norwell, MA.

GAP Committee on the Family, Berman E et al. (2006). Family Skills for General Psychiatry Residents: Meeting ACGME Core Competency Requirements. *Academic Psychiatry*, 30:1 69-78. [View full article](#)

GAP Committee on the Family, Berman, E et al. (2008) Family Oriented Patient Care Through the Residency Training Cycle. *Academic Psychiatry*, 32:#2:111-118.

Goldenberg, I, Goldenberberg, G. (2000) *Family Therapy: An Overview. 5th edition*. Australia: Brooks/Cole. Chapter 4: The family as a psychosocial system

Hertlein, K. M., Weeks, G. R., & Gambescia, N. (Eds.) (2009). *Systemic sex therapy*. New York: Routledge: Taylor & Francis Group, LLC. Chapter 3: Toward a new paradigm in sex therapy

- Heru, A. (2006) Family psychiatry: From research to practice. *American J of Psychiatry*, 163:962-968.
- Heru AM & Combrinck-Graham L (2008) The family in psychiatric emergencies, in *Emergency Psychiatry: Principles and Practices*. eds Glick RL., Berlin JS & Zeller SL. NY: Lippincott, Williams & Wilkins.
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- Keitner, G, Heru, A & Glick, I. (2010) *Clinical Manual of Couples and Family Therapy*. Washington DC: Guilford Press.
- Laqueur HP, LaBurt HA, Morong E. Multiple family therapy. In Masserman J, ed. *Current Psychiatric Therapies Vol 4*, NY: Grune and Stratton, 1964
- Lefley, Harriet. 2009. *Family Psychoeducation for Serious Mental Illness*. NY Oxford
- MacGregor, P. (1994) Grief: The Unrecognized Parental Response to Mental Illness in a Child. *Social Work* 39 #2.
- Marsh, D.T. & Lefley, H.P.. (1996). The Family Experience of Mental Illness: Evidence for Resilience. *Psychiatric Rehabilitation Journal*. 20 (2), 3-12.
- McGoldrick, M., Carter, B, Garcia-Preto N. (2010) *The Expanded Family Life Cycle: Individual, Family and Social perspectives. Fourth Edition*. Allyn and Bacon
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Whisman, M.A .& Uebelacker, L.A. (2006). Impairment and distress associated with relationship discord in a national sample of married or cohabiting adults. *Journal of Family Psychology* 20, 369–377.

## **WEBSITES**

**The following sites contain information for both professionals and families. We suggest that instructors review most or all of these and choose the handouts appropriate for their teaching. We strongly recommend SAFE (Support and education program for families)**

American Psychiatric Association [psych.org](http://psych.org)

NIMH <http://www.nimh.nih.gov/health/publications/index.shtml>

American Psychological Association <http://www.apa.org/>

Rochester Institute for the Family <http://www.urmc.rochester.edu/psychiatry/links/>

NAMI: [www.nami.org](http://www.nami.org); [www.nami.org/sites/NAMIPAMainLine](http://www.nami.org/sites/NAMIPAMainLine)

Depression Central: [www.psychom.net/depression.central.bipolar.html](http://www.psychom.net/depression.central.bipolar.html)

Association of Family Psychiatrists [AFP.org](http://AFP.org)

Depression Bipolar Support Alliance [www.dbsalliance.org](http://www.dbsalliance.org)

Support and Education Program for Families (SAFE):<http://www.ouhsc.edu/safeprogram/>

Mental Health Association In New York State. [mhanys.org](http://mhanys.org).

Training and Education Council (TEC, consumer organization, Philadelphia) [www.mhasp.org/services/tec.html](http://www.mhasp.org/services/tec.html)

Center for Couples and Adult Families at U Penn: <http://www.med.upenn.edu/ccaf/>

lesbian and gay issues in families: <http://www.gayfamilysupport.com/gay-help-books.html>

adults and children with ADD or ADHD consumer based organization:  
<http://chadd.org/>

Families in the medical hospital: Institute for Patient- and Family-Centered- Care  
<http://www.ipfcc.org/index.html>

### **BASIC TEXTS**

Heru A, Drury L. (2007) Working with Families of Psychiatric Inpatients. John Hopkins University Press.

Keitner, G, Heru, A & Glick, I. (2010) Clinical Manual of Couples and Family Therapy. Washington DC: Guilford Press.

McGoldrick, M., Carter, B, Garcia-Preto N. (2010) The Expanded Family Life Cycle: Individual, Family and Social perspectives. Fourth Edition. Allyn and Bacon

### **BRIEF BIBLIOGRAPHY BY TOPIC**

#### **ATTACHMENT**

Johnson, S. & Whiffen, V.(2003). *Attachment Processes in Couple and Family Therapy*.

Hofer, Myron. (2006) Psychobiological roots of early attachment. Current Directions in Psychological Science. vol 15 #2.

Fisher, H. (2004) *Why We Love: The nature and chemistry of romantic love* New York: Henry Holt and Co.

#### **BIOLOGY OF RELATIONSHIPS**

Fishbone, Mona. Wired to Connect: Neuroscience, Relationships and Therapy. *Family Process* vol 46 #3 Sept 07.

Siegel, D. (2006). *An Interpersonal Neurobiology Approach to Psychotherapy*. *Psychiatric Annals* 36(4), 248-256.

Viamontes, G, Nemeroff, C. (2010) The Physiological Effect of Mental Processes on Major Body Systems. *Psychiatric Annals* vol 40 #8

### **CAREGIVER BURDEN**

Choler, B. & Beeler, J.(1996) Schizophrenia and the life course: Implications for family relations and caregiving. *Psychiatric Annals*, 26(12), 745-756.

Heru AM, Ryan CE. Depressive symptoms and family functioning in the caregivers of recently hospitalized patients with chronic/recurrent mood disorders. *International J. Psychiatric Rehabilitation* 2002; 7: 53–60.

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