Family Skills for General Psychiatry Residents: Meeting ACGME Core Competency Requirements

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Objective: *The authors discuss the knowledge, attitudes, and skills needed for a resident to be competent in supporting and working with families, as mandated by the residency review committee (RRC) core competencies.*

Methods: *The RRC core competencies, as they relate to patients and their families, are reviewed. The Group for Advancement of Psychiatry (GAP) presents an operational version of these core competencies.*

Results: *Methods of assessment, challenges in teaching, and ways of overcoming programmatic constraints are outlined. Examples of training programs that offer ways of integrating the teaching of family skills into existing programs are described.*

Conclusions: *The implications of the current RRC core competency requirements pertaining to families have the potential to change the training environment substantially. The GAP Family Committee proposes recommendations to facilitate the training of residents in family skills.*

Academic Psychiatry 2006; 30:69–78

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According to the Residency Review Committee (RRC) for Psychiatry core competencies, psychiatric residents need to be specifically taught how to assess the patient within the family and larger social system, how to formulate a treatment plan that includes these psychosocial elements, and how to support the family system. This article presents the RRC competencies and the corresponding set of family skills, describing how four programs provide training and assessment in these family skills. Challenges in teaching and ways of overcoming programmatic constraints are outlined. This perspective is congruent with other areas of medical practice which are becoming more oriented toward family centered care. Family medicine and pediatrics, for example, actively include the families of patients in the assessment and treatment process. Exposure to families also widens a resident's worldview and improves their understanding of larger systems and institutional practices. Residents become more prepared for leadership positions through their understanding of the functioning of systems and the effectiveness of systems-focused interventions (1). However, former residents, when polled, stated that family skills were the least taught during residency and the skills most needed after graduation (2).

The Residency Review Committee Mandate

The RRC describes the core competencies as a "living document," thus anticipating that changes to the core competencies will continue to be made. As currently written, the core competencies for psychiatry are quite specific about the need to involve families in treatment. Taking each of the core competencies in turn, the major identified competencies that relate to families are described.

Under patient care, residents are asked to provide an integrative case formulation that includes socio-cultural is-

sues and develop a treatment plan addressing biological, psychological, and socio-cultural domains. They are also asked to be able to conduct a range of individual, group, and family therapies, using standard accepted models and to integrate these psychotherapies in multimodal treatment, including biological and socio-cultural interventions.

Under medical knowledge, residents are asked to have knowledge of the etiology of disorders, including socio-cultural factors, and to understand the experience, meaning, and explanation of the illness for the patient and family, including the influence of cultural factors and culture-bound syndromes.

Under interpersonal and communication skills, residents are asked to demonstrate the ability to educate patients, their families, and professionals about medical, psychosocial, and behavioral issues. Residents are expected to develop a working alliance with patients and their families and to ensure that the patient and/or family has understood the communication.

Under professionalism, residents are expected to show respect for patients and their families, and under systems-based practice, residents are expected to understand how to use a comprehensive system of care.

The RRC also mandates 5 psychotherapy competencies: cognitive behavior, psychodynamic, supportive, brief, combined psychotherapy-psychopharmacology. There is currently debate about whether this list will remain as is, be modified, or withdrawn in order to allow each residency a choice in the modalities it wishes to teach. Many programs have chosen to include family therapy as a psychotherapy competency. However, the thrust of the current Group for the Advancement of Psychiatry (GAP) Family Committee initiative is to integrate the teaching and assessment of family skills within the core competencies.

GAP Proposal for Family Skills Competency

The GAP Family Committee makes the following general observations about the RRC competencies:

1. The RRC states specifically that for the purposes of their document, "family" is defined as those people having a biological or otherwise meaningful relationship with the patient. Such "significant others" are to be defined from the patient's point of view.

2. The basic tenet of their document is that the family should be included as part of the treatment team, that family members be seen as allies and that it is critical to communicate with, educate and support family members.

3. All residents should be competent to form an alliance with, assess, educate and support families.

4. Family skills include being able to see a presenting problem through a systemic as well as an individual lens.

The GAP Family Committee proposes specific family competencies that consist of the knowledge, attitudes and skills required for a resident to be competent in working with families. These competencies are outlined below.

GAP Proposal for Specific Family Systems Competencies

Knowledge. The resident is expected to demonstrate knowledge of family factors as they relate to psychiatric and medical illnesses, based on scientific literature and standards of practice. The resident is expected to demonstrate knowledge of: 1) basic concepts of systems applicable to families, multidisciplinary teams in clinical settings, and medical/government organizations impacting the patient and doctor; 2) couple and family development over the life cycle and the importance of multigenerational patterns; 3) principles of adaptive and maladaptive relational functioning in family life and family organization, communication, problem solving, and emotional regulation; 4) family strengths, resilience, and vulnerability; 5) how age, gender, class, culture, and spirituality affect family life; 6) the variety of family forms (e.g., single parent, stepfamily, same-sex parents); 7) how the family affects and is affected by psychiatric and nonpsychiatric disorders (e.g., specific information regarding the impact of parental psychiatric illness on children); 8) special issues in family life (e.g., loss, divorce and remarriage, immigration, illness, secrets, affairs, violence, alcohol and substance abuse, sexuality, including gay lesbian bisexual transgender [GLBT] issues); and 9) relationship of families to larger systems (e.g., schools, work, healthcare systems, government agencies).

Residents must be informed about the current research on family functioning and evidence based treatment and practice. First, the role of family factors that influence the presentation and course of illness must be understood. In schizophrenia spectrum disorders, adoptees at high genetic risk for schizophrenic spectrum disorders are significantly more sensitive to adverse rearing patterns in their adoptive families compared to adoptees without this genetic risk (4). Maladaptive parental behavior is associated with the increased risk of psychiatric disorders in their children, regardless of the presence or absence of diagnosed psychiatric illness in the parents (5). Marital violence is correlated with disorganized attachment disorders in infants (6), and generational transmission of psychopathology has been demonstrated in boys with conduct disorder (7). Family factors also influence the course of psychiatric

illness. Patients with major depression, whose families have significant dysfunction, have a slower rate of recovery (8, 9). Conversely, good family functioning improves outcome in major depression (10). A family construct called expressed emotion (EE) describes the level of criticism, hostility and emotional overinvolvement in families (11). Although initially used with schizophrenic patients and their families, EE is studied extensively across the healthcare spectrum and in many cultures (12). High (EE) is a "significant and robust" predictor of relapse in many illnesses (13), such as schizophrenia (14), depressive disorders (15), acute mania (16) and alcoholism (17). High EE in families can also result from ongoing stressful interaction with a disturbed family member, thus indicating a bidirectional process (18).

Second, the residents must know about successful family interventions, which range from family psychoeducation to "manualized" family therapy. Family intervention reduces relapse rates and improves quality of life for patients with schizophrenia (19), bipolar disorder (20), major depression (21), alcoholism (22) and borderline personality disorder (23), obsessive compulsive disorder in children and adolescents (24) and eating disorders (25, 26). Multifamily groups in the treatment of chronic illness in children, such as bipolar disorder, are also proving effective (27). These clinical studies are considered to provide strong evidence of efficacy (28).

Attitudes. The attitudes held and demonstrated by the competent resident are empathy, curiosity and respect for all family members. The resident must accept differences in perspectives on the problem and solution and understand that in families, there is no ultimate truth. This is demonstrated by showing balanced concern for each member of the family and their point of view and working collaboratively with families and viewing them as allies.

Skills. The resident should demonstrate reasonable ability to conduct a family interview and complete an assessment and formulation that includes family factors.

Operational Skills. 1. The resident should be able to identify family members and other relevant persons in larger systems who are involved with the patient's current functioning. In adult residency programs, this might include parents, spouses, partners, extended family, staff persons in health care and/or other systems.

2. The resident should be able to meet with a patient's significant family members and be able to deal with any reluctance on the part of a patient or family to meet.

3. The resident should be able to foster a therapeutic alliance with a patient's family members by instilling feelings of trust, openness, and rapport.

4. In an assessment interview, the resident should a) elicit each family member's perspective of the presenting problem, and b) obtain a family history, including strengths, stressors, and repeating intergenerational patterns of behavior or illness. The ability to construct a genogram and a family timeline are helpful in this process. The resident should also be able to c) elicit the family's culture and socio-economic standing and describe how these factors may impact their response to the patient and his or her illness and treatment, and d) must identify and assess the emotional climate, family organization, and interaction problem solving as described by the Global Assessment of Relational Functioning (GARF). The GARF rating scale is on pages 814 to 816 of the DSM-IV-TR (3) and this score can be included in the assessment. The resident must also e) be aware of personal feelings in relation to family members and be able to tolerate and work effectively in the presence of intense affects, especially when directed at the resident. Finally, the resident should be capable of f) eliciting strengths, competencies, and resources of couples and families so that they might become useful and effective allies in treatment.

5. Following the assessment interview, the resident should be able to: integrate the impact of current relational functioning and the case formulation; present the case formulation and, when appropriate, psychoeducation, to the family within a framework that is respectful, culturally acceptable, and comprehensible; involve the family members in collaborative treatment planning; support the family in resolving differences of opinions with family members regarding treatment; and make recommendations for interventions which may include other members of the system, such as the treatment of depression in the spouse.

Family skills can be taught by a variety of professionals and have been discussed at length in the family medicine literature. In such settings, five graded skill levels for physicians are described (29): Level 1, which allows for minimal emphasis on the family; Level 2, which allows for the physician to engage families and provide ongoing medical information and advice; Level 3, which allows for empathic listening, attentiveness to feelings, normalizing, identifying dysfunction, and supportive coping skills; Level 4, which allows for systematic assessment and planned intervention, skill in family management, interactions, and recognizing dysfunctional patterns; and Level 5, which allows for family therapy.

The GAP Family Committee considers it possible for all psychiatric training programs to provide training in family skills for junior residents up to Level 3 and that senior residents can show proficiency at Level 4. Some residencies may have the faculty expertise to provide family therapy training at Level 5.

Assessment of Resident Competencies

Assessment of family skills will depend upon the resident year of training and the goals for that rotation. At Level 2, for example (i.e., openness to engaging families and providing ongoing medical information and advice), a list of the number of family encounters might suffice. At Levels 3 and 4 (see above), extensive evaluation will be necessary. As the resident's skill level increases, it is important to observe family interviews. The ACGME (30) toolbox of assessment methods provides several methods that are applicable to family oriented care. These include chart stimulated recall, checklists, standardized patients and resident portfolios. A wide range of evaluation methods can yield results; residency programs choose those most compatible with their teaching environment.

A family systems knowledge base is easily assessed by documentation of attendance at seminars or completion of assigned readings. Application of knowledge can be assessed during case discussion or chart stimulated recall that focuses on a bio-psychosocial formulation that takes family factors into account. Many programs include the ability to perform a genogram as an essential skill (31). Genograms are also useful ways of organizing information in individual therapy and, when written into the chart, can assess the resident's attention to family factors (32). Assessing the resident's attitudes and family interviewing skills is most easily done by the supervisor's observation of a family interview, either live or by videotape. An example of a family interview checklist for supervisors is included in Appendix 1. A more specific checklist for interview behaviors (originally designed for a "standardized couple") is listed in Appendix 2. Checklists should be used at multiple points during training to track resident growth (formative versus summative evaluations). The use of a resident portfolio and case logs are excellent assessment methods because they encourage resident self-reflection and self-assessment. For example, the resident can include a description of a case that illustrates how the knowledge and application of family factors enhanced treatment outcome or how a particular family interview was crucial in managing a patient within the family system.

For programs which desire more thorough evaluation techniques, several models are available. For example, the willingness of the resident to reach out to the family can be assessed by a "360" global rating which includes the observation of nursing staff, social workers and the family. A "360" evaluation provides the best assessment of attitude, as family contact can be unplanned or unpredictable and a positive attitude is reflected in a willingness to engage the family wherever they are encountered. A family satisfaction questionnaire can capture the family's assessment of the resident's respect, supportiveness and ability to communicate and provide information. Standardized patients are now a commonly used tool for teaching and evaluation in medical schools, although seldom used in residency programs. A standardized couple or family can provide a consistent stimulus against which to measure progress in both individual residents as well as the faculty's progress in conveying information to the group.

Teaching Family Skills: Challenges in Current Residency Programs

As early as 1979, RRC's requirements in psychiatry state that "family factors that significantly influence physical and psychological development" should be integrated into resident teaching (33). Many residency programs have found this a challenging process, but with the new competency requirements, there is a new opportunity to integrate family factors into residency training.

All family interactions are an opportunity for the resident to connect with family members, understand their point of view and support their caregiving efforts. On the inpatient unit and in the emergency room, most patients are brought by concerned family members. In the outpatient clinic, family members may provide transportation, want to see the resident or may call for information. As part of the residents' ability to work with larger systems of care, it is critical that they develop the ability to coordinate patient care with the families of their patients, as well as with other mental health or social services organizations.

Confidentiality is often the resident's greatest concern when working with families. The resident should explain to the patient the reasons for involving the family. These reasons may range from the mundane (e.g., provision of transportation) to the more complex, such as "help settling you in at home." The goals of the family meeting can be reviewed and specific patient concerns addressed. While the patient's written consent is needed before giving diagnostic and treatment information to the family, no permission is needed to listen to the family or to gain an understanding of their point of view.

Many psychiatric residencies provide some teaching about families, from seminars on family development and family research, to supervised meetings with families. Almost all programs have some therapists who do family work, often social workers who provide guidance for residents who encounter "difficult" families. In the outpatient clinic, some individual therapy models are particularly compatible with systems thinking. For example, cognitive behavioral therapy (CBT) has a long tradition of treating couples as well as individuals. (34, 35, 36). Likewise, Interpersonal Therapy (ITP) focuses on the individual's connection with others, but as the therapist does not meet with other family members, it is not as useful for addressing the family aspect of the core competencies (37). It is common practice in many communities for a family to be in treatment with a family therapist while one or more family members are concurrently in individual therapy. However, this form of combined treatment is almost never written about or taught in residency programs. Successful collaborative work with multiple therapists deserves attention in residency programs. As evidence accumulates for the role of family factors in psychiatric illness and the efficacy of family treatments, both residents and faculty must be made aware of the extent of family research. However residency programs face programmatic constraints and scarce resources both of time and faculty, making it more difficult to develop training in family skills. How to overcome some of these constraints is discussed below.

Programmatic Constraints

Prevailing Healthcare Paradigm of Single Model Care. The increase in biological knowledge necessitates more teaching time devoted to the biological aspects of illness, and psychotherapeutic approaches, including family work, become less central. The rapid discharge of inpatients limits the opportunity for residents on inpatient units to develop psychotherapeutic skills. Insurance companies also shape physician behavior. Residents may believe that their role after graduation is to prescribe medications and therefore do not see the need to learn other paradigms for understanding patients. Unfortunately, this results in difficulty teaching a bio-psychosocial model, with psychotherapy being seen as a separate treatment modality rather than a way of thinking about patients, and with a disregard for input of family members who are involved in the patient's life. In reality, patients present with biological, psychological and social/family issues intertwined. Residents need to become skilled at combining these components into a bio-psychosocial assessment and treatment plan.

Each time a family comes into the emergency room, inpatient, or outpatient unit, an opportunity exists for teaching. The attending can gradually expose the resident to increasingly complex families as the resident's skill level increases, but more important, support the resident's understanding of how biological vulnerability is magnified or mediated by both internal dynamics and family/larger system input.

Prevailing Department Culture. Defining the culture of a residency is not easy, but there are, in each program, preferred or dominant discourses regarding the central curative factors for patients. However, most psychiatric residencies, whether they are biologically or analytically based, embrace an individual rather than a systemic paradigm. A culture receptive to systems theory requires the belief that involving families improves the assessment and treatment outcome for patients. In many programs, faculty members are unfamiliar with, and may disagree with, some aspects of standard family systems practice, such as routinely seeing family members together, early in treatment. It may be easy to provide a volunteer faculty member to do a series of lectures on families, but it takes an active stance on the part of a department Chair and the director of residency training to set the culture within a department.

The hallmark of a good residency program is the exposure of residents to a wide variety of supervisors with different philosophies and styles. As a result, residents trying to develop their own blend of skills must grapple with the conflict between paradigms embodied by their supervisors. Residents always have to contend with supervisor differences, but it is difficult for residents to be faced with supervisors whose advice is contradictory. This is particularly true when supervisors disagree regarding involving family members.

The RRC mandate to teach family oriented care and family skills as part of the core competencies should focus attention on the family. Family involvement can occur during psychodynamic, CBT and supportive therapy, as well as during inpatient treatment, consultation liaison work, and in the emergency room. There is evidence that including family members in medication management visits improves patient compliance with treatment (38, 39). Research on the effectiveness of family interventions can be presented throughout general psychiatry training, in grand rounds, journal clubs and in seminars. The willingness of the systems-trained faculty to be available for consults,

case conferences and other training events can be a powerful factor in integrating family into the culture of a department.

Teaching Faculty. Psychiatrists who are able to teach the assessment and treatment of families and couples are difficult to find in some areas. Many family systems therapists are not physicians, and their integration into higher decision making levels of the academic medical hierarchy is difficult. A lack of respect for their work and concern about their suitability as role models for residents have, in some instances, hampered their integration. However, they represent an invaluable resource both in terms of knowledge and in teaching the resident the value of interdisciplinary work.

Respect and integration are "top-down" phenomena, and a Chair and residency training director wishing to make use of nonphysician therapists need to pay particular attention to integration. Ideally, psychiatrists and members of other disciplines can work together as teaching faculty.

The Family's Perspective. In order for patients to do well, families need to understand the signs and symptoms of illness, have an understanding of the treatment plan, and be aware of family behavior that is helpful and supportive of the patient's recovery. Unfortunately, families confronting the mental health system often fear being blamed and usually have internalized society's views that if you have a mentally ill child, that the family (and most intensely the mother) is to blame. Residents may therefore encounter hostility and resistance when meeting with families. Residents may also entertain negative ideas about the family.

It is important for residents to approach families with a "nonpathologizing" stance and to actively seek to develop an alliance with families. Family members usually want to be helpful and often appreciate guidance to lessen the likelihood of harm to their loved ones. Families can provide information that increases the likelihood of an accurate diagnosis or early detection of harmful behaviors such as substance abuse and self-injurious behavior. Listening to a patient's family members and recognizing them as valuable sources of information about the patient is an important first step in developing an alliance with the family.

Families can also receive support in the community. The National Alliance for the Mentally Ill (NAMI) and the Depression Bipolar Support Alliance (DBSA) provide support in the community and have developed sophisticated self-help groups. Family education programs are delivered by family members who are specifically trained as group leaders. The most widely used family education model is the Family-to-Family Education Program or FFEP (formerly the Journey of Hope Education Program), which was developed in the early 1990s. The program is free and is supported by a combination of grassroots donations and/or state mental health funds. Caregivers receive information about mental illnesses, treatments and medication and rehabilitation. They learn self-care and communication skills as well as problem solving and advocacy strategies and develop emotional insight into their responses to mental illness (40). FFEP classes are open to anyone with a family member who has serious and persistent mental illness, whether or not the ill person is receiving treatment. To date, FFEP is offered in 45 U.S. states, Puerto Rico, two Canadian provinces (British Columbia and Ontario), and three regions in Mexico. Online resources are also frequently accessed by families.

Residents can inform and support families about these services. Family and patient "psychoeducational" inpatient groups are suitable forums for providing this information, and speakers from NAMI or DBSA can be invited to these meetings.

Training Program Configurations

There is a great deal of variety in how psychiatry training programs can meet the challenge of incorporating family training into their teaching and supervision. The following programs illustrate different ways in which family work has been incorporated into residency programs in response to the goal of teaching family oriented care throughout the residency. Each of these programs was originally built around a faculty member with a particular interest (outpatient couples therapy at Penn, family consultation-liaison in Chicago, inpatient psychiatry at Brown, child psychiatry research at Buffalo). Over the last 2 to 3 years, programs have adapted to the core competency requirements by expanding their didactic training to include information previously omitted, examining each of its clinical components to find ways to involve family members when appropriate, and most important, altering goals from training a few interested residents in family therapy to insisting that all residents have a basic level of comfort with family members and an increased ability to perform a biopsychosocial formulation and treatment plan. All of these programs see themselves as works in progress, and details of each program change from year to year.

University of Pennsylvania: An Outpatient-Based Program

This program locates family skills training primarily within the PGY-3 and PGY-4 years; a PGY-1 and PGY-2

program is being developed. Faculty with primary responsibility for teaching includes one part-time salaried faculty member (a psychologist) and four volunteer faculty members brought in specifically to teach family skills (2 psychiatrists and two nonpsychiatrists). Additionally, several of the supervisors on the standing volunteer faculty have expertise in family therapy or experience with families in specialized areas (such as substance abuse) and serve as additional supervisors or lecturers.

The following summarizes the process of the training:

1. Thirty hours of required didactic course work (lecture, videotape, observed cases) spread over the second, third, and fourth years in order to make the material relevant to the resident's changing caseload.

2. In PGY-1 and PGY-2, there are observed interviews of consultations for families of inpatients twice monthly; participation in family meetings on the unit that focus on alliance, education, and discharge.

3. In PGY-3 and PGY-4, all of the resident's patients, regardless of presenting problem, are viewed through a systemic perspective. Couple and family cases are primarily developed from the resident's caseload, and cases that are appropriate for couple/family therapy are either converted to couples cases by the resident or referred to the PGY-4 elective residents. Supervision/consultation is available for all cases in which the resident does a formal family assessment or treatment. Residents are required to see two couples and two families in therapy (six sessions or more) in order to graduate, plus demonstrate that they have done multiple family contacts and assessments in the medications clinic, general psychotherapy clinic, and electives.

4. In PGY-4, an elective of 4 to 6 hours per week for the year is offered and is taken by many fourth-year residents. The elective concentrates on couples therapy and adults and their parents.

Competency is assessed by observing interviews, supervisory checklists in PGY-2 and PGY-3 (see Appendix 1) and by standardized patient interviews for the PGY-4 elective (see Appendix 2).

Brown Department of Psychiatry and Human Behavior: Inpatient and Outpatient Program

This program integrates family skills training into inpatient and outpatient rotations. The program is coordinated by a voluntary faculty psychiatrist and includes the supervisory skills of one full-time faculty plus three voluntary nonphysician supervisors, two senior social workers and a marriage and family therapist.

The following summarizes the training process:

1. The PGY-1 and PGY-2 residents convene inpatient family meetings with live supervision. The resident is briefed before the meeting and receives immediate feedback following the meeting.

2. At the beginning of the second year, the residents watch an experienced family therapist assess and take a family through the initial treatment process. This is done through a one-way mirror.

3. The PGY-2 and PGY-3 residents present videotapes of their meetings with outpatient families in weekly group supervision, throughout 2 academic years. The resident's performance is documented on the evaluation form in Appendix 3.

4. There are four seminars at the beginning of the 3rd year on family research, working with children and how to manage difficult families. Attendance is documented using sign-in sheets.

5. PGY-4 residents have the opportunity to run inpatient multifamily groups during a junior attending rotation. The director of the family program supervises these residents, with briefing before the group starts and immediate supervision following the group completion.

University of Chicago Pritzker School of Medicine: Specialized Consultation-Liaison Training

At the University of Chicago, family training is integrated in ongoing training contexts:

1. Family skills in the outpatient setting during the third year. The PGY-3 training includes a didactic seminar and weekly 2-hour group supervision.

2. Family assessment and brief intervention are integrated into psychiatric consultation-liaison for medical illness during the PGY-3 and PGY-4. Elective subspecialization in a family centered approach to chronic illness and disability allows PGY-3 and PGY-4 residents additional training.

3. In the PGY-4 elective, advanced skills in general family therapy or continued training focusing on chronic illness, disability, and collaborative family heath care are highlighted.

4. Competency is assessed by observing live and videotaped interviews, and presentation and write-up of cases using a family assessment outline. The emphasis is on family systems-based assessment, formulation, and intervention plan skills. A supervisory checklist (see Appendix 1) and evaluation form (see Appendix 3) are being incorporated into resident evaluation for PGY-3 and PGY-4 residents.

State University of New York at Buffalo School of Medicine and Biomedical Sciences: Evidence-Based Family Intervention Focus

Teaching and training in family skills in the adult residency are conducted by a full-time child psychiatry faculty member who is a family researcher/clinician (psychologist), and by 4 full-time child psychiatrists experienced in family assessment and intervention. Externally funded family research lends credibility and helps support family training.

Training occurs as follows:

1. Didactic course work in PGY-1–PGY-4 (6 weeks per year) and in the child fellowship program. A structured family interaction assessment protocol, adapted from research, is used to assess and teach the effects of family relations on patient function and illness.

2. Family assessment and brief intervention training (PGY-2 and PGY-3) take place during rotation on the adolescent inpatient unit led by a family trained child psychiatrist.

3. In PGY-4, a 6-week didactic course with emphasis on evidence-based family interventions. Elective opportunities in the child and adolescent division integrate family and individual assessment and intervention. Opportunities are available for participation in family research. Assessment of resident competency is based on live and video observation of their assessment and intervention, formalized in a rating system. As of 2005, the program will be using the forms presented in Appendix 1 and Appendix 3.

Conclusion

The GAP Family Committee supports the RRC's mandate for competency for the psychiatric resident to include skills in working with families. As psychiatric residency programs align with the core competencies, family skills can be taught to every resident. The family skills competencies and suggested assessment tools and reading lists presented here are intended to provide faculty with an outline and resources to begin to develop a family skills training program for residents. The RRC's acknowledgment of the family in the core competencies supports psychiatry's long held goal that a bio-psychosocial approach to patient care is attainable and desirable.

APPENDIX 1. Family Interview Checklist

Please rate, as appropriate on scale of 1 - 5, with 3 as expected level of performance.

The resident is able to:	poor				excellent
Identify the role of family in presenting problem	1	2	3	4	5
Identify the family's developmental stage/transition	1	2	3	4	5
Identify any pertinent cultural / special situations	1	2	3	4	5
Identify the family's strengths and resources	1	2	3	4	5
Be supportive, respectful and collaborative.	1	2	3	4	5
Show balanced concern for each person's point of view	1	2	3	4	5
Understand family interactions.	1	2	3	4	5
Be able to manage affect expression	1	2	3	4	5
Assess the family using the GARF scale.	1	2	3	4	5
Provide psychoeducation,	1	2	3	4	5
Intervene in basic problems.	1	2	3	4	5
Know when to refer complicated problems.	1	2	3	4	5

APPENDIX 2. Interview Behavior Checklist

The resident:		
Joined with both members.	Yes	No
Reviewed the structure and purpose of the evaluation.	Yes	No
Obtained information about the referring doctor.	Yes	No
Obtained identifying information about the current living arrangements of the couple:	Yes	No
names and ages of children,	Yes	No
others living in the household.	Yes	No
Asked about ethnicity/culture.	Yes	No
Asked for each partner's separate version of the presenting problem.	Yes	No
Obtained a couples history	Yes	No
Obtained an individual history from each	Yes	No
Obtained a three or four generation genogram	Yes	No
Identified issues in the timeline of the couple that may be central to the problem (e.g. job stress, birth of children, illness or death of significant people).	Yes	No
Inquired about substance abuse.	Yes	No
Did the resident use language that was appropriate to both partners?	Yes	No
Did the resident ask at least one question about family strengths?	Yes	No
Did the resident allow or request an enactment?	Yes	No
Did the resident control the session appropriately (encourage both to speak, end arguments when appropriate)?	Yes	No
Did the resident maintain connection to both partners?	Yes	No
Did the resident demonstrate empathy and active listening?	Yes	No

APPENDIX 3. Resident Family Skills Competency Evaluation Form

Resident_____ Year 1st or 2nd (circle)

Rating Scale: Excellent 5 4 3 2 1 Poor (3 = expected level of performance)

General Competencies. Attendance Participation

Ability to use supervision Overall Clinical Judgment

Specific Competencies.

A. Cognitive / Conceptual Knowledge:

1. Knowledge of family concepts and systems theory
2. Understanding dimensions of family functioning using McMaster model
3. Recognize when family treatment is indicated
4. Understand typical family transactional patterns

B. Perceptual / Clinical Knowledge:

1. Ability to engage the family in the assessment process
2. Ability to identify transactional patterns
3. Recognition of affect in family members and in therapist

C. Executive Skills.

1st Year.

1. Ability to do assessment and present problem list to family (minimum 3 assessments)
2. Ability to work with the affect in the family
3. Ability to pace work correctly to family's level of functioning

2nd Year.

1. Ability to construct a treatment contract
2. Ability to help family develop new healthier transactional patterns
3. Ability to know when and how to successfully terminate
4. Ability to identify other treatment needs, if any, with the family

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