Dr. Shapiro Copy

IRVINE: CALIFORNIA COLLEGE OF MEDICINE
DEPARTMENT OF FAMILY MEDICINE

September 8, 1987

TO: All residents and faculty,
Department of Family Medicine

FROM: Johanna Shapiro, Ph.D.
Director, Behavioral Science Training Program

RE: THE ROLE OF THE BEHAVIORAL SCIENCE ATTENDING IN CLINIC TEACHING

In all Family Medicine clinics, a target resident is assigned to meet with a behavioral science attending (BSA) once a week, during sessions when a Behavioral Science faculty member is scheduled. No special preparations for this behavioral science contact are necessary (ie., no special patients need to be scheduled, although residents may do so if they wish). However, the BSA does have certain responsibilities and functions, which are delineated below.

The BSA is expected to spend between 1 to 2 hours with each assigned resident (depending on a given session, each BSA is scheduled to work with 1-3 residents).

During this time, the Behavioral Science attending will perform the following functions:

1) The BSA will observe at least one patient-physician encounter and will provide feedback to the resident in some of these areas (including completion of a resident-patient encounter form):

   a) issues raised about the doctor-patient relationship
   b) interviewing techniques
   c) special problems in management posed by this patient
   d) implications for future care of this patient
   e) relevant family and other contextual issues

2) The BSA is available to see "special" patients with the resident, at the resident's initiative. The resident may, during a behavioral science session, schedule patients for the express purpose of:

   a) performing a psychological assessment and diagnosis
   b) taking a more in-depth family/psychosocial history
   c) engaging in ongoing therapy or counseling, with the BSA serving as:

      1. primary therapist (resident observer)
      2. co-therapist
      3. supervisor (resident primary therapist)

3) The BSA is available to consult about <u>any</u> patients seen by the resident in clinic or on other services, to explore:

   a) problems in patient management
   b) appropriate psychological therapies (family, behavioral etc.)
   c) anything else

4) The BSA may, on occasion, be available to accompany the resident on home visits, at the resident's request. The BSA may also use scheduled behavioral science time to discuss the results of a home visit previously performed.

5) In the event of no scheduled patients for a resident during a behavioral science time block, the BSA is expected to do one of the following:

   a) discuss with the resident other patients and families being seen
   b) discuss with the resident a behavioral science topic of special interest to the resident (i.e., family therapy, marriage counseling, etc.).

6) The BSA is also expected to participate in the daily wrap-up session for his/her scheduled clinic time. The BSA is expected to comment on any relevant psychosocial issues raised by the case(s) presented, or to lead a discussion of a behavioral science case as appropriate.

7) The BSA will also make audio/visual tapes of a physician-patient interview at the resident's request. In addition, it is expected that the BSA make one audio/visual tape of each of his/her assigned residents during the year.

In sum, the BSA is expected to act as a resource and teacher to the resident in terms of basic psychological assessment, diagnosis, and treatment. Except in the co-therapy situation described in #2, Behavioral Science attendings, like Physician attendings, will not assume direct patient care responsibilities for any of the resident's patients. All Behavioral Science attendings are thoroughly trained in the diagnosis and treatment of common psychological disorders, and in addition, have a special interest and expertise in working with families.

Thank you for your cooperation with and support of this aspect of the department's educational training program.

Johanna Shapiro

Johanna Shapiro, Ph.D.

JS/bt

X DID. SES

DIDACTIC TEACHING SESSIONS
(3 hours each)
1989-1990

1. Communication skills (Rubel)
   Cross-cultural issues

2. Dr./Pt. Relationship (Shapiro)

3. Review of psychotherapies; brief therapy (Masters)
   Introduction to cognitive therapy

4. Cognitive therapy applied to anxiety, depression (Masters)

5. Stress management (Weinstein)

6. Psychosocial aspects of disease; coping (Weinstein)]

7. Chemical dependency - Introduction (Lenahan)

8. Chemical dependency II (Lenahan)

9. Patient Education (Lenahan)

10. Death and dying (Shapiro/Lenahan)

11. Family developmental life cycle (Shapiro)

12. Family structure and dynamics (Shapiro)

13. Sexual counseling (Gonzales)

The above represents approximately 40 hours of teaching time in the second year.

JS/bt

July 11, 1989

ATTACHMENT 2

ATTENDING RESIDENT_____

1 2 3 4 5
Weak | Adequate | Strong

DATE _____ TIME _____

Presenting Problem _____

ID = insufficient data, NA = not appropriate

FAMILY PRACTICE CENTER
PATIENT ENCOUNTER CHECKLIST

		COMMENTS
I.	INTRODUCTION	
	Quality of greeting (warm, positive acceptance).	
	Effort to put patient at ease.	
	Comfortable, well-controlled presentation.	
II.	INTERVIEW STRUCTURE AND EXPECTATIONS	
	States goals for structure.	
	Notes time available.	
	Elicits patient's rationale for visit.	
	Scans other problem areas.	
	Elicits patient's expectation for treatment, practitioner behavior.	
	Overall use of time, structuring interview.	
III.	PROCESSING PROBLEMS AND SCANNING	
	Uses open-ended questions.	
	Uses specific questions.	
	Uses active listening skills.	
	Uses paraphrasing skills.	
	Awareness of patient nonverbal cues.	
	Requests information on health of family members.	
	Requests psycho-social information.	
	Explores possible emotional concerns/problems.	
	Shows empathy toward the patient.	
	Avoids criticism or judgment of patient.	
	Reinforces patient for initiative, self-responsibility.	
	Makes use of self-disclosing statements.	
	Uses appropriate gestures, facial expressions.	
	Checks patient compliance with past treatment directions.	
IV.	UTILIZATION OF OTHER RESOURCES	
	Refers to patient's chart.	
	Asks questions of person(s) accompanying patient.	
	Looks up information.	
	Consults with other health care providers.	
	Discusses own emotional reactions to patients.	
	Explains reasons for referral.	
V.	PATIENT INSTRUCTION/TREATMENT	
	Explains treatment and diagnostic procedures.	
	Makes a psychosocial intervention.	
	Avoids technical jargon.	
	Actively encourages patient to paraphrase instructions/information.	
	Writes down medical/behavioral tasks assigned to patient.	
	Discusses impact of disease on:	
	a. patient's life.	
	b. family's life.	
	Uses family to implement treatment program.	
VI.	SUMMARY OF SESSION	
	Summarizes information.	
	Specific future course of action.	
	Elicits feedback from patient.	
	Reassures patient appropriately.	

BEHAVIORAL SCIENCE CURRICULUM

The Behavioral Science program consists of several components, which are described below.

I. Behavioral Science Rotation

This is an approximately 120 hour three week rotation required of all first year residents. The rotation includes two weeks of general behavioral science training and one week of an experiential family program in an alcohol/drug abuse treatment center. The specific content of this rotation is outlined in Attachment 1. In general, this intensive experience provides didactic training in principles of family structure and dynamics; exposure to concepts of family development theory, as well as case-oriented applications; basic geriatric topics, including a visit to a nursing home and interview with patient; a seminar on death and dying; understanding and analysis of the interaction between family unit and disease process; intensive training in interviewing skills and aspects of the doctor-patient relationship; basic techniques of patient counseling, especially targeted toward dealing with "problem" patients; initial exposure to diagnosis and assessment of psychiatric disorders, taught by case example; human sexuality; fundamentals of behavioral counseling; alcoholism and drug abuse.

This rotation is taught by a seven person faculty of social workers, psychologists, and medical anthropologist. Each faculty submits an evaluation of the resident, and these are compiled by the director into a single, summative evaluation. The week experience at Care Manor, under the supervision of Dr. Andrea Kaye, is separately evaluated (see Attachment 2).

II. Behavioral Science Clinic Teaching Program

This is an ongoing program operating in all three family practice centers over all three years of resident training. Beginning in the first year, residents are assigned to be supervised on a regular basis by a member of the five-person behavioral science clinic teaching faculty. The frequency of contact varies from twice a month in the first year to 3-4 times a month in the second and third years. The responsibilities of the behavioral science faculty (BSF) are detailed in Attachment 4. Basically, the resident is directly observed in a patient-physician interaction and given verbal and written (Attachment 3) feedback. The BSF also consults with the resident regarding psychosocial aspects of patient management and, on a case-by-case basis, instructs the resident in areas such as a) psychological assessment and diagnosis, b) brief behavioral and/or supportive counseling, c) appropriate referral options.

III. Psychiatry Rotation

The psychiatry rotation is a one month rotation which involves the resident both with the inpatient Emergency Psychiatry unit, and the outpatient Crisis Intervention unit. This rotation is described more fully elsewhere. It emphasizes psychiatric diagnosis and assessment. It also has a strong psychopharmacology component, with a pharmacologist regularly available for consultation and didactic presentations.

IV. Additional Programs

A. Stress awareness and management

A segment of orientation week taught by a physician-psychologist team identifies sources of stress for residents and promotes the value of self-awareness and understanding. This is accompanied by 1-2 follow-up lectures during the first year seminar series on techniques for dealing with stress as well as other personal problems.

B. Home Visit

Each resident is required to complete a supervised home visit once each year of the program. The resident is also required to complete a family evaluation based on this visit (Attachment 5). The resident thus has an opportunity to apply some of the skills of family assessment and observation learned in the didactic portion of the curriculum. One lecture in the first year seminar series is devoted to issues on the home visit.

C. Remedial Program

1. For residents evaluated as deficient in interpersonal skills, a 12 week remedial course in Interpersonal Process Recall is required. This training develops resident self-awareness, and provides a safe environment to focus on interpersonal interactions and psychological sensitivity.

2. For residents judged deficient in terms of their attitudes toward sexual problems and therapy, residents are referred to the Sexual Attitudes Restructuring program.

D. Electives

The Department of Family Medicine offers three behavioral science electives. In a given year, 2-3 residents participate in each of these electives.

1. Family Therapy - a 10-20 week course, taught by Dr. Edward Kaufman, Department of Psychiatry & Human Behavior, which teaches structural family therapy principles and practice.

2. Hypnotherapy - a 10 week course, taught by Dr. Joyce Friedmann, clinical faculty, Departments of Family Medicine and Psychiatry, emphasizing nonpharmacological management of chronic pain and stress.

3. Sexual Attitude Restructuring - a two day intensive training experience designed to educate learners about their own attitudes, values and beliefs regarding sexuality.

C. Concepts

1. The family practice resident should be able to carry out all psychiatric phases of diagnosis and management of his/her nonpsychiatric patients within the hospital in 90% of the cases including non-compliant, passive, denying patients and to help patients to adapt to medical and surgical problems.

III. CLINICAL PSYCHOLOGY

A. Concepts

1. The family practice resident should be able to recognize those diagnoses and symptoms that are amendable to psychological techniques and therapies with consultation. The resident should be able to suggest appropriate therapists, therapies or techniques.

B. Skills

1. The family practice resident should be able to direct basic behavior management procedures to change the patient's health related behaviors or other simple problems with the advise of a consultant.

2. The family practice resident should be able to recognize the need for, and maintain primary responsibility of patients with simpler psychological problems after the resident has consulted an appropriate therapist.

IV. INTERVIEWING DOCTOR/PATIENT OBJECTIVES

1. Complete approximately eight hours of IPR (Interpersonal Process Recall) training.

2. Be able to differentiate between the various communication modes:

   a. Exploratory
   b. Listening
   c. Affective
   d. Honest labeling (confrontive)

3. Be able to demonstrate proficiency in the appropriate use of each of these modes.

4. Be able to demonstrate response proficiency using a combination of interviewing skills to a variety of patient stimulus cues.

5. Be aware of internal emotional, physical and cognitive cues which indicate idiosyncratic responses to patients.

6. Be able to use personal reactions in a way which is therapeutically beneficial to the patient.

7. Develop proficiency in short-term management of several types of "problem" patients:

a. Hypochondriacal
b. Depressed
c. Anxious
d. Patient in crisis
e. Chronic pain
f. Seductive
g. Hostile
h. Needy, demanding

8. Know how to structure interview including:

a. Time management
b. Introduction
c. Processing problems and scanning
d. Utilization of other resources
e. Patient instruction/treatment
f. Patient education
g. Summary of session

9. Be able to critique an audio or videotape of one of their own actual patient encounters using IPR techniques.

10. Be able to give at least three examples of how the doctor-patient relationship can either enhance or detract from patient care. Possible areas might include:

a. Compliance issues
b. Hypochondriasis
c. Management of patient fears

V. GOALS & OBJECTIVES: RESIDENT SELF-AWARENESS

The resident should accomplish the following:

1. View the entire tape "Stress and the Resident-Physician".

2. Be able to identify the types of stressors highlighted in each vignette.

3. Be able to accurately relate those stressors to his/her current situation.

4. Be able to generate adaptive, psychologically healthy coping strategies in response to these stressors.

5. Be able to identify internal cues which are signs of stress, tension, anxiety, hostility.

6. Be aware of the resident advisory system existing in the department and how to utilize it.

7. Be able to identify other formal and informal support mechanisms available in the community to deal with persona;/professional stresses and problems.

8. Be familiar with at least two basic nonpharmacological stress reduction techniques:

2. List the objectives of your teaching program for family practice residents, including any special skills to be learned.

I. THEORETICAL/PHILOSOPHICAL PREMISES

The development of a behavioral sciences curriculum in a family medicine residency program reflects a blend of conceptual analysis, skill identification, structural organization, formulation of evaluation and assessment procedures, and schema for implementation.

On a theoretical level, several major questions must be raised. What is the rationale behind introducing a core of behavioral sciences into a program aimed at training family physicians? In what ways will study of the behavioral sciences enhance the image-ideal of the doctor we are attempting to train?

In attempting to develop and implement such a curriculum, it appears we must wade between two dangers: the Scylla of simply grafting narrow skills of one discipline onto the deficits of another discipline; and the Charybdis of attempting to turn doctors into minipsychotherapists (Egner, 1977). The conceptualization of this curriculum will attempt to address itself to both of these concerns.

In order to explore the above questions and concerns, it is critical to examine the philosophical and theoretical premises which have yielded the current trend toward incorporation of the behavioral sciences in medical training. One key concept is that of the integral relationship of mind and body, psyche and soma, in patient treatment. As has been pointed out, (Sluzki, 1976), by labeling courses with psychologically slanted titles such as Family Process and Group Dynamics, we defeat the purpose of thinking interactionally about the two spheres. The commitment to principles of intergration and holism leads to a perception of the unity of medical and non-medical problems, to seeing people as people rather than as disease entities.

Another premise on which the behavioral sciences curriculum must be based is the importance of training doctors committed to primary care, not in the sense of the physician of first contact, but rather of commitment to people over technological advances (McWhinney, 1975). This commitment has been defined as extending beyond a warm, caring and respectful attitude toward patients (although this is also important), to a commitment to <u>stay with</u> the patient regardless of the physical, psychological, and developmental changes in that person's life.

A third premise posits a heuristic model of the ideal family physician, and also makes the assumption that training and education can advance students/residents toward that ideal. The ideal which most strongly justifies the inclusion of the behavioral sciences is characterized by several components which heretofore have been treated lightly or negligently in most medical training: a belief that the capacity for insight and self-awareness in the physician is highly significant to quality patient care; that a sensitivity to the emotional reactions of self and others is critical to the establishment of a satisfactory doctor-patient relationship; that a knowledge of behavioral dynamics, interviewing and communication skills is essential to adequately performing the full range of physician function.

A related premise concerns the image-ideal of the patient as well as that of the doctor. In this view, the patient is seen not as passive and ignorant, but as an equal worthy of respect and self-responsibility. It follows that there must be a serious emphasis on patient education, as a means of transferring responsibility for attaining and maintaining health from physician to patient and family. It also presupposes a problem-solving model in which patient/family and physician work together to understand and ameliorate the circumstances surrounding a particular medical or life crisis.

A further premise has to do with a way of perceiving people and patients not as isolated individuals, but as members of larger groups functioning in social and physical environments which have a significant impact on their lives. In this context, the family environment is viewed as particularly important, as it forms one of the most common groups of intimates found in the history of humanity. The focus on family and environment is seen as critical to understanding and treating patients (Vandervoort and Ransome, 1978). According to this view, at all times the interaction between disease entity and family process, cultural and community influences needs to be kept at the fore.

A final important premise derives from the concept of role innovation (Johnson, 1976). This premise challenges the definition of physician as technological specialist, a definition which previously has been a hallmark of the profession. Rather, it suggests that the primary care physician is fully competent to handle a wide range of patient complaints and concerns, and does not distinguish between problems of a medical and a non-medical nature. This premise implies expansion of the role of the physician to encompass the following: group facilitator and family counselor; consultant and teacher in training the family; change agent in instigating new behavior patterns in patient and family.

II. BEHAVIORAL SCIENCE TEACHING PROGRAM

The educational goals of the program derive from the theoretical and philosophical principles generated in the first section. Educational goals include both mastery of a theoretical body of knowledge and evidence of significant skill acquisition.

Educational goals relevant to a program in the behavioral sciences might include the following:

* Observational skills which include attention to both verbal and nonverbal behavior; awareness of interactive dynamics and small group process; sensitivity to affective and cognitive information being transmitted by the patient.

* Communication skills which include familiarity with techniques of active listening, empathy and rapport-building, confrontation; which promote qualities of coherency, relevance, openness, concern, and respect for the patient; and which pay attention to the self as a relevant variable in any interactive process.

* Interviewing skills, including techniques for eliciting affective and cognitive information, handling silence, acknowledging both negative and positive emotions clarifying, problem-solving, and summarizing.

* Awareness of the importance of physical and social environmental variables in assessing a patient's life situation, and ability to manipulate the environment in a way to facilitate mutually agreed upon medical goals.

* Awareness of characterisitc responses to illness, loss, and death; and familiarity with methods of dealing with psychosocial aspects of illness.

* Basic understanding of normal and variant psychosocial development, including an understanding of common psychopathologies.

* Theoretical familiarity with the fundamentals of family process and family dynamics.

* Ability to intervene constructively in a dysfunctional family/marital system.

* Theoretical and practical knowledge of basic counseling skills, especially skills most appropriate to dealing with a family practice population, such as brief therapy, crisis intervention, sexual counseling, etc.

* Demonstration of psychological skills necessary to promote self-awareness and self-understanding; ability to identify personal value systems in self and others.

* Ability to adequately identify patient and family expectations.

* Ability to act as a competent patient educator.

* Ability to interact in a collaborative and constructive manner with professional colleagues.

* Awareness of the community resources available to a specific patient population.

HUMAN BEHAVIOR AND PSYCHIATRY

3. Describe how your teaching program integrates Psychiatry and the Behavioral Sciences with Family Practice, Internal Medicine, Pediatrics and other disciplines.

Behavioral Science supervision during continuity care clinics insures that while residents are rotating through Internal Medicine, Pediatrics, etc. there is opportunity for discussion of patient approaches and care on these services from a behavioral perspective. In addition, a licensed pediatrician, Dr. Bea Lares, is a member of the full-time departmental faculty. Her teaching presence also emphasizes an integrative behavioral science/medical approach to pediatric problems.

4. Describe the component of your Human Behavior curriculum designed to promote physician well-being and prevention of physician impairment.

Our program addresses itself to these issues in several ways. First, during the orientation week, approximately five hours are devoted to reviewing and discussing the STFM film "Stress and the Resident Physician." The purpose of this session is to sensitize residents to the broad spectrum of issues impinging on their psychological and physical well-being. This presentation is followed up, during the first year, with two lectures on coping with stress and stress management techniques. Physician alcohol and drug-related impairment surfaces as an important topic both during the behavioral science rotation, and during the training week at Care Manor, a substance abuse treatment center. Finally, at any point during his/her three year career in the department, a resident may be referred to a remedial psychosocial program. This program is individually tailored to meet the needs of specific residents; but in all cases it emphasizes the importance of resident self-awareness and insight as the basis for the practice of good medicine. This is generally a 12-15 hour program.

5. Describe the Psychiatry component of your curriculum which encompasses recognition, diagnosis and management of emotional and mental disorders along with and/or as components of organic disease.

During the behavioral science rotation, in the first year of residency, the resident is instructed in specific details regarding the use of DSM III. The instruction includes discussion regarding various diagnostic categories and their appropriate axis. This is coupled with discussion generated from the DSM casebook which gives specific examples of the various pathologies. The goals and objectives are to generate discussion about DSM III for practical use by the resident during the interview process with patients.

In addition to formal diagnosis and assessment, two weeks of this three week required rotation are devoted to understanding the interaction between psychological/emotional factors and various disease processes (please see description of rotation for more complete information).

In the third year, all residents are required to do a month rotation in the Department of Psychiatry and Human Behavior. This includes lectures, conferences, and case discussion, as well as direct patient care, whose primary focus is recognition, diagnosis and management of mental disorders.

Finally, on an ongoing basis, throughout all three years of the curriculum, behavioral science teaching in the family practice clinics emphasize diagnosis, assessment, and basic strategies of management of common psychological disorders. Some of the

disorders in which almost all residents receive some case-oriented training include various manifestations of depression, anxiety disorders, various personality disorders, adjustment disorders, substance use disorders, and various somotaform disorders.

6. Please provide details regarding the inpatient psychiatric experience: length of rotation, location, supervision, content of experience, degree of responsiblity for an involvement with patients.

There is a required, one-month psychiatry rotation in the third year of the residency program. It involves responsibilities in both the inpatient Emergency Psychiatry unit, and the outpatient Crisis Intervention unit. All training occurs through the Department of Psychiatry and Human Behavior at UC Irvine Medical Center. The direct supervisor is Dr. Paul Blair, a full-time faculty member of the Department of Psychiatry. The emphasis of the rotation is assessment, diagnosis, and management of psychiatric disorders. There is also a strong emphasis on pharmacology, with a pharmacologist being available to consult with residents on a daily basis. The rotation stresses short-term emergency care, both in an inpatient and an outreach context. On the inpatient service, each team is assigned 6-7 patients, which results in a direct patient load for family practice residents of 1-2 patients. Family medicine residents have equal status with psychiatry residents and have primary responsibility for all aspects of these patients' care. On the outpatient crisis intervention, the family medicine resident is required to accompany a psychiatric social worker 1-2 times per week in a crisis resolution outreach effort. Additional follow-up of these patients is also available to the resident. Both adult and child, individual and family therapy cases are seen on this rotation.

ATTACHMENT 1

ORIENTATION: BEHAVIORAL SCIENCE ROTATION

The Behavioral Science rotation is a three-week rotation during the first year of residency. The rotation has two primary objectives: 1) To orient the resident toward psychological issues related to optimal patient care, and 2) To provide an experiential opportunity for the resident to learn about the complex interactions between family and disease process.

The first two weeks of the rotation are devoted to selected psychological topics (psychological diagnosis and assessment; interviewing and the doctor-patient relationship; death and dying; and certain illustrative chronic diseases (diabetes, cancer, alcoholism, burn trauma) in an effort to develop resident awareness of the patient as a person functioning in the context of family and community. An introduction to family systems theory and basic concepts in family therapy is also provided to further emphasize the importance of a family-oriented approach in dealing with patients.

The third week of the rotation is an intensive, participant-observer experience at Care Unit Hospital, a substance abuse treatment center. During this week, the resident will learn something about the interactive effects of family members regarding a specific disease entity (alcoholism). They will also learn something about themselves and their relationship to their own family of origin.

Requirements of the rotation:

1. Completion of the reading packet during the first week of the rotation (library time is provided during this week).

2. Attendance at all sessions scheduled with behavioral science faculty.

3. Attendance at at least one AA or Al-Anon meeting prior to the week at Care Manor.

4. Participation for the entire time indicated during the Family Program at Care Manor.

Three weeks' time is insufficient to adequately transmit the skills, knowledge, and judgment necessary in psychological assessment and intervention. However, the behavioral science team hopes to be successful in communicating to the resident and families; and in encouraging a willingness to become involved with patients and families at this level.

BEHAVIORAL SCIENCE OBJECTIVES

I. FAMILY ASSESSMENT

Assessment

1. The family practice resident should be able to identify when a family problem is causing or interferring with a medical problem.

2. The family practice resident should be able to discuss various family interaction problem themes such as spearation, pain, and abandonment. a) the family practice resident should also be able to identify particular families that are using these themes without consultation in 90% of the cases. b) the family practice resident should be able to determine if any therapy is needed.

3. Have a familiarity with a systems model for understanding family dynamics and interaction.

4. Be able to list four characteristics of a psychosomatogenic family.

5. Be familiar with and know how to administer a family APGAR for screening purposes.

6. Be familiar with basic data gathering strategies to use in family assessment.

7. Be able to explain the following major functions which the family serves for its members: socialization; communication; adaptation.

8. Be able to assess a family according to the family categories schema (problem solving; affective expression; communication; role behavior; autonomy; modes of behavioral control).

9. Be familiar with how to establish a family genogram.

10. Be able to assess:

    a. Historical, developmental perspective
    b. Psychosocial interior of family
    c. Family as sub-system within larger society

Family Interviewing

1. The family practice resident should be able to determine which families need therapy and which do not need therapy in 90% of the cases without consultation.

2. The family practice resident should be able to conduct and control a single psychological interview with a family and make a necessary evaluation of recommendation for follow-up treatment and 90% of the first family interviews without consultation.

3. Be familiar with basic joining strategies.

4. Be able to observe, record and interpret interactions during a family interview.

5. Be able to elicit sufficient information to be able to assess the family organization.

6. Be able to elicit view of the problem from each member.

7. Be able to elicit sufficient information to assess family functioning and resources.

8. Be able to recognize when a family interview is appropriate.

9. Basic familiarity with brief family intervention techniques.

10. Be able to gather information on:

    a. Family structure
    b. Presenting problems
    c. Role network
    d. Family goals and value orientation
    e. Patterns of communication
    f. Family rules and regulations

Family Intervention

1. The family practice resident should be able to determine the goals of family therapy in 90% of the cases with the advice of an appropriate consultant.

2. The family practice resident should be able to make an assessment of the psychosomatic symptoms that the family is either causing or perpetuating with consultation.

3. Familiarity with basic concepts in each of the following approaches to family therapy:

    a. Conjoint family therapy
    b. Structural family therapy
    c. Behavior modification techniques applied to the family unit

4. Be able to know when to refer to a behavioral specialist

5. Know how to set ground rules for communication in an initial family interview.

Family Life Cycle

1. Be able to identify and discuss key stages of the family life cycle:

    a. Unattached young adult
    b. The new couple
    c. The family with young children
    d. The family with adolescents
    e. Launching children and middle age
    f. The family in later life
    g. Important tasks at each stage

2. Be able to recognize important normative crises in the family life cycle; and be familiar with preventive or therapeutic responses:

   a. Birth of first child
   b. Impact of death and serious illness
   c. Separation, divorce, and single-parent families
   d. Resturctured (remarried) families
   e. Adolescence
   f. Empty nest phenomenon
   g. Retirement

3. Be able to identify and discuss major variations in the family life cycle:

   a. Socio-economic considerations; multiproblem poor family
   b. Cultural variations

II. COMMON DISORDERS

Psychiatry

A. Concepts

1. The family practice resident should be able to identify the clinical signs of depression, psychosomatic illnesss, hysterical disorders, anxiety, schizophrenia, personality types and disorders, mental retardation, organic brain syndrome, psychoses, and neuroses.

2. The family practice resident should be able to distinguish between those patients who require psychiatric treatment or should be referred to a psychiatrist or counselor and those that the resident can handle adequately without consultation in 90% of the cases.

3. The family practice resident should be able to define the interface between physical and psychological illness both for children and for adults.

4. The family practice resident should be able to discuss how a psychiatric diagnosis may effect medical treatment and visa versa.

B. Skills

1. The family practice resident should be able to recognize the need for, perform and interpret a formal mental status exam without consultation in 90% of the cases.

2. The family practice resident should be able to present a psychiatric case history including important family and social information, previous psychiatric history, current problems and possible diagnosis to his/her peers and psychiatrists or counselors at a seminar.

3. The family practice resient should be able to recognize the need for, develop, use correctly and interpret a psycho-social problem list for each patient and be able to suggest an appropriate treatment for each non-psychiatric problem on the list without consultation in 90% of the cases.

a. Relaxation response
b. Meditation
c. Deep muscule relaxation
d. Hypnosis

VI. GOALS & OBJECTIVES: INTERACTION OF FAMILY AND ILLNESS

The resident will be able to give examples of:

1. Epidemiology of illness in families. (eg., patterns of morbidity, periodicity, susceptibility, utilization of medical services).

2. At least one model of individual and family coping.

3. The resident will be able to demonstrate familiarity with research indicating a relationship between family structure and disease entity.

4. Be able to give specific examples of how family can be engaged in management issues of common problems:

   a. Childhood disorders
   b. Compliance problems
   c. Chronic illness

5. Be familiar with stages of family response to chronic or life-threatening conditions.

6. Be able to identify criteria for assessing a family's coping strengths and weaknesses:

   a. Marital relationship
   b. Social support
   c. Sense of meaning
   d. Ability to "normalize" situation
   e. Presence of specific coping skills
   f. Ability to communicate

VII. SUMMATIVE BEHAVIORAL OBJECTIVES FOR FAMILY PRACTICE RESIDENT IN PSYCHOSOCIAL INFLUENCES AND THE BEHAVIORAL SCIENCES

A. Concepts

1. The family practice resident should be able to define the roles of a family physician which include an integration of medical care within the milieu of the individual in his/her family and environment. The family practice resident should be able to discuss ways to individualize care and/or planned treatments as a result of the interface between the individual and his/her family and environment.

2. The family practice resident should be able to discuss psychosocial aspects of medical care.

3. In 90% of the cases for each of the problems or problem areas listed below, the resident should be able to:

a. List the minimum data base necessary to clarify the problem (including psychosocial history and other data such as psychological tests, mental status, exams, appropriate physical findings, laboratory data, and diagnostic procedures).

b. Assess the problems presented by the patient and the data obtained, and list the most appropriate diagnossis or descriptive statement of the problem.

c. Outline the expected course with and without appropriate treatment or intervention.

d. Outline a plan for treatment (or management or referral) and follow-up.

Problems Areas

1. Developmental

a. Child rearing and child development
b. Pre-adolescent sexual expression
c. Adolescent sexual concerns
d. Pre-marital counseling
e. Sexual adjustment (throughout life)
f. Marriage and family
g. Family planning (contraception, sterilization, abortion, etc.)
h. Pregnancy
i. Sexual mores and alternative sexual practices
j. Death of parents
k. Death in family or friends
l. Adjustment of aging (throughout life)
m. Recent widowing
n. Facing one's own death
o. Dysfunctional family

2. Situational

a. Recent marriage
b. Marital discord
c. Divorce
d. Malignant family system
e. Broken home (effects on parents and children)
f. "Special" children (e.g., hyperkinesis, mental retardation)
g. Poverty
h. Social isolation and alienation
i. Job or financial loss
j. Job change
k. Residential relocation of family
l. Chronic illness - psychosocial effects on individual and family
m. Accident or acute illness - psychosocial effects on individual and family
n. Physician's office visit
o. Hospitalization (acute, chronic, surgery)
p. Stigmatization (disfigurement; abnormality; ethnic, gender, or sexual prejudice, etc.)
r. Unwanted pregnancy
s. Stress - psychological stress and illness

3. Crisis

a. Suicide threat
b. Homicide threat
c. Drug overdose
d. Rape victim
e. Child abuse
f. Accidental injury

4. Individual Dysfunction

a. Sexual incompetence (e.g., impotence & frigidity)
b. Asthma & other respiratory illness
c. Chronic fatigue
d. Insomnia
e. Neurodermatitis
f. Phobias
g. Stomach disorders
h. Low back pain
i. Mental illness
j. Heart disease
k. Alcoholism
l. Veneral disease
m. Headache
n. Obesity
o. Irritable bowel
p. Accidental injury
q. Rheumatoid arthritis
r. Enuresis

5. The family practice resident should be able to list the indications, contraindications, and potentially undesirable effects of, and to discuss the application of these techniques from at least two of the following therapies in relation to 90% of the problems listed in number 3.

a. Group counseling
b. Individual counseling
c. Behavior modification
d. Marriage counseling and therapy
e. Biofeedback
f. Relaxation
g. Hypnosis
h. Family therapy and counseling
i. Sex counseling and therapy

6. The family practice resident should be able to describe the patterns of normal and abnormal behavior involved in the following:

a. Family and individual development stages
b. Differences in life style and value orientations according to socioeconomic class
c. Individual psychosocial needs
d. Psychological, cultural and social aspects of response to illness
e. Psychological factors associated with illness of a member that effect the family
f. Social factors associated with illness of a member that effect the family
g. Problems commonly effecting patient compliance
h. Human sexuality throughout life and alternative sexual practices

B. Skills

1. The family practice resident should be able to interview individuals and families with the purpose of eliciting information on the following: about the structure, communication, style and rule of the family and about themes in the family

a. Hypochondriacal
b. Depressed
c. Anxious
d. Patient in crisis
e. Chronic pain
f. Seductive
g. Hostile
h. Needy, demanding

8. Know how to structure interview including:

a. Time management
b. Introduction
c. Processing problems and scanning
d. Utilization of other resources
e. Patient instruction/treatment
f. Patient education
g. Summary of session

9. Be able to critique an audio or videotape of one of their own actual patient encounters using IPR techniques.

10. Be able to give at least three examples of how the doctor-patient relationship can either enhance or detract from patient care. Possible areas might include:

a. Compliance issues
b. Hypochondriasis
c. Management of patient fears

V. GOALS & OBJECTIVES: RESIDENT SELF-AWARENESS

The resident should accomplish the following:

1. View the entire tape "Stress and the Resident-Physician".

2. Be able to identify the types of stressors highlighted in each vignette.

3. Be able to accurately relate those stressors to his/her current situation.

4. Be able to generate adaptive, psychologically healthy coping strategies in response to these stressors.

5. Be able to identify internal cues which are signs of stress, tension, anxiety, hostility.

6. Be aware of the resident advisory system existing in the department and how to utilize it.

7. Be able to identify other formal and informal support mechanisms available in the community to deal with persona;/professional stresses and problems.

8. Be familiar with at least two basic nonpharmacological stress reduction techniques:

a. Relaxation response
b. Meditation
c. Deep muscule relaxation
d. Hypnosis

VI. GOALS & OBJECTIVES: INTERACTION OF FAMILY AND ILLNESS

The resident will be able to give examples of:

1. Epidemiology of illness in families. (eg., patterns of morbidity, periodicity, susceptibility, utilization of medical services).

2. At least one model of individual and family coping.

3. The resident will be able to demonstrate familiarity with research indicating a relationship between family structure and disease entity.

4. Be able to give specific examples of how family can be engaged in management issues of common problems:

   a. Childhood disorders
   b. Compliance problems
   c. Chronic illness

5. Be familiar with stages of family response to chronic or life-threatening conditions.

6. Be able to identify criteria for assessing a family's coping strengths and weaknesses:

   a. Marital relationship
   b. Social support
   c. Sense of meaning
   d. Ability to "normalize" situation
   e. Presence of specific coping skills
   f. Ability to communicate

VII. SUMMATIVE BEHAVIORAL OBJECTIVES FOR FAMILY PRACTICE RESIDENT IN PSYCHOSOCIAL INFLUENCES AND THE BEHAVIORAL SCIENCES

A. Concepts

1. The family practice resident should be able to define the roles of a family physician which include an integration of medical care within the milieu of the individual in his/her family and environment. The family practice resident should be able to discuss ways to individualize care and/or planned treatments as a result of the interface between the individual and his/her family and environment.

2. The family practice resident should be able to discuss psychosocial aspects of medical care.

3. In 90% of the cases for each of the problems or problem areas listed below, the resident should be able to:

a. List the minimum data base necessary to clarify the problem (including psychosocial history and other data such as psychological tests, mental status, exams, appropriate physical findings, laboratory data, and diagnostic procedures).

b. Assess the problems presented by the patient and the data obtained, and list the most appropriate diagnossis or descriptive statement of the problem.

c. Outline the expected course with and without appropriate treatment or intervention.

d. Outline a plan for treatment (or management or referral) and follow-up.

Problems Areas

1. Developmental

a. Child rearing and child development
b. Pre-adolescent sexual expression
c. Adolescent sexual concerns
d. Pre-marital counseling
e. Sexual adjustment (throughout life)
f. Marriage and family
g. Family planning (contraception, sterilization, abortion, etc.)
h. Pregnancy
i. Sexual mores and alternative sexual practices
j. Death of parents
k. Death in family or friends
l. Adjustment of aging (throughout life)
m. Recent widowing
n. Facing one's own death
o. Dysfunctional family

2. Situational

a. Recent marriage
b. Marital discord
c. Divorce
d. Malignant family system
e. Broken home (effects on parents and children)
f. "Special" children (e.g., hyperkinesis, mental retardation)
g. Poverty
h. Social isolation and alienation
i. Job or financial loss
j. Job change
k. Residential relocation of family
l. Chronic illness - psychosocial effects on individual and family
m. Accident or acute illness - psychosocial effects on individual and family
n. Physician's office visit
o. Hospitalization (acute, chronic, surgery)
p. Stigmatization (disfigurement; abnormality; ethnic, gender, or sexual prejudice, etc.)

with the purpose of eliciting information on the following: about the structure, communication, style and rule of the family and about themes in the family including how each member view the presenting problems and the family interview.

2. The family practice resident should be able to elicit information in a manner which is therapeutic and respects the members of the family so that the interview is as gentle and non-instructive as possible and which also gathers a maximum of information in a structure fashion in a minimum amount of time.

3. The family practice resident should also be able to effectively use Carkuff's Empathic responses with patients.

4. The family practice resident should be able to prepare patients for counseling or therapy which he/she may do or to refer elsewhere.

C. Skills

1. The family practice resident should be able to manage the initial counseling session before referral and some short-term counseling with a consultant using any of the psychological techniques mentioned in Category I - Concepts number 4.

D. Mode of Presentation

The resident receives didactic training during a three week rotation during the first year, under the direct supervision of Dr. Johanna Shapiro, a member of the Family Medicine faculty. In addition, ongoing training and supervision occurs on a twice monthly basis in clinics, under the direction of Dr. Shapiro.

E. Evaluation

At the beginning of the rotation, all faculty involved in Behavioral Science teaching received copies of the broad goals for the experience. Each faculty member completes an evaluation form assessing the resident's knowledge base performance in a variety of areas.

The Behavioral Science clinic teaching program uses an ongoing written feedback system with residents (see attached). In addition, each faculty completes a speciallly designed evaluation of residents with whom they have worked on a monthly basis (see attached).

F. Remediation

Residents judged deficient in psychosocial skills based on evaluations of Behavioral Science and physician faculty are referred to a 12 week remediation course designed to increase resident self-awareness and enhance interpersonal interactions.

2. List the objectives of your teaching program in Human Behavior and Psychiatry for family practice residents, including any special skills to be learned.

The basic goals of the teaching program in human behavior and psychiatry include the following:

a) The enhancement of the residents' interactive and interview skills so as to promote the development of optimal physician-patient relationships.

b) To ensure the residents' knowledge of normal and abnormal patterns of psychologic development and adaptation and its impact on human health and illness.

c) To provide sufficient cognitive knowledge and technical skill so that residents are able to recognize, initially manage, and, when appropriate, utilize psychiatric consultation in caring for patients with cognitive and affective psychiatric disorders.

d) To provide residents with the skills to provide interventive therapy in patients and families sustaining life crises.

e) To develop self-awareness on the part of the resident as to personality structure and its impact on their personal and professional lives.

f) To develop an appreciation of mental health in the context of different cultures, the impact of physical relocation, cultural disintegration and cultural assimilation.

Specific training objectives include:

1) Observational skills which include attention to both verbal and nonverbal behavior; awareness of interactive dynamics and small group process; sensitivity to affective and cognitive information being transmitted by the patient.

2) Communication skills which include familiarity with techniques of active listening, empathy and rapport building, and confrontation which promote qualities of coherency, relevance, openness, concern, and respect for the patient and which pay attention to the self as a relevant variable in any interactive process.

3) Interviewing skills, including techniques for eliciting affective and cognitive information, handling silence, acknowledging both negative and positive emotions, clarifying, problem-solving, and summarizing.

4) Awareness of the importance of physical and social environmental variables in assessing a patient's life situation, and ability to manipulate the environment in a way to facilitate mutually agreed upon medical goals.

5) Awareness of characteristic responses to illness, loss, and death, and familiarity with methods of dealing with psychosocial aspects of illness.

6) Basic understanding of normal and variant psychosocial development, including an understanding of common psychopathologies.

7) Theoretical familiarity with the fundamentals of family process and family dynamics.

8) Ability to intervene constructively in a dysfunctional family/marital system.

9) Theoretical and practical knowledge of basic counseling skills, especially skills most appropriate to dealing with a family practice population, such as brief therapy, crisis intervention, sexual counseling, etc.

10) Familiarity with frequently utilized psychotropic medications, including neuroleptics, anxiolytics, and anti-pressants, including indications, dosage, beneficial effects, and adverse effects.

11) The ability to initially recognize and initially manage psychiatric problems caused by acute drug intoxication and long-term substance abuse.

12) Demonstration of psychological skills necessary to promote self-awareness and self-understanding; ability to identify personal value systems in self and others.

13) Ability to adequately identify patient and family expectations.

14) Ability to act as a competent patient educator.

15) Ability to interact in a collaborative and constructive manner with professional colleagues.

16) Awareness of the community resources available to a specific patient population.

3. Describe how your teaching program integrates Psychiatry and the Behavioral Sciences with Family Practice, Internal Medicine, Pediatrics and other disciplines throughout the resident's total educational experience.

In addition to rotation experiences in behavioral medicine and psychiatry, behavioral science education occurs longitudinally in the family medicine centers through a formal preceptorship program. It is this ongoing behavioral science input in the context of the family medicine center that serves an integrative function with resident training received in the clinical disciplines.

4. Describe the component of your Human Behavioral Curriculum designed to promote physician well-being and prevention of physician impairment.

Our program addresses itself to these issues in several ways. First, during the orientation week, approximately five hours are devoted to reviewing and discussing the STFM film "Stress and the Resident Physician." The purpose of this session is to sensitize residents to the broad spectrum of issues impinging on their psychological and physical well-being. All first-year residents then participate in a year-long support group which meets monthly. First-year residents also have presentations on coping with stress and stress management techniques. Physician alcohol and drug-related impairment surfaces as an important topic both during the Behavioral Science Rotation and during the training week at CareUnit Hospital, a substance abuse treatment center. All residents are assigned a personal faculty advisor different from his/her academic advisor who can be utilized to assist in dealing with personal problems. Finally, at any point during his/her three-year career in the Department, a resident may be referred to a remedial psychosocial program. This program is individually tailored to meet the needs of specific residents, but in all cases it emphasizes the importance of resident self-awareness and insight as the basis for the practice of good medicine. This is generally a 12-15 hour program.

5. Describe the Psychiatry component of your curriculum which encompasses recognition, diagnosis and management of emotional and mental disorders along with and/or as components of organic disease.

During the Behavioral Science Rotation in the first year of residency, the resident is instructed in specific detail regarding the use of DSM III. The instruction includes discussion regarding various diagnostic categories and their appropriate axis. This is coupled with discussion generated from the DSM casebook which gives specific examples of the various pathologies. The goals and objectives are to generate discussion about DSM III for practical use by the resident during the interview process with patients.

In addition to formal diagnosis and assessment, two weeks of this one-month required rotation are devoted to understanding the interaction between psychological/emotional factors and various disease processes (please see description of rotation for more complete information).

In the third year, all residents are required to do a month's rotation in the Department of Psychiatry and Human Behavior. This includes lectures, conferences, and case discussion, as well as direct patient care whose primary focus is recognition, diagnosis and management of mental disorders.

Selected third-year residents have the opportunity to take a special year-long course in Structural Family Therapy. The course meets one half-day per week and is taught by Dr. Judith Anderson and Dr. Ed Kaufman from the Department of Psychiatry. The first trimester of the course provides didactic instruction through the assistance of videotaping. The second trimester involves direct observation of families in therapy and the third trimester includes "hands on" experience instruction in family therapy. There is also an eight-week course in hypnotherapy taught by Dr. Joyce Friedmann available to all family practice residents. This course is presented weekly at noon making it an available addition to the resident's existing rotation responsibilities.

Finally, on an ongoing basis throughout all three years of the curriculum, behavioral science teaching in the family practice clinics emphasizes diagnosis, assessment, and basic strategies of management of common psychological disorders. Some of the disorders in which almost all residents receive some case-oriented training include various manifestations of depression, anxiety disorders, various personality disorders, adjustment disorders, substance use disorders, and various somotaform disorders.

6. If there is an inpatient psychiatric experience, please provide details regarding length of rotation, location, supervision, content of experience, degree of responsibility for and involvement with the patients.

There is a required, one-month psychiatry rotation in the third year of the residency program. It involves responsibilities in both the inpatient emergency psychiatry unit and the outpatient crisis intervention unit. All training occurs through the Department of Psychiatry and Human Behavior at the University of California Irvine Medical Center. The direct supervisor is Dr. Paul Blair, a full-time faculty member of the Department of Psychiatry.

The emphasis of the rotation is assessment, diagnosis, and management of psychiatric disorders. There is also a strong emphasis on pharmacology with a pharmacologist being available to consult with residents on a daily basis. The rotation stresses short-term emergency care both in an inpatient and an outreach context. On the inpatient service, each team is assigned 6-7 patients which results in a direct patient load for family practice residents of 1-2 patients. Family Medicine residents have equal status with psychiatry residents and have primary responsibility for all aspects of these patients' care. On the outpatient crisis intervention, the family medicine resident is required to accompany a psychiatric social worker one to two times per week in a crisis resolution outreach effort. Additional follow-up of these patients is also available to the resident. Both adult and child, individual and family, therapy cases are seen on this rotation.

7. For each of the following elements indicate with an (X) the major site/mode used to achieve the objectives of the curriculum in Human Behavior. Mark secondary sites with (S). If none (0).

8. For each of the following elements indicate with an (X) the site(s)/mode(s) used to achieve the objectives of the curriculum in psychiatry.

	F P C	OUTPATIENT	INPATIENT	DIDACTIC	ELECTIVE	OTHER *
a) Diagnosis and management of the psychological components of illness	X	X	X	X		X
b) Management of psychological disorders	X	X	X	X	S	X
c) Family dynamics	X		X	X	X	X
d) Faculty and resident self awareness; personal and professional growth development	X			X		X
e) Physician/patient relationship	X	X	X	X		X
f) Patient counseling	X	S	X		S	
g) Interviewing and other communicative skills	X	X	X	X′		X
h) Patient education	X	X	X			
i) Normal growth and variants	X	X		X		
j) Stages of stress in the family life cycle	X	X	X	X		X
a) Psychotherapy	X		X		X	
b) Psychopharmacology	X	X	X			
c) Psychiatric counseling	X		X	X		
d) Broad spectrum of mental illness	X	X	X	X		
e) Alcoholism	X	X	X	X		X
f) Other chemical substance abuse	X	X	X	X		X

* Explain

*7a. Home visit program
7c. Home visit program, required AHEC-funded intensive one-week training at community family therapy center, and elective Family Therapy Course.
7d. Remedial program and behavioral science rotation.
7e. Remedial program.
7g. Remedial program.
7j. Home visit program and behavioral science rotation.
8e. Behavioral science rotation.
8f. Behavioral science rotation.

ATTACHMENT 1

FAMILY FOCUS PROGRAM: The specialty of Family Medicine should include training in how to work with families, how to make the family the preferred unit of health care. The behavioral science program in our department is able to provide some theoretical training in this area; however, we lack an observational component. Dr. Edward Kaufman, a family therapist in the Dept. of Psychiatry, confirms that such clinical training is not available on-site at UCIMC. This training is currently being provided by an experimental training program, one week in duration, integrated into a required 2 week behavioral science rotation for first year residents. During the first week of this experience, the resident is exposed to 4 areas of concentration:

1) Interviewing skills and the doctor-patient interaction.
2) Psychosocial management of common clinical problems.
3) Assessing and analyzing the interaction of chronic illness and the family unit.
4) Introduction to family therapy concepts.
   Funding is not sought for this week.
   During the second week of training, the resident spends 40 hours in the Family Program at Care Unit Hospital, an alcohol and drug abuse treatment center. Here the resident learns about the complex interactions between the family and the patient facing a chronic disease such as alcoholism.

The third week of training consists of an intensive training experience at Turning Point a family therapy center in Garden Grove. As is indicated on the attached schedule, residents spend approximately 40 hours/week participating in case conferences, observing family therapy session, attending didactic lectures and presentations, watching videotapes of family therapy and completing a selected reading list.

At the end of this time, we do not expect our residents to be qualified as family therapists. However, we do anticipate that they will 1) have developed a broad awareness of the importance of the family in influencing symptoms in the individual patient: 2) be able to accurately assess the presence and nature of family dysfunction; 3) be able to conduct an initial interview with an entire family and make appropriate recommendations; 4) be familiar with techniques of joining with the family, assigning homework, and making simple structural and behavioral interventions.

Our purpose in instituting this program is to use community resources to help us more adequately prepare our residents for the role they will be expected to fulfill as family physicians.

ATTACHMENT 2

ORIENTATION: BEHAVIORAL SCIENCE ROTATION

The Behavioral Science rotation is a three-week rotation during the first year of residency. The rotation has two primary objectives: 1) To orient the resident toward psychological issues related to optimal patient care, and 2) To provide an experiential opportunity for the resident to learn about the complex interactions between family and disease process.

The first week of the rotation is devoted to selected psychological topics (psychological diagnosis and assessmemt; interviewing and the doctor-patient relationship; death and dying; and certain illustrative chronic diseases (diabetes, cancer, alcoholism, burn trauma) in an effort to develop resident awareness of the patient as a person functioning in the context of family and community. An introduction to family systems theory and basic concepts in family therapy is also provided to further emphasize the importance of a family-oriented approach in dealing with patients.

The second week of the rotation is an intensive, participant-observer experience at Care Unit Hospital, a substance abuse treatment center. During this week, the resident will learn something about the interactive effects of family members regarding a specific disease entity (alcoholism). They will also learn something about themselves and their relationship to their own family of origin.

The third week consists of training at Turning Point, a community-based family therapy center. Training will emphasize supervised observation of live family therapy sessions, but will also include required reading and lectures to provide a solid theoretical base in family therapy.

FACULTY	DAY and SUBJECT
Joe De Rose	Monday - The Cancer Patient and His/Her Family; The AIDs Patient
Joyce Friedman	Monday - Hypnotherapy; Pain Management
Dave Naishtut Duncan Wigg (Turning Point)	Monday-Tuesday-Wednesday-Friday - Family Therapy - Working with Families
Pat Lenahan	Tuesday - Alcoholism/Preparation Care Unit
Johanna Shapiro	Thursday - Interviewing/Problem Patients
Jill Volkman	Thursday - Visit to Nursing Home
Mike Masters	Thursday-Cognitive Behavior Therapy

	M	T	W	Th	F
AM	10:00-11:00 De Rose 11:00-12:00 Friedmann	9:00-12:00 Lenahan	8:00-12:00 CLINIC	10:00-12:00 Masters	9:00-12:00 Naishtut
PM	2:00-5:00 Naishtut	1:30-5:30 Naishtut	1:30-5:30 Wigg	1:00-2:00 Volkman 2:00-5:00 Shapiro	CLINIC

Monday - Tapes to be viewed are:

1) Physicians & Alcoholism
2) Family Assessment
3) Death & Dying

Effective January 1, 1986

ATTACHMENT 4a

BEHAVIORAL SCIENCE OBJECTIVES

FAMILY ASSESSMENT

Assessment

1. The family practice resident should be able to identify when a family problem is causing or interferring with a medical problem.

2. The family practice resident should be able to discuss various family interaction problem themes such as separation, pain, and abandonment. a) the family practice resident should also be able to identify particular families that are using these themes without consultation in 90% of the cases. b) the family practice resident should be able to determine if any therapy is needed.

3. Have a familiarity with a systems model for understanding family dynamics and interaction.

4. Be able to list four characteristics of a psychosomatogenic family.

5. Be familiar with and know how to administer a family APGAR for screening purposes.

6. Be familiar with basic data gathering strategies to use in family assessment.

7 Be able to explain the following major functions which the family serves for its members: socialization; communication; adaptation.

8, Be able to assess a family according to the family categories schema (problem solving; affective expression; communication; role behavior; autonomy; modes of behavioral control)

9. Be familiar with how to establish a family genogram

10. Be able to assess:

    a. historical, developmental perspective
    b. psychosocial interior of family
    c. family as sub-system within larger society

Family Interviewing

1. The family practice resident should be able to determine which families need therapy and which do not need therapy in 90% of the cases without consultation.

2. The family practice resident should be able to conduct and control a single psychological interview with a family and make a necessary evaluation of recommendation for follow-up treatment in 90% of the first family interviews without consultation

Attachment 4a (continued)

3. Be familiar with basic joining strategies.

4. Be able to observe, record and interpret interactions during a family interview.

5. Be able to elicit sufficient information to be able to assess the family organization.

6. Be able to elicit view of the problem from each member.

7. Be able to elicit sufficient information to assess family functioning and resources.

8. Be able to recognize when a family interview is appropriate.

9. Basic familiarity with brief family intervention techniques.

10. Be able to gather information on:

    a. family structure
    b. presenting problems
    c. role network
    d. family goals and value orientation
    e. patterns of communication
    f. family rules and regulations

Family Intervention

1. The family practice resident should be able to determine the goals of family therapy in 90% of the cases with the advice of an appropriate consultant.

2. The family practice resident should be able to make an assessment of the psychosomatic symptoms that the family is either causing or perpetuating with consultation.

3. Familiarity with basicconcepts in each of the following approaches to family therapy:

    a. conjoint family therapy
    b. structural family therapy
    c. behavior modification techniques applied to the family unit

4. Be able to know when to refer to a behavioral specialist

5. Know how to set ground rules for communication in an initial family interview.

Attachment 4a (continued)

BEHAVIORAL SCIENCE OBJECTIVES

Family Life Cycle

1. Be able to identify and discuss key stages of the family life cycle:

   a. unattached young adult
   b. the new couple
   c. the family with young children
   d. the family with adolescents
   e. launching children and middle age
   f. the family in later life
   g. important tasks at each stage

2. Be able to recognize important normative crises in the family life cycle; and be familiar with preventive or therapeuticresponses:

   a. birth of first child
   b. impact of death and serious illness
   c. separation, divorce, and single-parent families
   d. restructured (remarried) families
   e. adolescence
   f. empty nest phenomenon
   g. retirement

3. Be able to identify and discuss major variations in the family life cycle:

   a. socio-economic considerations; multiproblem poor family
   b. cultural variations

ATTACHMENT 4b

BEHAVIORAL SCIENCE OBJECTIVES

CRISIS INTERVENTION

1. Be able to define a family crisis

   a. Distinguish between normative and non-normative
   b. List four categories of crisis (addition, abandonment, demoralization, status change)
   c. Be able to distinguish between types of crises (crises of anticipated life transitions, sudden traumatic stress, developmental, psychiatric emergencies etc..)

2. Be able to state and define four signals of family crisis (e.g., known precipitation stress, adaptive dysruption, long-term negative potential consequences, perceived feeling of crisis among family members).

3. Be able to evaluate family members' value orientation toward a crisis

4. Be familiar with a taxonomy for identifying family resources (e.g., SCREEM; social, cultural, religion, economic, education, medical).

5. Have a basic understanding of crisis theory and coping processes (e.g., homeostatic balance; adaptive vs, maladaptive)

6. Be familiar with the concept of the life cycle of an emotional crisis (e.g., stages or phases of a crisis)

7. Be able to identify the four stages of crisis intervention

8. Be familiar with general principles of therapeutic value in dealing with individuals in crisis (e.g., help individual face crisis; assist fact finding; avoid false reassurance; discourage projection; help individual accept help; help with everday tasks)

9. Be able to state and give specific techniques in the three general principles of crisis intervention: (reeduce stress, provide support, work to build strength within family)

   a. Reduce stress - direct problem-solving; facilitating problem-solving, calm family's emotions (talking, focus on thinking, distancing, drugs)
   b. Support - provide strength for family; guiding family; follow-through
   c. Building strength - self-awareness; self-assertion

10. Be familiar with the uses of an intervention contract

11. Be familiar with the four levels of intervention (empathy, facilitation, assertion, control)

Attachment 4b (continued)

12. Be familiar with characteristics of facilitation level interventions (listening, informing, referral-assisting, supporting, insuring)

13. Be familiar with basic brief counseling techniques (personal guidance, advice, behavior shaping, successive approximation)

14. Be able to list two helping behaviors related to assertion level interventions (confrontation, persuasiveness).

15. Be able to discriminate when to employ a facilitative intervention, an assertion intervention, or a control intervention.

BEHAVIORAL SCIENCE ASSESSMENT AND PROBLEM IDENTIFICATION SHEET

	R	SEEN BY B/S	DATE	PROB. RES.	PROB. PERS.	N/A
Serious and acute psychological problems. (Severe depression, suicidal ideation or gestures, acute psychosis, family in crisis etc).						
Significant family health problems (terminally ill patient, family with multiple health complaints, chronically ill or disabled family members, survival problems).						
High social risk factors (e.g. hx child abuse, alcoholism, drug addiction, adolescent mother).						
Maladaptive family responses to family member's illness (e.g. distortion of medical information, emotional withdrawal, adherence/compliance problems).						
"Problem" patient/family (hypochondriac, non-complaint, seductive, obsessive, dependent) and management problems.						
Common medical diagnoses with psychosocial aspects (obesity, diabetes, hypertension, depression, anxiety, psychosomatic disorders, pain).						
Dysfunctional family relationships (marital discord, child behavior problems, psycho-sexual problems).						
Family life cycle problems (birth of child, adolescent, geriatric issues).						
Environmental problems (e.g. inadequate housing, financial problems)						
Other _____						

To be seen in counseling clinic: immediate; ASAP; routine.

Referring Resident: _____

Date _____

Brief description of referring problem: _____

_____

_____

PRIORITIES FOR BEHAVIORAL SCIENCE REFERRAL

I. Immediate Intervention

- A. Potentially suicidal patient
- B. Severe depression
- C. Acute psychotic episode
- D. Patient/or family member appears dangerous to others
- E. Family in crisis
- F. Child abuse
- G. Immediately prior to and/or following patient death
- H. Survival problems (inadequate food and shelter)

II. Less Immediate Priorities

- A. High social risk
- B. Significant family health problems
- C. Maladaptive family responses to illness
- D. Patient/family management problems

III. Routine Referrals

- A. Problem patients
- B. Family life cycle problems
- C. Common medical diagnoses with psychosocial dimensions
- D. Dysfunctional family/marital relationships

ATTACHMENT 5

REQUIRED HOME VISIT REPORT

Patient Name: _____

Chart Number: _____

What was the purpose of this home visit? _____

_____

Why did you choose this particular family? _____

Who is in this family?

Name	Age	Sex	Relationship	Occupation	Education

Who was present during the home visit? _____

_____

In what language was the home visit conducted? _____

Give a brief description of the home (mention type of residence ie., apartment, house, hotel; approximate size; orderliness and cleanliness; amount of furniture; any potential health hazards; also note any peculiar sleeping arrangements).

_____

_____

_____

What did you observe about the interactions of the family members present? (include both verbal and nonverbal information)

What did you learn about the relationships between family members?

Review roles of various family members and describe below. Include "leadership", spiritual/religious leadership, communication problems, security of the family unit, styles of coping of various members, family origins, social involvement of each member.

What is the economic situation of this family? (note maternal/paternal employment, other sources of income).

Note any current (chronic or acute) health problems in this family:

Family Member	Nature of Health Problem

Describe impact on family of above illness, with special attention to management proble

Note any particular strengths and/or weaknesses of this family which emerged from this home visit.

How do you intend to incorporate information obtained from this home visit in the ongoing health-care of this family?

Family Problem List:

Signature of Resident _____ Date _____

Signature of Supervisor _____