BEHAVIORAL SCIENCES CURRICULUM

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 stay with 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 functions.

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 respon-

sibility 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 Ransom, 197?). 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. Educational Goals

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 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 mutally agreed upon medical goals.

* Awareness of characteristic 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.

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

III. Competency-based Program

The curriculum is competency-based in the sense that instructional objectives are specified for each course; assessment of relevant resident skills is undertaken, and residents are made aware of specific options for satisfying a particular competency. Common options might include oral interview, written essay exam, videotape analysis, etc.

IV. Instructional Objectives

Instructional objectives are specified for each core course, seminar, supervisory period, and lecture. Instructional objectives specify performance (measurable behavior), conditions (situational factors), and criterion levels where appropriate.

V. Structure

The curriculum employs several structural formats in an effort to fully satisfy its educational goals. A core group of seminars has been developed which incorporates the fundamental skills deemed essential according to the program's set of educational goals and philosophical premises. This core is required of all residents except under unusual circumstances. In addition, there is mandatory participation in a supervisory system designed to provide residents with behavioral science feedback. A series of individually tailored electives is also available to residents. A variety of interpersonal and process groups (eg., discussion groups, women's groups, experiential groups, assertiveness groups) also exist, some on an optional and some on a required basis. The behavioral science curriculum is also supplemented by a noon conference series oriented around family development. A final structural aspect would stress faculty development in the form of evening and weekend seminars, in order to successfully create a "renaissance" faculty whose supervision and training of residents can include feedback in both behavioral and medical areas.

BEHAVIORAL SCIENCES REVISED CURRICULUM

YEAR I

A. Behavioral Science supervision and consultation with residents will occur on a one-to-one basis during selected clinic sessions. Sessions will last approximately three hours. It is recommended that residents reduce their patient load accordingly (i.e., schedule approximately three to four patients during that session). This will be the responsibility of the residents themselves, so everyone please note where your name occurs on the attached schedule.

These sessions will be case oriented and will emphasize psychosocial aspects of patient care. Their focus will be on specific interviewing and communication skills and the appropriate use of psychological intervention techniques.

YEAR II

A. Same as above

B. Individual work on an elective basis with behavioral science faculty members will satisfy requirements for a fourth clinic session. Examples of electives currently available in the Department include the following:

Management of obesity
Management of depression
Treatment of sexual dysfunction and sexual counseling
Behavior therapy (including clinical experience)
Family therapy (including clinical experience)
Clinical research methods
Chicano psychology and family life
Alcoholism and drug abuse
Interviewing techniques (including interpersonal process recall)
Independent study

C. In addition residents on the Family Medicine ward rotation will participate in a behavioral science seminar weekly throughout the rotation. This seminar will be devoted to interviewing, communication skills and basic individual and family psychological intervention strategies.

YEAR III

A. Same as above

B. Same as above

Other Behavioral Science Didactic Programs

The CCOC noon conference series in the Behavioral Sciences will consist of several topic clusters lasting between three and five weeks. A representative subject list includes:

1. Introduction
2. Family therapy
3. A. Alcoholic families
   B. Psychosomatogenic families
   C. Hospital experience of patient and family
4. Interviewing techniques
5. The doctor/patient relationship
6. Crisis counseling
7. Behavior therapy
8. Compliance and adherence
9. Chicano psychology and family life
10. Childhood problems
    A. Enuresis encopresis
    B. Retardation and learning disorders
    C. Divorce and single-parent family stress for the child
    D. Interviewing the child
11. Group therapy

In addition both a women's group and a discussion group for first year residents will be offered.

BEHAVIORAL SCIENCES CURRICULUM

III. Competency-based Program

The curriculum will be competency-based in the sense that instructional objectives will be specified for each course; assessment of relevant residents skills will be undertaken, and residents will be aware of specific options for satisfying a particular competency. Common options might include oral interview, written essay exam, videotape analysis, etc.

IV. Instructional Objectives

Instructional objectives should be specified for each core course, seminar, supervisory period, and lecture. Instructional objectives should specify performance (measurable behavior), conditions (situational factors), and criterion levels where appropriate.

V. Structure

The curriculum will employ several structural formats in an effort to fully satisfy its educational goals. It is recommended that a core group of courses or seminars be developed which would incorporate the fundamental educational goals and skills deemed essential according to the program's set of educational goals and philosophical premises. This core would be required of all residents except under unusual circumstances. In addition, there would be mandatory participation in a supervisory system designed to provide residents with behavioral science feedback. A series of electives would also be open to residents. A variety of interpersonal and process groups (eg., discussion groups, women's groups, experiential groups, assertiveness groups) would be open to residents, some on an optional and some on a required basis. Finally, the behavioral science curriculum would be supplemented by a noon conference series oriented around family development. A final structural aspect would stress faculty development in the form of evening and weekend seminars, in order to successfully create a "renaissance" faculty whose supervision and training of residents would include feedback in both behavioral and medical areas.

BEHAVIORAL SCIENCE PROGRAM

FAMILY FOCUS SEMINAR

* Understand basic principles of family systems theory/ family life cycle, structural family therapy
* Gain experience in family assessment through videotape review
- Status: current
! Problems: residents at different levels of exposure

HOME VISIT PROGRAM

* Field experience in family assessment, specifically as it relates to health care issues
* Opportunity to practice basic family interventions
- Status: current, ~~but unmonitored~~ (now monitored)
! Problems: lack of enforcement; lack of supervision (Esperanza, volunteer M.D. faculty); no opportunity for feedback

INTERVIEWING TRAINING

* Develop basic skill in interviewing
- Status: ~~nonexistent~~ remedial and 1st year teaching series established
! Problems: no formal training at present (IPR teaching series?); no audio-video taping of residents; no opportunity for supervision even if tapes are made (FF seminar?)

DEPARTMENTAL SEMINAR SERIES

* Didactic education in psychosocial issues in patient care
- Status: Current
! Problems: integration with physician teachers; equal time for primarily behavioral topics

INPATIENT PSYCHIATRIC ROTATION

* Diagnosis and assessment of common psychological disorders
* Primary therapeutic responsibility for counseling families, individuals
- Status: current
! Problems: ?

ELECTIVES

* Behavior therapy
* Clinical research
* Hypnotherapy
* Child psychiatry
* Intensive family therapy
- Status: Current
! Problems: ~~no~~ insufficient time to take electives

CLINIC SUPERVISION

* Regular feedback about psychosocial aspects of patient management, doctor/patient relationship
* Consultation about specfic psychological diagnoses, interventions
- Status: 29A, ~~sporadic~~ ok; CCOC, FH: minimal ~~to nonexistent~~
! Problems: insufficient personnel, inefficient delivery

FAMILY FOLLOW-UP

* Opportunity to assess family from medical/psych. perspective over time
- Status: nonexistent; !Problems: no criteria developed; supervision?

APPENDIX D

BEHAVIORAL SCIENCE ROTATION

Week One

Days 1-2 Interviewing skills; doctor-patient relationship
IPR Tapes; Carlin tapes; Carkhuff tapes
Reading; discussion
review of resident audiotape
roleplay of interview situations

Days 3-4 Introduction to brief psychological interventions
Supportive therapy
Behavioral therapy techniques
Crisis intervention
Relaxation training
Systematic desensitization
Common clinical problems
- depression/anxiety
- obesity
- headaches/chronic pain
- marital/sex counseling
- death and dying
- problem patients

Day 5 Introduction to family systems theory
Genogram, structural/spatial techniques
Assessment
Basic principles of structural family intervention
Tapes and discussion

Week Two

Family program at Care Manor. I have already gotten tentative approval for 12 interns a year from Dr. Andrea Kaye, Director of Adult Programs.

BEHAVIORAL SCIENCE ROTATION

	MORNING	AFTERNOON	EVENING
MONDAY	8:30-10:30 reading - family & illness 11:00-1:00 observation dd family group Dr. Shapiro	2:00-4:00 topic seminar (death/dying) P. Lenahan	
TUESDAY	CLINIC	1:30-2:30 Dr./Pt. relationship, Drs. Rubel, Shapiro 2:30-3:30 topic seminar Dr. Rubel 3:30-5:00 Interviewing Dr. Shapiro	8:30-10:00 - Adult Children of Alcoholics meeting
WEDNESDAY	8:30-10:30 affective response tapes 10:30-12:00 - interviewing Dr. Shapiro	1:30-4:30 Counseling strategies/clinical problems Dr. Shapiro Family systems theory & practice: tapes Dr. Shapiro	Relaxation tapes Obesity tape Marital therapy tape
THURSDAY	8:30-10:00 reading-family & chronic illness 10:00-12:00 Observation burn unit-clinical treatment of insomnia, anxiety, pain Dr. Friedmann	2:00-4:00 Observation diabetes unit 4 Tower waiting area	Family therapy workbook
FRIDAY	CLINIC	1:30-3:30 Introduction to Alcoholism P. Lenahan 3:30-5:00 Alcoholism readings	

Tentative Family Therapy
Rotation Schedule

Monday - at Turning Point, Garden Grove

8:30 - 12:30 Videotape observation and analysis (Dr. Shapiro and Turning Point staff).

1:30 - 4:00 Training with D. Naishtut

4:00 - 6:00 At Diversion in Santa Ana
Live supervision with Art Williams, Ph.D.

Tuesday - at Turning Point, Garden Grove

9:00 - 12:00 Training and consultation with D. Naishtut and Interns

1:30 - 4:30 Selected family therapy readings and discussions (Dr. Shapiro and Turning Point staff).

Wednesday - At Turning Point, Santa

9:00 - 12:00 Videotape observation and analysis (Dr. Shapiro)

1:00 - 3:00 Consultation and live supervision with D. Naishtut

OR

3:00 - 5:00 Live supervision with Dr. Art Williams at Turning Point, Garden Grove.

Thursday - At Ampaio in Garden Grove

10:00 - 12:00 Consultation with counselors reviewing tapes.

1:00 - 5:00 Selected family therapy readings and discussion (Dr. Shapiro and Turning Point staff).

Friday - At Turning Point, Garden Grove

9:00 - 11:00 Staff consultation

11:00 - 12:00 with D. Naishtut

1:00 - 4:00 Live observation and discussion (Turning Point staff).

APPENDIX E

Patient Name: _____

REQUIRED HOME VISIT REPORT

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 problems

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 _____

THE ROLE OF THE BEHAVIORAL SCIENCE CONSULTANT IN CLINIC TEACHING

In both the 9A and CCOC clinics, each resident is scheduled to meet with a behavioral science consultant (BSC) once a week. 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 BSC does have certain responsibilities and functions, which are delineated below.

The BSC is expected to spend between ½ hour and 1 hour with each scheduled resident (depending on a given session, each BSC is scheduled to work with 1-3 residents). It will greatly facilitate the teaching process if this time can be worked out in advance between the BSC and the resident (ie., if consultant A is in clinic Monday mornings from 9-12, s/he may negotiate with Dr. Smith to meet from 9:30 to 10:30, and with Dr. Jones to meet from 10:30 to 11:30 on a weekly basis).

During this time, the behavioral science consultant will perform the following functions:

1) The BSC will observe at least one patient-physician encounter and will provide beedback to the resident in some of these areas:

    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 BSC 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 BSC serving as:
        1. primary therapist (resident observer)
        2. co-therapist
        3. supervisor (reisdent primary therapist)

3) The BSC 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 BSC is available to accompany the resident on home visits, at the resident's request. The BSC 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 BSC 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 (ie., family therapy, marriage counseling etc)

6) The BSC is also expected to participate in the daily wrap-up session for his/her scheduled clinic time. The BSC 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 BSC will also make audio/visual tapes of a physician-patient interview at the resident's request. In addition, it is expected that the BSC make one audio/visual tape of each of his/her assigned residents once during the year.

In sum, the BSC is expected to act as a resource and teacher to the resident in terms of basic psychological assessment, diagnosis, and treatment. It is expected that every BSC have background in diagnosing and treating common psychological disorders, and in addition, have a special interest and expertise in working with families.

Johanna Shapiro, Ph.D.

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.

Family Interviewing (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 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.

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 therapeutic responses:

    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

BEHAVIORAL SCIENCE OBJECTIVES

COMMON DISORDERS

Psychiatry

A. Concepts

1. The family practice resident should be able to identify the clinical signs of depression, psychosomatic illnesses, 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 resident 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.

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 hosptial in 90% of the cases including non-compliant, passive, denying patients and to help patients to adapt to medical and surgical problems.

Clinical Psychology

A. Concepts

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

2. The family practice resident should be able to recognize mental problems when they exist in his/her patients to make the appropriate referrals with a consultation.

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.

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 everyday tasks)

9. Be able to state and give specific techniques in the three general principles of crisis intervention: (reduce 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)

Crisis Intervention (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.

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

I. 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 diagnosis 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.

Problem 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

Problems Areas (continued)

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. Acceptance of illness and compliance with regimen
   q. 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. Venereal disease
   m. Headache
   n. Obesity
   o. Irritable bowel
   p. Accidental injury
   q. Rheumatoid arthritis
   r. Enuresis

4. 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.

4. Continued

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

5. 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.

I. 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 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.

II. 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.

1 2 3 4 5

Weak Adequate Strong

ID = insufficient data
NA = not appropriate

ATTENDING/RESIDENT

DATE _____ TIME _____

Presenting Problem _____

FAMILY PRACTICE CENTER
PATIENT ENCOUNTER CHECKLIST

		COMMENTS
I. INTRODUCTION		
Initial greeting	____	
Social amenities	____	
II. INTERVIEW STRUCTURE AND EXPECTATIONS		
States goals for session	____	
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 appropriately	____	
Uses specific questions appropriately	____	
Uses active listening skills (uh-huh, head nods)	____	
Elicits patient expectations for treatment, practitioner behavior	____	
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 appropriate initiative, self-responsibility	____	
Makes use of self-disclosing statements	____	
Uses appropriate gestures, facial expressions	____	
Discusses own emotional reactions to patients	____	
Checks patient compliance with past treatment directions	____	

IV. UTILIZATION OF OTHER RESOURCES		COMMENTS
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	____	
Discusses impact of disease on:		
a. patient's life	____	
b. family's life	____	
Uses family to implement treatment programs	____	
VI. SUMMARY OF SESSION		
Summarizes information	____	
Specific future course of action	____	
Elicits feedback from patient	____	
Reassures patient appropriately	____	

ATTENDING ASSESSMENT OF BEHAVIORAL SCIENCE PROGRAM

1. Please rate the following behavioral science instructor _____ according to the following criteria:

1 Very poor	2 Poor	3 Average	4 Good	5 Excellent	DK

	1	2	3	4	5	Don't Know
Punctuality						
Contributions at wrap-up conferences						
Rapport with residents						
Knowledge of the field						
Usefulness of psychosocial feedback to residents						
Intiative in contacting residents						
Ability to integrate psychosocial aspects of patient care with medical treatment						
Ability to interact in a collaborative way and constructive manner with professional colleagues						

2. What are particular strengths you have observed in this person?

_____

_____

3. In what areas could this individual improve as a teacher.

_____

_____

Please return to Johanna Shapiro: CCOC Box Suite I - Bldg. 9A, Office

00

EVALUATION QUESTIONNAIRE

Behavioral Science Clinic Sessions

A. Name of behavioral science instructor: _____

1. What aspect of the sessions do you find most valuable? _____

_____

_____

2. What aspect of the sessions do you find least valuable? _____

_____

_____

3. Please rate the helpfulness of feedback from behavioral science teachers received about the psychosocial aspects of your performance as a physician. (Circle one)

1	2	3	4	5
Very poor	Poor	Average	Good	Excellent

4. To what extent are the sessions successful in integrating psychosocial aspects and medical treatment? (Circle one)

1	2	3	4	5
Not at all	Slightly	Moderately	Well	Extremely

5. Please rate the extent to which your psychosocial skills have improved in the following areas as a result of behavioral science teaching sessions:

1	2	3	4	5
Not at all	Slightly	Moderately Improved	Improved	Greatly Improved

_____ Interviewing

_____ Communication skills

_____ Ability to think about the interaction between psychosocial and medical aspects of patient care.

_____ Ability to develop a caring doctor-patient relationship

_____ Awareness of own internal dynamics as significant in doctor-patient interactions

_____ Basic counseling skills

_____ Ability to assess and/or intervene therapeutically in the family system (ie., parent-child relationships; marital relationships)

_____ Ability to interact in collaborative and constructive manner with professional colleagues (eg., psychologist, social worker)

_____ Ability to recognize common psychological problems:

_____ depression

_____ anxiety

_____ marital dysfunction

_____ psychosomatic illness

_____ learning disorders

_____ other

_____ Sensitivity and knowledge of cultural factors affecting patient health care

6. Is there any aspect of behavioral science which you feel is being consistently overlooked in the clinic teaching sessions: If so, please elaborate.

_____

_____

_____

_____

FACULTY EVALUATION QUESTIONNAIRE

Faculty Member:

1. What were your goals for this seminar?

2. Please rate the extent to which you achieved these goals? (Circle one)

1	2	3	4	5
Not at all	Slightly	Moderately	Well	Very well

3. What aspect of the seminar did you find most valuable?

4. What aspect of the seminar did you find least valuable?

5. Please rate the quality of exposure to skills not acquired in other aspects of your medical training. (Circle one)

1	2	3	4	5
Very Poor	Poor	Average	Good	Excellent

6. Please rate the quality of feedback received about the psychosocial aspects of your performance as a physican. (Circle one)

1	2	3	4	5
Very Poor	Poor	Average	Good	Excellent

7. How meaningful was the course to your total educational experience? (Circle one)

1	2	3	4	5
Not at all	Slightly	Moderately	Very	Extremely

8. To what extent do you feel the seminar facilitated your own personal growth? (Circle one)

1	2	3	4	5
Not at all	Slightly	Moderately	Well	Extremely

9. Please rate the degree of opportunity in the seminar for you to share your professional concerns. (Circle one)

1	2	3	4	5
Very Poor	Poor	Average	Good	Excellent

10. Please rate the instructor according to the following criteria:

1	2	3	4	5
Very Poor	Poor	Average	Good	Excellent

a. __ Preparation

b. __ Involvement in the seminar

c. __ Concern for participating in the seminar?

d. __ Openness to participants' ideas.

e. __ Willingness to share relevant personal/professional experiences.

f. __ Ability to guide group discussion.

g. __ Availability for additional discussion.

h. __ Awareness of personal biases and limitations.

i. __ Openness to criticism.

j. __ Ability to generate enthusiasm for the topic under discussion.

k. __ Level of knowledge regarding the seminar topic.

11. Are you interested in pursuing behavioral science topics as a result of the seminar?

Yes_____ No_____

12. Please note any other criticisms, comments, suggestions.