BEHAVIORAL SCIENCES CURRICULUM

Possible Curriculum Options

Three to four 1st and 2nd year residents would rotate through a sixteen-week behavioral sciences cycle, which would include the core curriculum (see below). The cycle would be repeated three times per year so that all residents would rotate through it. Cycles would be divided into three five-week segments (with one week for introduction, review, etc.) of approximately three hours each. Thus, each core course would have a total of fifteen hours devoted to it. Year Three would provide a choice of elective experiences for residents in the behavioral sciences (see content sheet).

Electives would be offered for a period of eight weeks which would provide residents with an additional twenty-five hours of behavioral science training.

CORE SEQUENCE

Year I: Doctor/Patient/Family relationships, interviewing, family systems, family dynamics.

Year II: Psychopathology, psycho-social aspects of disease, basic family counseling.

Year III: Electives.

BEHAVIORAL SCIENCE HOURS

Years I & II = 96 hours

Year III = 25 hours

Noon series = 145 hours

Grand Rounds = 20 hours

Behavioral science supervision = 100 hours

Group experiences = 50 hours

Total behavioral science hours = 435 hours

BEHAVIORAL SCIENCES CURRICULUM

Possible Curriculum Option - Content

CORE Courses/Seminars

Doctor/patient/family relationships

Interviewing/observation/communication skills

Basic (individual & family) counseling

Family systems

Psychopathology (diagnosis & treatment)

Psycho-social aspects of illness

Electives

Behavior therapy

Parent training

Family therapy

Theory (family therapy practice)

Problem solving/decision making

Marital counseling (practice)

Research methods

Small group dynamics

Organization behavior

Counseling practicum

Community psychology

Mexican-American family life and culture

Independent study

Supervision

Advisory system for behavioral science feedback - systems approach to patient care; tape review

Personal/professional advisory system

Faculty Development

How to give behavioral science feedback

Training in IPR (interpersonal process recall)

Training students in comprehensive interviewing

Advising for professional and personal concerns

Training in research methodology

Noon Lectures

A comprehensive series organized developmentally around the family (see attached)

Group

Coping group for personal awareness, growth, interface of personal/professional issues

Women's group
Residents/faculty retreat

NOON SERIES LECTURES

Noon series would meet once a week and would be required of all residents. We need to discuss whether this series would be open to all CCOC staff, or to residents only. We also need to decide on a structure for the noon series. Four options seem feasible:

1. A one-year plan which would include all thematic content material. The series would be repeated each year, but the specific topics or content of the lectures would vary.

2. A three-year plan which would proceed developmentally with year I devoted to general introduction to the family/childhood, etc.; year II spent on adolescence and middle years; year III focusing on aging, death and dying.

3. The third option would be to tie the noon series to the core curriculum, so that year I would focus on doctor-patient relationships, interviewing, family dynamics; year II would focus on psycho-pathology, psycho-social aspects of disease, and basic family counseling; and year III might be devoted to a variety of unrelated topics.

4. A fourth option would be independent lectures with no family theme (this is the least attractive of the options to me).

Below is a rough outline for noon lecture series which would be organized developmentally around the family.

1. <u>The Family - Introduction</u>

    - Family systems
    - Family dynamics
    - Family in crisis
    - Family dysfunction
    - Family intervention procedures
    - Acute illness in the family
    - Chronic illness in the family
    - Family health attitudes and behaviors
    - Cross-cultural perspectives on the family
    - Family in the hospital
    - The family in the physician's office
    - Sexual counseling
    - Psychological counseling for the family
    - Family assessment in interviewing
    - Family compliance with medical regimen
    - Terminal illness in the family
    - Alcohol in the family
    - Drug abuse in the family
    - Teaching the family
    - Violent families

II. Childhood - Introduction

- Psychology of childbearing and infant care
- Psychology of breastfeeding
- Infancy and attachment
- Parenting skills
- Learning problems
- Hyperactivity
- enurises and caprises
- Retardation
- Child abuse
- Acute illness in children
- Chronic illness
- Terminal illness in children
- Hospitalization of the child
- Interviewing the child
- The child in the physician's office

III. Adolescence and the Middle Years

- Identity in adolescents
- The empty nest syndrome
- Career pressures
- Stress-related diseases
- Techniques for interviewing adolescents
- Terminal illness in adolescents
- Preparing the adolescent for parental dysfunctions
- Sleep dysfunctions
- Obesity in the adolescent
- Anorexia in the adolescent
- Obesity
- Depression
- Divorce

IV. Death and Dying

- Aging in the family
- Death and dying
- Grief
- Attitudes toward our own death
- Counseling the dying patient and family

VI. Content

Three - four 1st and 2nd year residents rotate through a sixteen-week behavioral sciences cycle, which includes the core curriculum (see below). The cycle is repeated three times per year so that all residents rotate through it. Cycles are divided into three five-week segments (with one week for introduction, review, etc.) of approximately three hours each. Thus, each core course has a total of fifteen hours devoted to it. Year Three provides a choice of elective experiences for residents in the behavioral sciences (see content sheet).

Electives are offered for a period of eight weeks which provide residents with an additional twenty-five hours of behavioral science training.

CORE SEQUENCE

Year I: Doctor/Patient/Family relationships, interviewing, family systems, family dynamics.

Year II: Psychopathology, psychosocial aspects of disease, basic individual and family counseling.

Year III: Electives.

BEHAVIORAL SCIENCE HOURS

Years I & II = 96 hours

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Noon series = 145 Hours

Grand Round = 20 hours

Behavioral science supervision = 100 hours

Group experiences = 50 hours

Total behavioral science hours = 435 hours

VII. Faculty

The curriculum stress involvement of all faculty in its behavioral science program. At present, five individuals have primary responsibility for behavioral science training.

1. Johanna Shapiro, Ph.D., coordinator of the behavioral science program.
   Specialties: behavior therapy and family therapy.

2. Zeke Lujan, C.M.S.W.
   Specialties: Mexican-American and community psychology

3. Ed Kaufman, M.D. (half-time in behavioral sciences)
   Specialties: family therapy and alcoholic families.

4. Ellen McGrath, Ph.D. (half-time in behavioral sciences)
   Specialties: group therapy and child psychology.

5. Herb Fendley, M.D. (part-time in behavioral sciences)
   Specialties: interviewing and communication skills.

These core faculty emphasize a team approach in instruction. In addition, other faculty are involved in a variety of roles:

1. Participation in noon conference series
2. Participation in videotape feedback session
3. Involvement with residents "coping" group

The behavioral science program includes a faculty development component which focuses on skill training in the areas of resident counseling, videotape supervising, and clinical research methodology.

VIII. Format

CORE Courses/Seminars

Doctor/patient/family relationships

Interviewing/observational/ communication skills

Basic (individual & family) counseling

Family systems

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Electives

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Family therapy

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Noon Lectures

A comprehensive series organized developmentally around the family (see attached)

Group

Coping group for personal awareness, growth, inter-face of personal, professional issues

Women's group
Residents/ faculty retreat

IX. Noon Series Lectures

Noon series meet once a week and are required of all residents. The series is designed to be a coherent, unified experience organized around the family and its interface with illness and wellness behavior. The series proceeds developmentally starting with a general introduction to the family/childhood, etc.; progressing through adolescence and middle years, and culminating with sessions on aging, death and dying.

Below is a rough outline for noon lecture series which would be organized developmentally around the family.

I. The Family - Introduction

- Family systems
- Family dynamics
- Family in crisis
- Family dysfunction
- Family intervention procedures
- Acute illness in the family
- Chronic illness in the family
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- Learning problems
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- Enurises and Caprises
- Retardation
- Child abuse
- Acute illness in children
- Chronic illness
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- Techniques for interviewing adolescents
- Terminal illness in adolescents
- Preparing the adolescent for parental dysfunctions
- Sleep dysfunctions
- Obesity in the adolescent
- Anorexia in the adolescent
- Obesity
- Depression
- Divorce

IV. Death and Dying

- Aging in the family
- Death and dying
- Grief
- Attitudes toward our own death
- Counseling the dying patient and family

Key Behavioral Science Content Areas

Brief Counseling (behavioral)

Crisis Intervention

Family/marital counseling

Psychosexual counseling

Problems in patient management (seductive, hostile, noncompliant, obsessive, dependent; death and dying)

Evaluation and management of common disorders (depression, anxiety, hypochondriasis, psychosomatic disorders, addictions, pain, family problems etc.)

Cross-cultural aspects of health care

Patient education

Physician self-awareness (impairment, emotional responses to patients)

Family Life cycle (geriatric patients, adolescent patients)

Family Assessment (structure and dynamics)

Communication and relationship skills, interviewing techniques

Common Clinical Problems (partial list)

Depression
Obesity
Headache
Sexual dysfunction
Hypochondriasis
The problem ("hateful") patient
Anxiety
Marital/family problems
Drug addiction
Alcoholism (check with Dr. Anderson for readings)
Death and dying (check our family and illness files)
Chronic illness (check our family and illness files)
Psychosomatic patients
Adherence/compliance problems
Chronic pain

GUIDELINES FOR CASE PRESENTATIONS

Criteria for Selection of Cases

* Case may involve medical or psychiatric diagnoses commonly seen in clinic (i.e., pregnancy, depression)

* Case may involve difficult or "problem" medical or psychiatric diagnoses (i.e., management of obesity)

* Case must involve at least one other family member; and attention paid to how a specific disease entity effects the family as a whole

* Case must involve at least a resident, a nurse, and a behavioral science team member; and may involve dietician, public health nurse, pharmacist, etc.

* Case must involve at least one home visit

Format for Presentation

* Resident will present brief medical and psychosocial history
  Note: a videotape of resident and patient is highly desirable

* Nurse presents additional observations, information

* Behavioral science team member provides further input based on home visits, interviews, observation, etc.

* Input from other staff as appropriate

* Resident and behavioral science team member will formulate several problem areas for discussion which will include both physical and psychological aspects of patient management

* Discussion of high priority problem areas; participation of all staff involved in patient care

* Formulation of intervention strategies at medical and psychological levels

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.

Behavioral Medicine Seminar Series, 1981-1982

September 14-18:	The Somatizing / Seductive Patient
October 12-16:	The Noncompliant Patient / Entitled Demanders / Dependent Clingers
November 9-13:	Brief Family Therapy
December 14-18:	Transcultural Interviewing and Health Care
January 11-15:	How to Talk to Children
February 8-12:	Depression: Drugs and/or Therapy / DSM III
March 8-12:	Advice Giving vs. Counselling and Confrontation
April 12-16:	How to Say Goodbye
May 10-14:	Death and Dying
June 7-11:	Primary Care Wrap Up

BEHAVIORAL SCIENCE CURRICULUM

Attendance clinic sessions: 6 hr./month = 72 hr./year

Attendance noon series: 1 hr./week = 24 hr./year.

Attendance training seminar: 3 hr. 12 mo. = 24 hr./year

Attendance emergency ER = 50 hr.

Elective Behavioral Science electives = 100 hr.

Specially scheduled videotapes and consultations 1 hr./month/resident = 12 hr.

Monthly case consultation: 1½ hr./month = 18 hr.

Home visit - 10 hr./year

Total = 310 hr/year

CURRICULUM RESPONSIBILITIES

Supervision and participation: One-to-one consultation program

Organize noon conference series

Conduct inpatient seminar

Coordinate women's group

Coordinate CCOC behavioral science team

Coordinate behavioral science electives

Participate/coordinate family medicine case conferences

Participate in Grand Rounds

Supervise home visit program

Evaluation of behavioral science program

Faculty development in the behavioral sciences