Family Therapy: A Necessary Core Competence for Psychiatric Trainees

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Contents

Abstract

Psychiatric disorders interact with the social context of the affected individual. The family interactions may affect the mental health of the individual, and simultaneously, psychiatric disorders affect family members and relationships.

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M. H. M. Hermans et al. (eds.), *Education about Mental Health and Illness*,
Mental Health and Illness Worldwide, https://doi.org/10.1007/978-981-10-0866-5_29-1

As a psychiatrist, it is important to have insights in how patients and families can be stuck in negative circles reinforcing psychiatric symptoms and undermining good outcome. The interactions between psychiatric disorders and family interactions are discussed. Some theoretical concepts and techniques of systemic family therapy will be given, and the importance of family intervention in psychiatric care will be stressed. For the psychiatrist in training, this implicates that he should acquire the skills to perform a systematic assessment and plan intervention with attention for the family system. He should obtain knowledge of family management, interactions, and be able to recognize dysfunctional patterns.

Keywords
Family therapy · Systemic therapy · Competence · Psychiatric trainee

Introduction

Psychiatric disorders do not occur in a vacuum. Patients with psychiatric disorders are not wholly detached from a social context. They (were or) are part of families which are more or less supportive to them. These present or past family interactions may affect their mental health and how they are coping with the psychiatric disorder. Simultaneously, psychiatric disorders are affecting the family members and relationships and are challenging family resources to support the mentally ill relative. As a psychiatrist, it is important to have insights in how patients and families can be stuck in negative vicious circles reinforcing psychiatric symptoms and undermining good outcome. Psychiatrists should gain sufficient competences and tools to block unhelpful family interactions and to unlock family resources. In this chapter, the interactions between psychiatric disorders and family interactions will be discussed. Further, some theoretical concepts and techniques of systemic family therapy will be given, and the importance of family intervention in psychiatric care will be stressed. Finally, some implications for the clinical competences of psychiatrist (in training) will be explained since, as Stefan Priebe has in 2013 stated in the *British Journal of Psychiatry*, the future of academic psychiatry may be social.

Family Interactions and Psychiatric Disorders

With an average life-time prevalence of 25% for any mental disorder, at least one in four Western families will be affected by a psychiatric disorder (Alonso et al. 2004). Moreover, most psychiatric disorders such as depression, anxiety disorders, eating disorders, and substance abuse run in families, meaning that they are frequently reported in different first and second degree relatives (such as parents, offspring, grandparents, uncles) (McLaughlin et al. 2012). Furthermore, recent research indicates parent psychopathology is not only strongly associated with an increase of class specific, but also of every class of offspring psychiatric disorders (McLaughlin

et al. 2012). A daughter of a parent with a substance use disorder is as an adult not only at risk for substance use disorders but also for other psychiatric disorders such as anxiety disorders, mood, or behavior disorders.

The etiology of most psychiatric disorders is multifactorial with a notable genetic component varying between 30% and 70% combined with stressful environmental factors (Prescott and Kendler 1999). However, the family environment remains the most immediate psychosocial context. Families can function as a source of social support, growth, and development, but for many people suffering from psychiatric disorders, they may also be a cause of stress. An increasing body of research points to the important role the family environment plays in gene expression and brain development (Heru 2006). Increasing genes-family correlation and interaction studies increase our understanding how the complex relationship between biological and family factors plays an important role in the development and course of psychiatric disorders (Hudson and Rapee 2005).

Different family factors have been identified to play a role in the development and course of psychiatric disorders. Although these factors may vary depending on the different psychiatric disorders, they can be classified in different domains such as stressful family events, parenting style, the family climate, and the marital relationship. The presence of negative factors within these domains is generally associated with development and negative course of most psychiatric disorders, whereas positive factors within these domains seem to be protective. Family maltreatment and abuse is associated with different adult psychiatric disorder such as mood disorders, anxiety disorders, self-harm, depression, eating disorder, substance use abuse, PTSD, and personality disorders (Hudson and Rapee 2005).

However, until now, it remains unclear why different persons affected by similar negative family factors develop different psychiatric disorders. At the same time, psychiatric disorders affect not only the individual with the illness, but also have an important impact on the well-being of the relatives, the relationships (e.g., couple and parent-child relationship) and the family functioning. Thus, most family domains, which are affected by psychiatric disorders, are simultaneously reinforcing psychiatric symptomatology, leaving the family stuck in a negative vicious circle. The complex and close interactions between family characteristics and different psychiatric disorders will be further discussed and illustrated with some examples of different psychiatric disorders.

Stressful Family Events

Several negative family events are linked with psychiatric disorders. They include early death of a parent, psychopathology of a parent, child abuse, low socioeconomic status, and poverty. As stated before, each parent psychopathology is associated with increased risk for every class of mental disorder in their children (McLaughlin et al. 2012). Mood and anxiety disorders in the mother relate to a wide range of psychiatric disorders in the offspring. Parental death is associated with a higher risk of psychopathology in the offspring. This is especially true when children

lose their parent from external causes, like suicide, accidents, or homicides and for children who lost a parent early in life (Berg et al. 2016). A recent review article states that socioeconomically disadvantaged children and adolescents are two or three times more likely to develop mental health problems (Reiss 2013). Especially, a decrease in socioeconomic status (SES) and persistently low SES are predictors of the onset of psychopathology. Low income and low parental education are indicators of SES with the most important impact on mental health (Reiss 2013). Material deprivation is associated with the onset of mental health problems, whereas parental education seems to have an impact on their course or severity (McLaughlin et al. 2011).

Adverse life events in early life are also related to the development of psychiatric disorders in adulthood. Subtypes of early life stress are associated with several psychiatric disorders. Physical abuse, sexual abuse, and unspecified neglect are related to the development of mood disorders and anxiety disorders. Emotional abuse is associated with personality disorders and schizophrenia (Carr et al. 2013). Childhood abuse is common in bipolar disease, and it also predicts a more severe course of the disorder with earlier onset, psychosis, suicidality, aggression, and more mood episodes, hospitalization, and comorbidity (Johnson et al. 2016). Bipolar depressive symptoms are particularly related to negative life events associated with loss and danger (like financial difficulties and job loss) (Johnson et al. 2016). There is a strong relationship between early adverse experience and substance use and abuse (drugs, alcohol, and nicotine) later in life (Anda et al. 2006).

Parental Style

Parental style, which refers to the strategies that parents use in their child rearing, plays an important role in the development of children and it, among other factors, may modify attachment of children. Parental autonomy support has been linked to several positive developmental outcomes in adolescents, including well-being, and school achievement (Vansteenkiste et al. 2004), whereas negative parental styles are often associated with insecure attachment of children, which, on its turn, is strongly related with the development of psychiatric disorders (Hudson and Rapee 2005; Vansteenkiste et al. 2004). A parenting style characterized by rejection/criticism and control/intrusiveness has a higher risk of developing depressive disorder in the child (Hudson and Rapee 2005). Affectionless control, a parental style characterized by low care and overprotection, is correlated with a longer duration of the depressive episode (Handa et al. 2009). Other parental characteristics like a lack of warmth, autonomy support, and monitoring and the presence of parental conflict, aversion, and over involvement are positively related with depression (Yap et al. 2014). Several parental characteristics have been reported to have an influence on the development and course of behavior disorders in children. They include lack of clarity when giving assignments, inconsistently dealing with undesirable behavior, harsh punishment, lack of surveillance in young children, and insufficient knowledge of the comings and goings of older children (Reid et al. 2002). Adolescents

with anorexia nervosa (AN) also report more parental problems (i.e., separation, criticism, high expectation, over-involvement, under-involvement, depression in the mother, low affection, critical comments on shape, weight, or eating) compared with healthy controls, but not with psychiatric controls (le Grange et al. 2010). Research investigating the role of psychologically controlling parenting (Tetley et al. 2014) has demonstrated indirect associations between psychologically controlling parenting and the development of eating disorders (ED) symptoms mediated by variables such as maladaptive perfectionism, distress, or self-competence (Snoeck et al. 2007). Parental psychological control is related to maladaptive perfectionism of ED patients, which in turn is related to ED symptoms (Soenens et al. 2008). High maternal psychological control leads to lowered adolescents' self-competence, which in turn predicts increased bulimic symptoms in a community sample. Finally, adolescents with binge-eating purging behaviors experience more maternal psychological control compared to restrictive patients (Depestele et al. 2017).

Affective Family Climate

A family climate characterized by low levels of warmth and support and high levels of conflicts and rejection is frequently reported to be associated with different adult psychiatric disorders (Handa et al. 2009). Higher levels of verbal abuse, greater family conflict, and less family cohesiveness have been noted in families of borderline personality disorder, and a home environment characterized by high communication deviance (e.g., a measure of distracted or vague conversational style) and a strongly negative affective climate puts adolescents at risk for psychotic disorders (Schaub 2002). More specifically, expressed emotion (EE), measured by the amount of critical remarks, signs of hostility, and amount of involvement, is an important measure for the affective climate in a family and plays a considerable role in the onset and relapse of different psychiatric disorders such as depression, bipolar disorders, schizophrenia, and eating disorders (Di Paola et al. 2010; Schaub 2002). Children with a mother high in criticism are at higher risk of developing a depression (Burkhouse et al. 2012). A patient with schizophrenia living in a family with a high level of expressed emotion, i.e., criticism, hostility, an emotional over involvement, has a higher risk of relapse (Kavanaugh and Hooley 1992) whereas having a supportive, involved family member was a strong predictor of medication compliance and good outcome.

Coercive and aversive interactions are characteristic in families with children with oppositional defiant disorders and conduct disorders. There is a higher risk of developing these negative interaction patterns when there is distress or psychopathology in a parent. When parents do not support each other, abuse alcohol or drugs, experience stress or if parents themselves exhibit antisocial behavior, there is less chance that they will have a positive attitude and be able to keep calm when confronted with undesirable behavior.

When considering behavior disorders, the emphasis should not only be on the family context. Peers and the school constitute an important part of the environment

when assessing and treating behavior disorders. The same coercive interactions can develop in contact with other children and children with behavior problems are often rejected by peers. Rejection itself is a risk factor for developing behavior problems and when children become excluded they miss the opportunity to practice their social skills. Children who share the school environment with other children with aggressive behavior problems are at risk for developing more aggression. There is more aggression in schools situated in a neighborhood with more socio-economically disadvantaged groups. In the adolescence, there is a higher risk of the teenager with behavior problems to join a delinquent group of peers. In this group, rule breaking behavior, which is often positively validated, could result in an increase of deviant behavior. This so-called "deviancy training" can be a contraindication for group therapy, and the same increase in delinquent behavior is observed when young people are assigned to judicial institutions.

Marital Relationship

Being in a relationship has frequently been associated with greater psychological well-being and physical health. However, the advantages of having a relationship may not compensate for a distressed relationship. A strong correlation between marital conflict and different psychiatric disorders in partners and offspring has been reported. Children are at greater risk of psychopathology (e.g., externalizing and internalizing problems) if they are exposed to interparental conflict (Dwyer et al. 2006; Hudson and Rapee 2005). Dwyer et al. (2006) even stated that the elimination of parental verbal conflict and mood problems would result in 20% less child mental health problems. Interparental violence significantly predicts anxiety disorders, conduct disorders, alcohol use disorders, and property crime in the offspring (Fergusson and Horwood 1998). Several studies have indicated that marital distress is strongly associated with increases in depressive symptoms and incidence of depression for both men and women (Beach and Whisman 2012). Sharing of positive activities and spousal caretaking may have beneficial effects on alcohol use, whereas withdrawal and avoidance of the drinking family member, negative verbal comments about the drinking, and physical violence directed at the drinking family member may serve as cues to further drinking (McCrady et al. 2016).

Family Burden

As previously mentioned, psychiatric disorders have also an important impact on the family members, their relationships, and the family functioning. Family members taking care for the depressive relative have more depressive and other psychiatric symptoms and report a lower life satisfaction (Van Wijngaarden et al. 2004). Children living with a depressed parent show more internalizing and externalizing problems (Beardslee et al. 2011). Family members of a patient with AN experience more distress, anxiety, and diminished quality of life and reducing the caregiver's

strain could be important in improving outcome (Le Grange et al. 2010). Psychiatric disorders also modify the way parents interact with their children. Attention-deficit/hyperactivity disorder (ADHD), parental conflict, financial problems, and cramped housing have a negative influence on parenting skills. Depressive parents are more unpredictable, critical, hostile, and less involved and able to compromise when arguing with their children (Beardslee et al. 2011). Further, psychiatric disorders affect the partner and sibling relationships and the family as a whole. Parents of children with ADHD report less marital satisfaction and more marital conflict than those of nonproblem children, and interactions between children with ADHD and their sibling relationships are characterized by greater conflict than those of non-problem sibling dyads. Couples in which one partner abuses drugs or alcohol show more relationship problems with increased risk of separation or divorce. Couples with a partner suffering from depression show more negative dyadic distress, less constructive and more avoidant/demand-withdrawal conflict communication, more violence, and less dyadic coping (Rehman et al. 2008). Families of patients with eating disorders show more problems with affective involvement, communication, task accomplishment, and problem solving (Holtom-Viesel and Allan 2013). The organization of most families of psychotic patients undergoes a variety of changes, including alienation of siblings; exacerbation, or even initiation, of marital conflict; severe disagreement regarding support versus behavior control; even divorce (McFarlane 2016).

Family Recovery

With the recent deinstitutionalization of residential services (e.g., reduction of inpatient beds) and the development of community-based services in most Western welfare states, the family remains the most salient interpersonal context for patient with psychiatric disorders. Over 50% of Australians living with severe mental ill-health have daily contact with their family member/s (Morgan et al. 2012) and roughly 20% live with dependent children (Mayberry et al. 2009). But families often feel abandoned by the mental healthcare workers not receiving sufficient support for their own needs and information about how to manage the illness of their relative (Transvag and Kristoffersen 2008). They are seldom invited to participate in the treatment of their relative although they often want to be involved.

However, the shift from rehabilitation to *recovery*, which has taken place in policy and practice in the international realm since the mid-1980s, offers new opportunities for the involvement of families in the care of psychiatric patients (Glynn et al. 2006). Within a post-Cartesian understanding of recovery processes patients' personal experiences of hope, healing and empowerment are seen as inseparable from the social and cultural milieus from which they emerge and is recovery seen as an inherently social process where family members play a pivotal role in (Rhys et al. 2016). We are no longer seen as beings in relationship, but rather as relational beings from the outset, and it is through social relationships that we are able to redefine our experience. As a result, different authors have emphasized the

importance of "family recovery" (Glynn et al. 2006; Rhys et al. 2016), where targets and pathways for recovery are embedded in the relationships between family members, the family and the environment, and the interactions among them. For persons living with mental illnesses, recovery is a dynamic process that contributes to and is influenced by family life, family experiences, and the well-being and functioning of other family members. The focus on intrapsychic experiences is replaced by a complex, situated, and processual understanding of the ways in which mental ill-health and recovery manifest in someone's life. Further, Glynn et al. (2006) have stated that most evidence-based psychoeducational family interventions for schizophrenia, developed over the last 35 years, are generally consistent with the principles of the recovery approach since they assume a non-pathologizing stance, utilize a collaborative approach, teach problem-solving and communication skills, and include mutual self-help and peer support.

Concepts and Techniques of Family Therapy

Family therapy is a relatively recent development in the field of psychotherapy. It emerged in the early fifties of the twentieth century in a variety of different countries and within a variety of different movements and services including social work, psychoanalysis, child guidance clinics, marital counseling and therapeutic and research traditions (Carr 2012). As a result, family therapy is a broad psychotherapeutic movement which contains many constituent schools and traditions. The central focus that united the family therapy pioneers is that human problems are essentially interpersonal and that their resolution requires an intervention which addresses relationships between people. Thus, in systemic thinking, there is a reciprocal interaction between a person with a psychiatric problem and the family and its family members, and treating these interactions will benefit the individual's symptoms. These systemic ideas were in the early days supported by research of the Bateson group proposing that schizophrenic behavior occurs in families characterized by specific patterns of "double bind" communication and by new insights stemming from cybernetics ("a transdisciplinary approach for exploring regulatory systems") and general systems theory (GST), which offered a framework for conceptualizing family organization and processes and the occurrence of problematic behavior. The general systems theory was developed by the biologist Ludwig von Bertalanffy (1901–1972) who studied the organization of chemical reactions in a living organism. Applying the ideas from GST, families were seen as systems organized in subsystems (e.g., parental and child subsystem, male and female subsystems) with mutual relations, patterns of interaction, boundaries, hierarchy, and feedback process. Families display a recurring pattern of interactional sequences in which all family members participate. It helps to maintain family relationships and modify transactional patterns in keeping with the changing needs of the family members. Psychiatric symptoms were regarded as representative of a family system in disequilibrium, and family therapist, as external experts, tried to change the dysfunctional relations between the family members. Hereby they focused on

problem-maintaining recursive behavior patterns, pathological triangles involving incongruous intergenerational patterns, difficulties making lifecycle transitions, extreme family enmeshment or disengagement, rigid complementary relationships or escalating symmetrical relationships, unclear, chaotic or rigid family rules. Therapeutic techniques included restructuring the family, joining, enactments, changing parental roles in pathological triangles, rituals, reframing, boundary-making, and paradoxical interventions. Important therapeutic schools of this family approach include structural, strategic/communicative family therapy.

In the late 1980s and 1990s, the mechanical systemic metaphor came under pressure. Under the influence of the constructivism and especially the social constructionism, the concept of the objective external environment was abandoned: language creates realities and meaning is socially constructed. The focus of systemic therapy moved from behavior and interactions towards ideas, perception, language, and dialogue, which subserved interaction patterns. In unhealthy families, the belief systems are not sufficiently flexible to promote the changing demands of the family life cycle and the wider ecological system. Family members with symptoms are entrapped in dominant narratives closing down of the possibilities for new narratives to emerge. Problems are seen as socially constructed and are reformulated in every conversation. The therapist's position shifts from the expert outsider to the interested, not-knowing participant in the therapeutic process. The therapeutic relationship becomes central in therapy. The therapist currently tries to change the family beliefs and narratives using circular questioning, positive connotation, deconstruction of symptoms, and externalization of the problems, reflecting team, working with the self of the therapist, enquiring about unique outcome of exceptions, recruiting family members to act as an outsider witness, re-authoring personal narratives, generating polyphonic/multiple voices, and open dialogues conversations. The Milan, social-constructionistic, solution-focused, narrative, and dialogical family therapies are main representatives of this family therapy approach.

Finally, some family therapy approaches have a specific focus on transgenerational family processes, attachment within families, or the wider social context of the family. In transgenerational family therapy and contextual family therapy, problems may occur through the legacy of invisible loyalities over generation or when adaptation problems are experiences in the different phases of the family lifecycle or during its transitions. Uncovering family loyalities and contextualizing problems using a genogram helps the therapist to unravel and create more healthier intergenerational family scripts. More recently the attachment concept has gained increasing attention in family therapy, which has led to the development of attachment-based and emotion-focused family therapies. In unhealthy families, the attachment needs of the family members are not met leading to negative interactional cycles. The therapy is used as a secure base created for mutual expression and acceptance of disowned unmet attachment needs and related emotions. The central premise of multisystemic and multidimensional family therapies is that adolescent functioning, including behavior problems, is influenced by the interplay among important aspects of the youth's life, such as family, friends, school, and neighborhood. Within this family therapy, individual, family, peer-group-based, and

community-based interventions are combined to harness systemic strengths and to disrupt problematic behavior.

To conclude, four main components are part of every family therapy approach: interactions/relations, context, social systems, and resources. These main components are illustrated in depth below:

- Looking closer at the interplay of people helps to understand individual functioning. An individual's cognitions and emotions develop through **interactions and relations**. In family therapy, these cognitive-affective schemes are seen as social constructed beliefs. The schemes on the other hand shape current relations. Over time, preferential interactions, patterns, and relations may develop. These can become maladaptive if the cognitive-affective schemes and corresponding interactions do not adjust to the changing context. In family therapy, it is important to detect the schemata underlying specific interactions so they can be changed or expanded.
- Interactions and relations occur within their **context** and that context gives meaning to the interactions and relations. Various contexts resonate in every interaction: spirit of the age, development phase, society, culture, gender, family history, family context, social network, living situation, personality. How different contexts form interactions and relations and how these can be (mal)adaptive in a specific context are explored in family therapy.
- Family therapy also includes **social systems** that refer to a broader system than the family. Nowadays every system that has some connection with the original complaint can be invited in therapy, e.g., partners, the school, peers, local community. Therapeutic social communities can also be created in family group therapy for different psychiatric disorders.
- Finally, the focus of family therapy is on **strengths and resources** present in social systems. Resources within a system are able to help an individual beat his or her problems.

Family and Couple Interventions for Psychiatric Disorders

The last two decades, an increasing number of random controlled trials (RCTs), including reviews and meta-analyses, have demonstrated the efficacy of different couple and family interventions in the treatment of different adult and child and adolescent psychiatric disorders (Lebow 2016). Frequently reported benefits are decreased psychiatric symptomatology, reduced relapse rates (up to 40%), decreased family burden, improved family member wellbeing, and improvements in family and social functioning. The strength of the current evidence greatly varies depending on the psychiatric disorder and the used treatment model. Some interventions still require additional empirical support. But there are a lot of well-validated treatments of which most are recommended in de NICE guidelines and ready for dissemination and utilization in the treatment of psychiatric disorders around the world. They

include attachment-based family therapy for adolescent depression and/or suicidal adolescents (Diamond et al. 2016), functional family therapy, multidimensional family therapy, and multisystemic therapy for juveniles with antisocial or delinquent behavior and substance use disorders (Henggeler and Schaeffer 2016; Hartnett et al. 2017; Liddle 2016), eating disordered-focused (multi-)family therapy for anorexia nervosa and boulimia nervosa (Jewell et al. 2016), psychoeducational (multi-)family therapy for schizophrenia and psychotic disorders (William and McFarlane 2016), behavioral couple therapy for alcohol and substance abuse (McCrady et al. 2016), family focused and family psychoeducation for bipolar disorder (Oud et al. 2016), behavioral marital therapy, systemic couple therapy and systemic multifamily therapy for depression (Barbato and D'Avanzo 2008; Lemmens et al. 2009), and behavioral marital therapy and emotion focused therapy for marital distress (Wiebe and Johnson 2016).

Implications for Training in Psychiatry

Despite the important interactions between family interactions and psychiatric disorders and the efficacy of several couple- and family-based interventions for different psychiatric disorders in child, adolescent, and adult patient populations, family therapy knowledge and skills remain a neglected core competency in most psychiatric residency training programs (Heru et al. 2012). Improving the understanding of family interactions and therapy would help psychiatric trainees to adopt a more interactional and social stance which would complement the dominant biological and, to a lesser extent, psychological perspective during their training. They should acquire several basic competences in working with families ranging from communicating with, forming an alliance with, assessing, educating, supporting, to treating families of patients with a psychiatric disorder. Collaborating with the families and the social environment will enhance the recovery of psychiatric patients and their families.

As many psychiatry residents acquire expertise in one form of psychotherapy, mostly an individual therapy such as cognitive behavior therapy or psychodynamic psychotherapy, it would be recommended to also obtain proficiency in one form of family therapy. At least, the acquirement of some basic family skills is necessary to work with families. Therefore, different core competences consisting of knowledge, attitude, and skills should be included in the training program for psychiatry residents (Berman et al. 2006).

Knowledge

A psychiatry resident should have some knowledge about the structure, relationships, and organization of families, about the basic theoretical concepts of family therapy, and about how families and psychiatric disorders interact. A notion

of couple and family development over the family life cycle, the importance of multigenerational patterns, and how age, race, gender, class, culture, sexuality, and spirituality can affect family life will give insight in normative family processes. An understanding how families are changing in our current society with a variety of family forms, changing gender roles, complex family life cycles, and multiculturality will help to explain how psychiatric disorders may be influenced by the context of newly composed families, single parents and same-sex parents, divorce, loss, immigration, or illness, in which they occur. Knowledge about vulnerability but also strengths and resilience of these families will help to prevent relapse or enhance recovery, respectively. When principles of adaptive and maladaptive relational functioning in family life and family organization, communication, problem solving, and emotional regulation will be discussed during the training program, the trainees will gain more insights how family life interacts with psychiatric disorders and vice versa.

Finally, a good understanding of the current evidence-based couple and family interventions is necessary to develop a treatment plan for the psychiatric patient.

Attitudes

The attitude of the psychiatric trainee in working with families should be based on two major assumptions. First, most involved family members of individuals with mental illnesses need information, assistance, and support to better assist the ill family member and cope with the severe challenges posed to the family system. Next, the way relatives behave toward and get along with the mentally ill person can have important effects, both positive and sometimes negative, on that person's well-being, clinical outcome, and functional recovery. Mutual empathy, curiosity, and respect will help to build a therapeutic and collaborative relationship with the family. Hereby, a therapist should create space for the different voices of the family members and their different perspectives/stories on the psychiatric problem and its solution. Acknowledgment and validation of these different viewpoints may help to develop a collaborative treatment and/or crisis plan.

Skills

Working with families of psychiatric patients inherently implies that the psychiatric trainee is able to communicate with the family members and to develop a therapeutic relationship with them. Further, a trainee should develop competencies in completing a family assessment in the context of the patient's presenting problem, in explaining to the patient and the family what is occurring in the family, and in discussing evidence-based family treatments. During the assessment interview, the psychiatrist should gain information about different aspects of the family: family member's perspectives of the presenting problem, the family history and strengths, stressors during the family life cycle, intergenerational patterns of behavior or

illness, the emotional climate in the family, the family organization and interactions, problem-solving in the family, and a family's culture and socio-economic status. After the assessment interview, the resident must be able to integrate biological, psychological, and social factors into a comprehensive formulation that helps the patient and family members understand the illness and the ways in which they may be helpful or detrimental to its management (Heru et al. 2012). Psychoeducation about the psychiatric illness, its treatment, and impact on the family life should be given to every patient and his family. Family psychoeducation is based on the premise that families need to be supported in their care of the mentally ill person. It includes the provision of emotional support, illness education, help with finding resources during periods of crisis, and help with problem-solving skills (Heru 2006). He should be able to involve family members in medical decisions and the development of a treatment and/or crisis plan. If there is a family conflict, the psychiatrist can assist in resolving the conflict through sensitive response to emotional distress. He should be able to support the family in resolving differences of opinions with family members regarding treatment and involve them in medical decision taking and developing a crisis plan. With their understanding of evidence-based therapeutic treatment programs, the trainee can make recommendations for interventions, which may include other members of the family or social context. The resident can assist in providing training for the family in structured problem-solving techniques and encourage the family to expand their social support networks (e.g., participation in multifamily groups). If the resident has not acquired specific skills in family therapy, he can refer the family to a family therapist for more specialized help (Heru 2006). During training, the resident should preferably have some "exposure" to couple or family therapy. By incorporating these skills in residency training, psychiatrists should be competent to include family members in the assessment and treatment process and obtain a better outcome for the patient and his family.

Conclusion

There is a strong association between family interactions and psychiatric disorders, which has led to the development of different evidence-base couple- and family interventions in in child, adolescent and adult population. Some basic understanding about how families and psychiatric disorder may interact may help the psychiatric trainee to take a more interactional stance in the assessment and treatment of psychiatric disorders with families as a collaborative resource.

Cross-References

► A Global Perspective on Psychiatric Training
► Training in Psychotherapy

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