The Family in Family Medicine
Graduate Curriculum and Teaching Strategies

Second Edition

Developed and Compiled
by the
Society of Teachers of Family Medicine
Task Force on the Family in Family Medicine

1989

The Society of Teachers of Family Medicine
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Society of Teachers of Family Medicine
Task Force on the Family in Family Medicine

In 1981, at the Annual Spring Conference of the Society of Teachers of Family Medicine in Boston, a challenge was made by this author. The challenge developed from frustration and personal loss. The question was, "Where is the family in family medicine?". This led to the development of the Task Force on the Family in Family Medicine and a survey that led to the first monograph, The Family in Family Medicine: Graduate Curriculum and Teaching Strategies.

Now, seven years later, this new monograph is the result of a similar survey with surprising results. The family in family medicine is alive and well; it has taken new curricular forms and methods, and diversity is evident. It continues to be interdisciplinary, a partnership with psychology and social science, with much input from family doctors. One has to be impressed with the great progress that has been made over such a short time frame, and in particular, in the short life cycle of our discipline. It is obviously the result of renewed effort and much work by sincere members of our discipline who feel that the family in family medicine is indeed the cornerstone of our specialty. I think the future looks bright for the continuation of this modality of curriculum and wish to thank the task force for giving me an opportunity to make these comments.

By Roy J. Gerard, MD
Professor and Chair
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One Path Toward Integration of the Family Into Family Medicine

Family practice basically developed from the long-standing tradition of general practice. The name "family" was added for political purposes and not because the majority of the pioneers believed in the importance of the family in family practice, the clinical specialty, or family medicine, the academic discipline, to use Carmichael's distinction. There were, however, a small group of people who believed that unless the family was integrated into all aspects of family medicine and family practice, there was a danger that our discipline would not have a body of knowledge uniquely our own. Without this unique area of expertise there was a real danger that medical schools could cover the other areas of general practice/primary care education and research without using family medicine, and therefore there might not be a valid reason for our continued existence as an academic discipline.

In addition to this external danger, there is an internal opposition which must be dealt with. This was brought home to me by the reaction of two leading members of our discipline (both of whom subsequently became presidents of STFM) to a lecture I gave on "Family Diagnosis" at the John Cassel Memorial Symposium in 1977. Their reaction was that family diagnosis, as I had outlined it, was a pipe dream and, by implication, had no place in family medicine or practice. Although they did not state it as such, their view might be restated as implying that although the family might be important, unless family assessment and management can be made realistic and become integrated into everyday practice, it will not be adapted by the discipline or specialty. This is an important point, so let us look at how much we have accomplished in the development of our conceptual and classificatory thinking.

In 1964 Medalie described five levels of practice: 1) symptomatic, 2) case approach, 3) whole person, 4) individual-in-family, and 5) family-in-community. McWhinney in 1969 categorized three levels: 1) clinical, 2) individual, and 3) ecological. Approximately one year later, Dykhuis in Holland, building on Medalie's classification, described five tasks of the practitioner: 1) primary assessor, 2) general physician, 3) personal doctor, 4) family doctor, and 5) community doctor.

Medalie (1978) classified and described our levels of practice as follows:

1. Individual level
   -- Case approach
   -- Whole person
2. Family level
   -- A family orientation
   -- The family as a unit
3. Community level
   -- The practice
   -- The neighborhood
   -- Community networks
   -- Special groups

Since then an interesting development has occurred. On the one hand, there has been more specification around levels of practice, and on the other hand, there have been more details of individual and family diagnosis.

The levels of practice areas received two important infusions at the family and community levels. Doherty and Baird described the range of ways physicians are involved with families as: Level 1, minimal emphasis on family; Level 2, ongoing medical information and advice; Level 3, feelings and support; Level 4, systematic assessment and planned intervention (family counseling); and Level 5, family therapy. A few years earlier, Kark described a scientific basis for application at the community level and the expression "community oriented primary care" (COFC) has caught on, with people like Mullan, Farley, Mettee, Massad, and Nutting leading its development in the United States.

In a parallel and important development, others have concentrated on individual and family diagnostic categorizations. An important breakthrough in this area was Glenn's contribution of the multi-axial diagnostic system. This included: Axis I, physical disorders; Axis II, psychological disorders: 1. individual, b. family; Axis III, personality and developmental disorders: a. individual, b. family; Axis IV, psychosocial factors; and Axis V, optimal level of functioning in past year.
On a parallel front the family has been the subject of examination. Many family therapists such as Minuchin, Bowen, Epstein, Ackerman, and Whitaker, just to mention a few of the pioneers, had developed family diagnosis schemes for their discipline. However, their schemes were inappropriate for family practice, so attempts have been made to adapt and modify these to make them suitable for family medicine. Practitioners working in our field who had family therapy training were at the forefront of these endeavors. People such as Ransom, Worby, Talbot, Christie-Seeley, Kosch, Cole-Kelly, etc., have been very active in this regard. Similarly, family physicians without family therapy training, like Smilkstein, Huygen, and Medalie have attempted comprehensive family assessment schemes where family functioning is only one, albeit very important, aspect of an overall diagnosis.

These developments varied but have transported us a long way from the individual approach of general practice. Much has been done, but much remains to be done before “the family” is integrated into family practice; thus, the vital importance of the Task Force on the Family in Family Medicine

By Jack H. Medalie, MD, MPH, FAAFP
Dorothy Jones Weatherhead Professor
Case Western Reserve University

References

Teaching About Family in Family Medicine

The struggle that family medicine as a discipline has had with integrating attitudes, knowledge, and specific skills of involving families in health care is part of our overall difficulty of maturing as a medical specialty. We have come from the roots of the general practitioner (GP)—the personable, broadly skilled generalist—at a time in medical history when specialization has become the symbol of societal and personal success. As generalists we have continued to do well in the marketplace where consumers desire a personal primary care physician. However, now that other specialties are more intent on claiming a "primary care" identity, we have been uncertain how to distinguish ourselves from others. This is particularly troublesome since fewer and fewer family physicians are doing obstetrics, general hospitals have become multiple floors for intensive care, and family physicians are practicing more and more adult and geriatric medicine. How are we really different from general internal medicine and from those trained in the combined med-peds program?

This survey demonstrates one of the ways in which we are unique among medical specialties. We have become interested in and moderately knowledgeable about families as they relate to health care. As a medical discipline, family medicine can now demonstrate an expanding literature integrating family systems theory and medical practice, an array of family social science and family therapy professionals with whom we collaborate for teaching, research, and patient care, and widespread attempts to integrate family issues into our training programs. No other medical specialty has demonstrated this interest in the family and related contextual issues.

In the past I have been reluctant to boldly state that our collective self-interest would be served by declaring that our specialness related directly to integrating families into health care (family-centered health care). Despite our specialty's name, until recently family issues were not widely discussed in our professional literature, were not commonly demonstrated in our teaching programs, and were not relevant to our research efforts. Much of this has now changed. Fewer questions focus on whether family issues are relevant to our specialty. However, many questions do remain. What is the best method to teach and do research about families and health? How do we integrate physicians or others who are skilled at family interviewing or counseling into practice? How will physicians or others be paid for this time spent with patients and families? What are the benefits and risks involved? How do we create research topics that reasonably assess this activity? How do we maintain an appropriate medical focus while attending to the family or other relevant context of the patient's care?

As demonstrated by this survey, we are heavily involved in asking the above questions. Now we must do what other specialties have done by defining our areas of vital interest. We must confidently declare that family issues are vital to our medical specialty. This survey demonstrates our strength, diversity, and our unanswered questions. At least we are beyond ambivalence. Our specialty's adolescence was painful but exciting. Now we must move confidently into our adult role and responsibly fulfill our potential.

Family physicians are experts at family-centered care. That is our niche! It is distinct from pure family therapy and more focused than general primary care. When we see individual patients we can assist them medically in the context of their family and social surroundings. When indicated, we are skilled at seeing the family together as a unit. On some occasions we can identify when specific short-term interventions or longer-term therapy is indicated. Under special circumstances we, family physicians, may provide these interventions ourselves or with the collaboration of other professionals. In the future our research must investigate the nuances of our specialness as well as explore more routine issues relating to primary care.

By Macaran A. Baird, MD
Introduction

As the Task Force on the Family in Family Medicine reviewed its work in 1987, there was a consensus that the annual workshop meetings showed that teachers were developing richer, deeper, broader, and at the same time more practical curricula on the family. The Task Force directed an update of the survey on Graduate Curriculum and Teaching Strategies, which had been published as an STFM monograph, The Family in Family Medicine, in 1981.

For that original survey, Don Cassata had designed four simple, open questions, and circulated a questionnaire to 383 family practice resident programs. Responses were received from 100 programs (30%), and the responses were presented as one section of the monograph. Abstracts of papers presented at the first Workshop on the Family, commentaries by the parents and godparents of the Task Force, and an extensive bibliography framed the report. Many STFM members and teachers have used that monograph as a source of stimulating and orienting ideas as they develop their own curricula for teaching about family.

The method used for this updated report was to recirculate Cassata's four questions, again to about 380 training programs (some had come and some had gone). Mailings went out in last 1987 and early 1988 and brought responses from 234 programs, a 60% response rate.

A new feature of this edition is the identification of the several programs that contributed each of the items drawn by content analysis from the completed questionnaires. Thus, you will fund in the survey report (Section 1) a clump of numbers under each item representing the program number which was randomly assigned to each questionnaire in the order it was received. Appendix A is an index by program number to lead you to the program locations. The Task Force hopes readers will actually use this directory to keep conversation about teaching family alive and vigorous by networking with colleagues all over the continent.

Network!

Harley Racer, MD
for the
Task Force on the Family in Family Medicine
Section 1:

Survey Responses
Question 1: How Do You Teach (Implement) the Curriculum on the Family?

Summary Comments

The following pages summarize more than 13 kinds of ways to teach the family content of family medicine in graduate training. In comparison with the responses to the 1981 survey, the richness of these ideas in breadth and depth, taken as a whole, is striking. It speaks to the energy and creativity of the many teachers of family medicine who are continuing to develop the content of the discipline and to be able to teach it.

The largest number of programs (136) list didactic sessions as the most common way they teach family content. The content descriptions cover a wide spectrum of family issues, from basic family systems concepts through family structure to such innovative organizing ideas as the “Seven Greatest” family problems (and how to solve them!). Such didactic approaches are designed in many ways: regular weekly lectures; seminars (both in graded levels by resident year and in program-wide formats); intensive instruction during specific rotations; during orientation or on retreats.

Case-centered conferences, either incorporating family content by design in other clinical conferences or by presenting family issues as the central focus of the clinical conference, are the next most-often reported strategies. Several programs build such conferences around required family study by a resident who presents longitudinal and comprehensive dimensions of a single family worked up over time. Some are problem-solving, case consultation conferences that use family therapists or other behavioral medicine clinicians as resources.

There are 95 programs which emphasize the conscious commitment to deal with family content in the process of ordinary daily precepting both in the ambulatory clinic and at the bedside in hospitals and nursing homes. Some programs conduct behavioral science rounds in those settings to address family issues and needs as well as the patient’s individual problems.

Direct work with families by residents under supervision is reported by 87 programs (compared with 37 in the 1981 survey). In many programs residents conduct sessions or participate in co-therapy with a faculty supervisor with their own patient’s families; in some programs residents join as co-therapists for the consultant’s patients. Such involvement of the resident can either be within the training program or in the practice of an outside consultant or agency.

The resident’s work with patients and families is videotaped and critiqued for family content in 83 programs. Critique sessions may be one on one or in a conference setting.

Audiovisual resources that address family content are used by many programs. The most common medium is videotape, and a wide spectrum of subject material is in use, from resident or faculty videos of their own patient interactions as mentioned above, to curriculum on the family or on the approach of the family physician to the family (for example, level of involvement from Baird and Doherty). Some programs have used bits from popular movies to present family content.

Opportunities are provided in 76 programs to observe and work with others who are serving families: family therapists, psychiatrists, and community agencies outside the training program’s own practice, or in some programs, a “family intervention center” is structured within the practice. Home visits and nursing home visits are part of the family content teaching method in 15 programs.

Genograms are alive and in use in 54 programs, sometimes described chiefly as a teaching tool, sometimes clearly in clinical applications. Three programs require genograms in all clinic charts. Other family instruments are used to describe family structure and function in 16 programs.

Some programs organize family systems studies around varied events: community based studies; collected readings in family curriculum; family content in art, literature, and the humanities. Some programs
use retreats devoted to family studies.

Thus, this second survey of *Graduate Curriculum and Teaching Strategies in Family Medicine* collects reports from working teachers. They describe increasingly rich and vital ways of teaching and applying knowledge about families that family doctors can use in patient care.

Again, look at these lists as stimuli for your own teaching ideas and plans. Look up the program numbers in the Appendix and call or write your colleagues for details about their experiences. Reshape their strategies to fit your own program. Perhaps even those programs that reported "no formal curriculum," or "no satisfactory curriculum" at this time will recognize teaching methods they are already using or can readily adapt for their own use. We all do better with a little help from our friends.
QUESTION 1 HOW DO YOU TEACH (IMPLEMENT) THE CURRICULUM ON THE FAMILY?
(STRATEGIES, USE OF A/V RESOURCES, WHERE AND WHEN, ETC.)

NUMBER OF PROGRAMS REPORTING STRATEGY

USE OF DIDACTIC TEACHING AND CONTENT

Didactic sessions
FAMILY SYSTEMS/GENOGRAM/FAMILY MAKEUP/FAMILY STRESS/STEP-FAMILIES
RECOGNIZING FAMILY SYMPTOMS/SEVEN GREATEST PROBLEMS OF FAMILIES AND HOW
TO SOLVE THEM/ALCOHOLISM/CHRONIC ILLNESS....
1, 2, 3, 4, 6, 7, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 21, 22, 23 24, 26, 28, 30, 31
32, 33, 35, 39, 40, 41, 44-50, 52, 54, 55, 57, 59-82, 84-90, 92,
95, 96, 97, 99, 101, 103, 104-123, 125, 154-170, 171, 174, 175, 179, 180,
182-203, 205-213, 215-222, 224, 225, 227-34
TOTAL 136

TEACHING FAMILY IN CASE-CENTERED CONFERENCES
Incorporated into other clinical conferences 2, 12, 52, 55, 56, 70, 71, 79,
80, 81, 83, 84, 86, 89, 90, 91, 93, 94, 95, 97, 99, 102, 105, 107,
109, 113, 115, 117, 120, 126, 136, 139, 140, 144, 155, 159, 176, 178, 180, 181
184, 190-198, 200, 207, 210, 212, 215, 217, 221, 224, 225, 230, 233
(61)
Family care clinical conference/family presentations
118, 119, 127, 131, 133, 137, 155, 156, 162, 165, 166, 171, 177, 216
180, 182, 202, 203, 213, 215, 217, 219, 220, 224, 228, 230, 233
(28)
Family study/family interviews/Family Case Rounds
19, 20, 21, 54, 69, 103, 109, 110, 113, 137, 142, 146, 155, 157,
175, 172, 184, 194, 224, 227
(23)
Live family interviews in conferences 24, 194, 215
(3)
Monthly psychosocial grand rounds
51
(1)
Resident presentation of family study 43, 103, 224
(3)
Family content/individual cases conference 106, 127
(2)
TOTAL 121

TEACHING FAMILY DURING CLINICAL PATIENT CARE
During individual precepting (in-p/t. & out-p/t.) and rounds
3, 4, 6,7, 11, 15, 16, 17, 20, 24, 30, 31, 35, 38, 39, 42, 51, 55, 56, 61
66, 68, 70, 75, 76, 77, 81, 86, 87, 92, 93, 95, 96, 97, 99, 101, 102, 104, 107, 109
110, 112, 117, 121, 122, 123, 126, 134, 136, 137, 139, 141, 147, 148, 152, 154, 155
156, 159, 160, 164, 165, 166, 176, 177, 184, 185, 189, 193, 195, 197-201, 207
208, 210, 213, 215, 217, 222, 224, 225, 227, 230-2
(89)
During Behavioral Science rounds 7, 76, 131, 135, 150, 177
(6)
TOTAL 95

SUPERVISION OF RESIDENTS WORKING WITH FAMILIES
Individual sessions: residents and families/consultations
1, 12, 21, 28, 33, 62, 119, 125, 165, 198, 202, 205
211, 215, 216, 219, 220, 224, 225, 227, 231-3
(23)
Co-therapy/ family assessment/supervised resident therapy
5, 15, 18, 21, 28, 39, 50, 58, 59, 61, 77, 81, 82, 84, 97, 108, 111, 113, 117, 119,
131, 133, 136, 137, 141, 142, 143, 145, 149, 152, 155, 157, 158, 165, 166
168, 173, 174, 177, 180, 181, 182, 192, 196, 198, 202, 203, 205, 208, 211
214, 215, 216, 219, 220, 221, 224, 225, 227, 231, 233
(62)
Marital/family therapy (resident’s patients)
(2)
TOTAL 87
VIDEO CRITIQUE OR INSTRUCTION
Videotape review (resident-family interaction) individual critique/conference
7, 9, 21, 25, 28, 44, 54, 55, 61, 70, 72, 74, 76, 83, 89, 90, 91, 92, 97, 98, 112
13, 15, 21, 23, 25, 70, 76, 82, 114, 119, 28, 38, 44, 46, 50, 51, 69, 85, 116
122, 124, 126, 131, 136, 137, 141, 142, 145, 147, 148, 150, 151, 153, 155, 157
160, 165, 171, 184-186, 186, 189-195, 197, 199, 201, 203, 204, 211, 214
TOTAL 83

A/V RESOURCES IN CONFERENCES/WORKSHOPS
1, 3, 16, 26, 27, 33, 44, 50, 52, 53, 54, 56, 62, 73, 78, 3, 95, 97, 100,
165, 166, 168, 172, 173, 176, 177, 178, 179, 180, 182, 183, 194, 197, 198, 201, 203
210, 215, 216, 221, 225, 227
 TOTAL 67
(examples of video vignettes):
family problems/ family symptoms
mcdaniel family videotapes
beavers-timberlawn family evaluation
levels of physician involvement with families
resident tapes of their patients' families
popular movies (ordinary people, best friends, annie hall...)
TOTAL 100, 225

OBSERVING AND WORKING WITH OTHERS
M.D. faculty example, working with families
Block rotation
Family counseling rotation/individual supervision
Family Systems practicum elective
Rotation on psych/adolescent psych/chem dep
Family Stress Clinic/Family Stress Center/Family Assessment Clinic/
Chronic Illness Center (within the Family Medical Center)

During home visits/nursing home visits
Social worker/visiting nurse consults
Collaborative training with social work interns
Adolescent/family therapy sessions
Family therapy observation
TOTAL 76

GENOGRAMS
Teaching use of genograms
Supervised use of genograms in Family Health Center
Family Charts/Family diagram in chart
Genograms in all clinic charts
TOTAL 54

FAMILY INSTRUMENTS
Use of instruments (Ecomap/Family Circle/APGAR/Life Cycle, FORE, etc.)
Computer graphics presentations of family interactions
"Family-at-a-glance" printout (Amos Asnon)
Family circles/genogram during resident recruitment
TOTAL 16
FAMILY SYSTEMS STUDIES
Residents explore own family of origin/current family 27,74,133,136,143,190,198,208,225,233
Personal/family counseling for resident/family 100,204
Residents role-play families/therapy sessions 12,21,38,40,93,225
Preceptor-training workshops in family content/methods 19,74
"Life" interviews with elderly patients (family content) 20
During Balint Seminars/resident support group 38,53,100,147,223,225,229
Family psychodramas/simulated family interviews 38,166,190
Family Therapy Club 76,177
TOTAL 33

COMMUNITY-BASED STUDIES
Family Service/community counseling center rotation/crisis center/resident participation in support groups (AA, ARDA, etc.) 134, 58,77,82,83,110,111,125,136,174,189,225,233
Resident teaching of family life education in schools 44
TOTAL 14

RECORD REVIEW
Chart review (family content) individual residents 19,58,92,126,165
Family Medicine Chart Review 63,92,94,95,117,190
Family filing/family billing system/family data card 81,123,182
TOTAL 14

OTHER RESOURCES
Readings in family curriculum (ex., program Source Book, bibliography) 5,7,16,17,62,67,97,102,110,134,137,143,145,210,233
146,161,165,173,182,207,215,219,224,228
Families in art, literature, etc. ("Humanities") 68
TOTAL 26

RETREATS
Retreat/extended seminars devoted to study of family systems, therapy, etc. 183,190,207,215,221,230
TOTAL 6

No satisfactory/formal curriculum at present 36,69,94,132,163,166,169,196,188
TOTAL 9
Summary Comments

Survey respondents answered with a rich and very practical spectrum of concerns that need family involvement. Most teaching about the family is done by direct, natural contact with the patient’s family members because of clinical events that stretch from conception through death.

The largest number of responses cluster around illness, its effect on the family, and the family’s effect on the patient with the illness. The more serious, the more urgent the illness, the more the need for family involvement. Most of these family contacts are far from formal, structured “family interviews,” but occur in intensive care units, emergency rooms, hospitals, clinics—wherever or whenever a threat to the patient’s life threatens the homeostasis of the family. Families are mobilized to work with chronic illness when doctors are “stuck” either in diagnosis or treatment or when the patients are labelled “noncompliant.”

Programs frequently list conditions that by definition are systemic problems: substance abuse and addictions of other kinds; eating disorders; parent-child issues, from baby feeding to teen-age pregnancy to family violence; major psychoses, racial/minority stresses, alternative sexuality. Concerns that can bewilders patients, families, and doctors become opportunities for working with families and thus for “teaching family.”

Teachable moments include major family changes, both of increase and loss; parent-child development (simple well-child visits used to explore the family function around the growth of the child); and therapies of all kinds that challenge the patient (and the family) to consider life-style changes.

Some programs use family interviews proactively as residents hand off their families to the oncoming residents. Others refer families internally to their own family consultation clinics, chronic illness consultation clinics, or other variants of such a model. Some programs simply follow guidelines for working with families that are becoming classic in family medicine literature.

To the question “where?”, most program responded with the expected use of the family practice center and the hospital. It is of interest in planning for space usage that more than 25% of the respondents identified a specific space or physical region of the center as a family consultation room.

Home visits have not disappeared; 20 programs report using home visits in working with families.

When asked about the frequency of family work, program responses fall into two large groups; those that suggest adequate attention to family issues and those that seem almost wistfully to be wanting to do more. The first group uses words like “as often as needed,” “frequently,” “daily,” “part of the flow,” “whenever more than one (family member) is present.” The second group uses words like, “required minimum (1-2 x/year),” “infrequent,” “not as often as desirable,” “rarely,” “few,” and “occasionally.” Some cross-fertilization of the two groups might yield how-to ideas that could activate family teaching in programs that want to do more.
STFM/FAMILY SURVEY

QUESTION 2: FOR WHAT PURPOSES DO YOU SCHEDULE A FAMILY CONFERENCE
OR FAMILY INTERVIEWS/ (WHERE? HOW OFTEN?)

IMPACT OF ILLNESS

Medical illness: acute and chronic/serious/significant/new dx/life-threatening
(ex., depression, somatization, disabling, devastating, cancer, terminal, AIDS, etc.)
3, 8, 9, 11, 15, 19, 22, 24, 25, 31, 35, 36, 40, 42, 45, 48, 49, 54, 58, 63-65, 67,
76, 77, 80, 83, 86, 87, 89, 90, 91, 96, 98, 100-102, 104, 106, 111-115, 119, 120
121, 122, 123, 129, 131, 134, 136-7, 139-142, 146-8, 154-5, 157, 168, 170, 173
175, 177-8, 180, 197-203, 205, 209, 211, 218, 219, 224, 225-7, 230-1, 233-4 (99)

Medical problems involving other family members/family stress-related illness
12, 13, 15, 22, 24, 43, 45, 56, 63, 65, 71, 83, 86, 101, 113, 114, 119, 129, 141
155, 182, 190, 198, 204, 211, 218, 219, 222, 225-7 (31)

Hospital: dx studies/surgery/dying/death/management/code status/autopsy
pediatric admissions/quality-of-life/ethical decisions/AIDS
12, 18, 19, 22, 24, 25, 26, 27, 31, 32, 38, 43, 47, 48, 54, 58, 69, 70, 73, 75, 79, 80, 86
87, 91, 94, 95, 101, 112, 119, 120, 121, 122, 132, 139, 141, 143, 146-8, 155-6, 6,
161, 164, 174, 176, 177, 179, 182-4, 189-191, 194-203, 205, 212, 215, 216, 224, 225-6
231, 233-4 (including angry patient/angry family #18) (120)

Hospital discharge planning
7, 18, 26, 27, 32, 47, 62, 74, 84, 89, 95, 121, 137, 174, 181, 190, 195, 199, 201, 224, 225 (21)

Diagnostic/therapeutic dilemmas ("getting stuck")/new dx/"non-compliance"
(ex., poorly managed asthma, diabetes, dementia dx)/hi utilizers:
8, 19, 24, 25, 26, 27, 32, 33, 35, 36, 40, 50, 54, 56, 58, 62, 75, 82, 86, 88, 90, 95, 97
98, 102, 109, 113, 114, 121, 122, 123, 131, 139, 152, 155, 157, 161, 168, 170, 171, 173
179, 180, 197-8, 200-1, 215, 219, 224, 225, 231 (52)

FAMILY SYSTEM PROBLEMS

Families with problems/intrafamily/family therapy/family crisis
6, 13, 16, 18, 20, 22, 24, 27, 49, 59, 62, 66, 70-72, 74, 79, 83, 91-93, 97, 99, 103
104, 109, 127, 129, 130, 135, 141-2, 143, 152, 153, 157, 159, 161, 170, 173, 174
178-9, 181, 183, 189, 204, 213, 221, 223, 225, 227, 229, 230, 233 (74)

Parent-child issues/conflicts/chronic symptoms/disorders

Couple interviews/marital conflict/discord
3, 10, 11, 17, 26, 28, 32, 35, 36, 38, 40, 41, 58, 64, 68, 70, 74, 76, 97, 227
95, 99, 102, 127, 148, 161, 164, 168, 176, 183, 203, 205, 219, 221, 222, 224, 225, 233 (36)

Sexual problems
11, 35, 197, 225, 233 (5)

Family violence/abuse/neglect
8, 18, 26, 36, 38, 50, 75, 171, 189, 203, 219, 225, 227, 229, 237 (13)

Substance abuse/addiction/alcoholism/chronic pain/co-dependency/adult children of
alcoholics
3, 10, 16, 20, 26, 32, 33, 35, 49, 54, 58, 62, 75, 76, 83, 89, 90, 92, 97, 102, 112, 114, 136
142, 164, 168, 171, 177, 191, 194, 197, 203, 219, 222, 224, 225, 227, 233
ex., interventions
16, 62, 194 (41)

Behavior problems in a family member/child/adolescent/other/school issues
parent issues/child issues/teen pregnancy
9, 16, 17, 24, 26, 28, 29, 32, 40, 45, 50, 58, 68, 74, 75, 77, 80, 82, 83, 88, 90, 92, 95-98
102, 109, 111, 114, 119, 127, 134, 140, 142, 153, 155-7, 164, 168, 179-80, 183, 189, 191
194, 196-7, 200, 202-3, 205, 219, 221, 224, 225, 229, 234 (59)

Emotional/psychiatric/social/stress/racial/minority/gay/lesbian issues/ somatization problems in a family member
12, 16, 17, 22, 29, 30, 33, 35, 43, 48, 50, 69, 77, 80, 83, 84, 92, 95, 96, 99, 100
102, 111-114, 129, 131, 142, 148, 168, 182-3, 189-90, 194, 196, 199, 201, 205
210-12, 215, 223, 224, 225, 227, 230, 233-4 (51)
MAJOR FAMILY CHANGE

Dying, death in family/suicide/grief/pregnancy loss
33,50,64,74,75,83,102,111,113,123,134,139,153,162,164,168
197,213,223,224,225,227,233

Major change in "usual and customary" life pattern of patient/family
14,22,27,30,33,38,42,45,63,70,92,93,97,101,104,109,111,113,
122,131,159,184,190,194,197,203,205,224,231,234

Geriatric assessment/management/care status (DNR/DNI, etc.)/rehab plan
mobilizing/using community resources/nursing home entry
1,7,12,26,31,33,38,42,54-55,58,67,70,77,83,88,94,95,102,106,114,121,122
136,147,159,164,178,180-1,183,187-91,194,197-201,203,205,224,225,227

LIFESTYLE AND EDUCATION

Lifestyle problems (eating, smoking, activity levels, etc.)/health-wellness
19,22,50,92,106,131,190,200,224

During parent-child visits/prenatal care/birth/postpartum
3,8,9,38,74,91,97,112,127,134,137,139,147,157,181,197,203,204,213,224,225

Family conferences for education (ex. child-care, chronic illness)
18,25,62,63,72-3,127,134,181,189,197,205,213

Genetic consultation clinic/infertility

BEGINNING/CHANGING RELATIONSHIPS

Introductory family interview/new families/new physician/
family health assessment 9,15,22,41,82,146,157,215,219,221,233

To enhance family/resident connection

When resident has strong + or - countertransference in a case

Referral for family therapy
82,102,128,227,230

TEACHING/Therapy Plans

Co-therapy (resident/faculty)/family counseling
23,79,82,127,130,142,215,216,225,227,233

Family Crisis/Chronic Illness/Stress Clinic (in the Family Practice Center)
7,201,217,220

Resident/family requests
1,15,16,58,61,137,186,200,225,229,233

Faculty recommendation (from chart audit/predepting/video review)
21,137,233

TEACHING/GUIDELINES

Family study/teaching (residents/medical students)
30,32,33,41,46,82,99,100,105,115,130,136-7,145,198,210,214

Baird-Doherty guidelines (Family-Centered Care)

Schmidt guidelines (J.FamPrac.16:967-973,1983.)

Christie-Seeley guidelines (Working with Families:206-7)

Have not used this method
STFM/FAMILY SURVEY  QUESTION #2 (CONT.)
WHERE?

Family Practice Center
1,2,3,5,7,9,11,12,13,14,18,19,21,24,26-29,31,32,33,35,36,38,40-50
55-59,62,66,67,74,76,77,79,81,82,84,86,88,92,94,102,105,108,111,113
114,119,120,122,123,126-131,135,136,139,142,145,148-51,155-6,158,
161-2,164,168,171-2,177,179,182-4,189-190,192-3,196-7,199,201,203
204,207-8,211,215,217,219-225,230-1,233-4 TOTAL 126
(Family consultation room/Family Consultation Clinic/Family Stress Clinic
11,12,29,43,48,49,50,73,75,76,81,82,111,122,131,142,151,153,156,
173,177-8,183,197,201,220,225 SUBTOTAL 35)

Hospital
1,3,7,12,14,18,19,21,26,27,28,30-35,42,48,52,53,54,55,56,58,62,67
70,74,77,79,81,88,99,94,102,113,122,123,128,129,131,136,139
142,143,148,155-6,161,168,172,174,176,178-9,182-3,187,189-90,
193,195-6,201,203,215,219,222,224-5,231,233-4 TOTAL 74

Home visits
1,31,33,38,41,55,61,77,79,107,113,114,119,120,168,189,203,211,219-20,224
TOTAL 20

Nursing home/Geriatric center/hospice
12,36,70,94,102,114,148,150,190,195-6,224,225 TOTAL 13

Chem dep treatment program 54,136
Physical Medicine & Rehab service 55
Community mental health center 136

HOW OFTEN?

Observed need (as indicated) by resident/faculty/s.w., visiting nurse
1,4,5,7,8,10,11,15,17,19,21,22,23,24,25,26,27,44,45,46,61,82
88,93,94,98,100,109,111,118,128,134,139,140,143,144,148,150-1
171,178,182-3,193,203-4,206,221-2,225,228,232 TOTAL 52

As requested by family member(s) 1,22,26,50,94,109,139,178,193,203 (10)

Frequently/regularly/often
27,43,58,79,136,139,182,184,187,189,216,219,224,231 (14)
6-15x/week (all causes) 77,149,166

Daily/1 per day (all causes)/part of the "flow"/
whenever more than one is present 12,123,131,139,190

Weekly x 1-10/wks/complete brief therapy intervention (ex., 3-8 wks)
5,12,13,49,50,53,54,57,72,75,92,102,109,119,142,145,193,197,215 (19)

One or more times/month
13,14,24,29,36,38,56,57,76,81,89,97,124,130,153,161,177,188,198
201,204,224,217,232,233 TOTAL 25

Several x/yr (assessment/therapy) 35,44,93,190
(Prenatal care) 2-3x/pregnancy 38,74,91

Required minimum: ex., 1-2/yr / videotape 1/yr / quarterly home visit
38,40,46,107,134,177,180,219 (8)

Block rotation on chem dep service 54,136
Block rotation (Human Behavior/Family Assessment) 98,201,215-66
Department Grand Rounds q.o. month 86

Infrequent/not as often as desirable/occasionally/not often/rarely/few
164,173,176,192,220,225 TOTAL 25
Summary Comments

When this question was answered in the 1981 survey, there were about 16 kinds of responses; in the current survey, 38 kinds of resources are identified by the responding programs. The variety and creativity shown by the wide range of sources, the willingness to draw both on familiar and less familiar fields as well as on “lay” people (“our patients,” day care workers, “arbitration specialist”) to enrich family teaching indicates exciting vitality in the growth of the curriculum.

In 1981 more than 60% of the respondents appeared to rely heavily on social workers, psychologists, and psychiatrists for teaching about family. Only 20% actually identified their family physician faculty members (the form of the question may have skewed the response). But it is worth noting that 60% in this sample specifically recognize that their family physician teachers carry significant responsibility for teaching about family. It appears that some of the early questions in the development of family medicine faculties (“Who should teach what?”) are being answered in practice, and in a broadly inclusive, collegial way. To emphasize even more the “family” teaching role of the family physician, it is interesting to find 14 programs reporting that one or more of their family physician faculty members have advanced certification or training in family therapy or family systems.

Stimulating ideas for content come from many programs which draw on rich resources in the community: policy, judges, family violence workers, parent groups, AA and Al-Anon and ACOA members. And almost at the other end of the spectrum, there are highly trained specialists: medical sociologists, anthropologists, communications specialists, ethicists, and educators with several kinds of training backgrounds.

Certainly the people who teach in family practice graduate programs represent the curriculum in the family content of those programs in a way that no neatly written curriculum guide can do.

Combing this list for ideas and calling or writing the programs who use these resource people can refresh your own curriculum as you put it into action.
STFM/FAMILY SURVEY

QUESTION 3: WHAT DISCIPLINES OR PROFESSIONALS DO YOU USE TO HELP IN TEACHING CURRICULUM ON THE FAMILY?

Psychologists 2, 3, 6, 7, 11, 13, 16, 18, 19, 20, 22, 23, 27, 28, 30-36, 39-49, 52-60, 68, 70, 74
75-91, 93, 96-97, 99-101, 103-120, 124-132, 134-7, 141, 142, 145-8, 150, 151
153, 155-6, 158-62, 164, 167, 168, 170-4, 177, 179-181, 184, 186-8, 190-4, 196-9
201-2, 205-6, 207-8, 210, 213, 218, 220, 223-4, 226-7, 229-34 (150)

Family physicians
2, 7, 11, 14, 16, 18, 19, 20, 21, 25, 27, 30-36, 38-56, 58, 59, 61, 62, 65, 66
68, 70, 72, 73, 75-79, 82-84, 86-91, 93-95, 97, 99-104, 106, 107, 109
191, 193, 195, 197-204, 205, 208, 210, 213, 217-222, 224-5, 227-8, 231, 233-4 (147)

Family physician/family therapy trained/some family therapy training
13, 30, 74, 76, 136, 140, 149, 155, 161, 167, 176-7, 197, 204 (14)

Social workers/L.C.S.W./clinical social worker/counselors/psych
3, 6, 14, 15, 16, 18, 20, 23, 24, 26, 27, 31, 35, 39, 45, 46, 51, 52, 53, 54, 58, 61, 62
63, 66, 67, 72, 73, 75-79, 81, 87-89, 92, 94-96, 99, 100, 110-12, 113, 115, 117, 120
121, 122, 125, 128, 130-134, 136-4, 142-4, 146-51, 153, 156-7
159, 164-5, 167-8, 172-44, 177, 181-2, 189-90, 195, 199, 203, 205, 210-11
213, 216-7, 219, 222-3, 225, 227-230, 232-3 (104)

MSW
1, 7, 10, 21, 22, 38, 48, 57, 83, 85, 91, 93, 106, 109, 123, 152
155, 158, 161, 168, 175, 178, 181, 194, 197, 201-2, 207, 213, 225-6 (31)

Psychiatrists
1, 2, 7, 18, 20, 24, 26, 27, 31, 34, 38-43, 44, 49, 50, 53, 54, 55, 57, 59, 62, 66
70, 72, 74, 75, 78, 80-81, 83, 85, 87, 91, 98, 100, 102, 104, 107, 108
111, 115, 116, 117, 120, 125-126, 131, 133, 135, 139, 141-2, 146, 148, 150
151, 153, 158, 170, 176, 179, 182, 186, 191, 193, 195, 198-9, 200, 203, 205
207, 213, 216-7, 225-231, 233-4 (87)

Child psychologist/psychiatrist
29, 32, 131, 168 (4)

Family therapist/family therapy trainee
8, 13, 18, 22, 23, 24, 25, 47, 50, 54, 70, 74, 75, 79, 80, 81, 82, 85, 86, 98, 140
99, 103, 105, 114, 115, 135, 136, 139, 141, 143, 146, 149, 152, 153, 155, 157
166, 178, 183, 187, 189, 194, 196, 203, 205, 206, 210, 215-6, 218, 227, 233 (53)

Nurses/nurse-practitioner/P.A./nurse clinician
6, 20, 27, 52, 59, 76, 87, 90, 93, 94, 104, 106, 117, 153, 156, 160, 1
67, 178, 182, 189, 194, 197, 202, 211, 224-5, 233 (27)

Behavioral scientist
1, 2, 29, 23, 31, 61, 71, 72, 88, 92, 95, 101, 105, 119, 154
182, 184, 186, 191, 192-3, 200, 205, 208, 211-12, 221 (27)

Community resources: police, judges, child abuse/family violence workers
8, 60, 67, 92, 95, 97, 116, 125, 128, 148, 156, 190, 205, 221, 225, 232-3 (17)

Clinical Chaplain/clergy
1, 6, 52, 60, 81, 95, 123, 133, 139, 143, 155, 216, 223 (13)

Alcoholism counselors/psychiatrist
23, 67, 70, 75, 79, 90, 131, 136, 142, 179, 186, 203, 222 (13)

Pediatrician/peds gastroenterologist
18, 36, 37, 41, 57, 68, 84, 92, 104, 151, 155, 182 (12)

Patient educator/educational counselor/Educator (EdD)/adult, child development, family life educators/minority studies
65, 105, 127, 129, 147, 180, 196, 204, 230, 233 (10)

Geriatrician/gerontologist
18, 20, 44, 142, 153, 167, 182, 225, 230 (9)

Obstetrician/Gynecologist
18, 30, 68, 92, 104, 149, 195 (7)

Family counselors
16, 26, 27, 99, 102, 158, 230 (7)

Dietitian
50, 75, 117, 153, 172, 182, 211 (7)
<table>
<thead>
<tr>
<th>Role</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sociologist/family sociologist/medical sociologist</td>
<td>65,123,139,152,170,196,230</td>
</tr>
<tr>
<td>Family social scientist</td>
<td>(7)</td>
</tr>
<tr>
<td>Our patients/extended family/friends/lay teachers (ex., perinatal loss)</td>
<td>38,67,95,128,230,233</td>
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<tr>
<td>Ethicist</td>
<td>75,87,105,155,227</td>
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<tr>
<td>(5)</td>
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<tr>
<td>Internist/Oncologist/Cardiologist</td>
<td>26,68,78,182</td>
</tr>
<tr>
<td>(4)</td>
<td></td>
</tr>
<tr>
<td>Director/coordinator/behavioral sciences</td>
<td>17,18,30</td>
</tr>
<tr>
<td>(3)</td>
<td></td>
</tr>
<tr>
<td>Pharmacist</td>
<td>14,59,182</td>
</tr>
<tr>
<td>(3)</td>
<td></td>
</tr>
<tr>
<td>Medical anthropologist</td>
<td>27,201,233</td>
</tr>
<tr>
<td>(3)</td>
<td></td>
</tr>
<tr>
<td>Residents</td>
<td>38,73,95</td>
</tr>
<tr>
<td>(3)</td>
<td></td>
</tr>
<tr>
<td>Rehab counselor</td>
<td>119,182</td>
</tr>
<tr>
<td>(2)</td>
<td></td>
</tr>
<tr>
<td>Women's issues specialist (psychiatrist)</td>
<td>131,232</td>
</tr>
<tr>
<td>(2)</td>
<td></td>
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<tr>
<td>Home health teams (nurse/MSW/hospice volunteer)</td>
<td>38</td>
</tr>
<tr>
<td>(1)</td>
<td></td>
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<tr>
<td>Arbitration specialist</td>
<td>38</td>
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<td></td>
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<tr>
<td>Christian counselors</td>
<td>50</td>
</tr>
<tr>
<td>(1)</td>
<td></td>
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<tr>
<td>Faculty Development fellows</td>
<td>10</td>
</tr>
<tr>
<td>(1)</td>
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<tr>
<td>Hospital administrator/fiscal</td>
<td>95</td>
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<tr>
<td>(1)</td>
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<tr>
<td>Communications specialist (PhD)</td>
<td>119</td>
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<tr>
<td>(1)</td>
<td></td>
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<tr>
<td>Day care workers</td>
<td>151</td>
</tr>
<tr>
<td>(1)</td>
<td></td>
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<tr>
<td>Families of family physicians</td>
<td>156</td>
</tr>
<tr>
<td>(1)</td>
<td></td>
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<tr>
<td>Sex therapist</td>
<td>178</td>
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</table>
Question 4: What Workshop Topics Would You Like to See
Presented at the Conferences on the Family?

More than just a list of subjects for workshop planning, this question yields a hundred ideas, calls for help, evidence of program strengths ready to share, needs to be met, or interests to be pursued in building curriculum on the family.

For this report, the responses are clumped into four general categories:
  • Family Systems Content
  • Teaching Methods
  • Working with Families
  • Practice Issues

Searching these lists may turn on ideas for curriculum you may not have developed or may stimulate you to make contact with the programs that offered those ideas.

Family Systems Content

How do you use the family systems thinking in the practical assessment of families while taking care of the business of being a family doctor? What should family doctors learn about systems approaches to family structure and function when they are dealing with healthy families, multigenerational family relationships, family staging, parenting, grandparenting, and adults relating to older parents?

Some programs want to work on research in family systems (what? and, how?). They are seeking to share or learn from others about defining the family as it is experienced in family practice, genetic imprints in families, and the relationship of family functioning to illness. They want to know about single parenting and alternative family structure (example, gay/lesbian), multiple-problem families, poverty, homelessness, urban and rural family issues, and about family violence in its several tragic manifestations.

So it appears from this survey that interest among family medicine teachers about family systems thinking, practice, and research is at a high level. There is widespread agreement indicated by the respondents that what goes on in families is the business of the family doctor who is trying to take care of any family member. And they appear to be willing to learn both at conceptual and applied levels of understanding what this “family” paradigm of general systems theory can offer in training family doctors.

Teaching Methods

The responses that have been gathered under this umbrella yield an almost plaintive expression of the tension in which the teachers of family medicine live and work: “give us some help in being able to teach family curriculum that is so powerful and attractive and convincing that it will make sense to residents who are most anxious about the demands of ‘good, solid medical science.’ Curriculum on the family has to overcome resistance to ‘soft science’ in both faculty and residents. It has to be so subtle and wily and appropriate that it will make the clinical work of busy doctors more effective. It has to be taught in the working settings where patients are regularly seen—in the examining rooms of the clinic and in the hospital while patients are being treated medically.” (And it can’t make more work for the doctor!) Again and again, the need for training physician faculty is emphasized, and programs are looking for help in getting them to use family concepts in their own practice and teaching.

Other programs want evidence that collaborative teaching of family by physicians and behavioral scientists working together can actually be viable. Some programs raise the question of a de facto division of labor: “medical” by the doctor, “family” by the behavioral specialist. Some of them are discouraged about the possibility of bringing it all together in the personal practice and teaching of family doctors.

Clearly, this section of the survey shows much to explore and must yet to be done in developing effective practice and teaching skills about the family, both for faculty and for residents.
Working with Families

In early meetings of STFM and of the Task Force on the Family, a lot of energy and discussion was invested in learning ways to teach “whole family” interviewing, to “convene the family,” to do “conjoint” therapy with the family to deal with the patient’s behavior. While it was admitted that such interventions by the family doctor would necessarily be “brief therapy,” there was an implication that the new family physician would be recognized as “special” because of the acquisition of such skills, learned from family therapy. Programs still use some of that language in the responses collected in this section of the report, but their suggestions go beyond interest in family therapy skills—really, how to work with families or any family members who become available to respond to almost any clinical problem.

Programs do want to know about “brief family counseling techniques,” and about the teaching of family therapy as a special skills of family doctors, but they also want to be able to work with alcoholic families, families with hypertension or diabetes, approaching family interventions through the initial complaint that brings a family member into care.

One fresh and exciting area of need or interest is the idea of working with families in primary prevention, such as life-style guidance (nutrition, exercise, work, play, avoidance of chemicals) and child/parent development. Some programs are interested in the use and yield of family intake interviews as families enter the practice.

Practice Issues

Mammon’s head, with dollar signs for eyes, rises up in this setting—concerns about the real-world practicability of family assessment and family interventions by family doctors. What about the time constraints, the need to keep volume and productivity up? What about billing for family counseling by family doctors? Do patients even want their families involved in their care?

But at a deeper level, the respondents seem to be asking for convincing evidence that family interventions of many kinds belong in the family doctor’s bag. How family doctors relate to others who work with family issues, how the fees should be allocated between the doctor and other therapists if they are in the same practice, or even how the fees should compare—nuts-and-bolts questions are asked. And then there are the other housekeeping questions about how to work with families in a medical practice: the organizing of a family care system, its charting, quality, cost of care, and outcome measures.

Taken together, these responses to the question describe the need for a great deal of very practical clinical research, some of which is beginning to be done, and the need for discussion in the family practice teaching community of these realities.
FAMILY SYSTEMS CONTENT

Alcohol/substance abuse and family effects 1,54,83,88,116,124,127,130,131
Genetic aspects of substance abuse and depression 1
Traits of the healthy family 9,27,107,144,166,186
Multigenerational families/aging families/old children c/o older parents 16,17,44,81,142,175,180,194,208,221
Long-term effects of growing up in divorced families 16
Definition of "THE FAMILY" (moral, practical, and societal issues) 22,179
Relationship of family and work to health 25,161
Alternative/nontraditional families (cohabiting w/b/o kids/ gay/lesbian) 26,78,179

Single-parent families/dual-career 66,107,221
Enmeshed/extruded/extended/engaged/disengaged family systems 26
Parenting issues/effective parenting 27,44,92,221
Research in family systems/family medicine (what/how?) 27,44,86,96,97,195
Grandparents' problems / lonely and neglected elders 42,159
"The problem child" and the family/school behavior problems 49,69,80,111,229

Developmental life cycle of the family 52,89,132
Genograms/ family conferences/research validation? 53,195,210
Ethnicity/religion/humanism/newly-immigrated/other cultures/sub-cultures 59,194,223,233

Family violence/incest/sexual abuse 54,131,194,229
Advanced workshops in psychosomatic families 77,163
Recognizing patterns of family dysfunction 79
Multiple problem families with limited resources/poor families rural/inner city 80,116,135,233

Families with impaired adult children 81
Relating identified patients to their families' issues 81
Illnesses: family causes/responses/coping mechanisms 81,94,127,144,157-8,161,166,176
Family and depressive disorders/anxiety disorders 83,111,175,194

Family's role and function in life/death decisions (advance directives, etc) 90,95,158

Demanding families in hopeless situations 95

Needs of the caretaker of a chronically ill family member 138
Screening/assessment instruments/validation 195
Relating environment/social influences to family health 148
Applying family systems theory in the work setting 176

AIDS/gays/IV drug abuse in families 176,194
Adoption/effect on family 193
Homeless families 194
Family issues from literature/other humanities 197
STFM/FAMILY SURVEY (CONTINUED)

TEACHING METHODS

How to make (family systems curriculum) exciting to uninterested residents applying family systems to family medicine
3,204,210,212

Keeping residents and faculty practicing "family" in daily practice 7,20,24
32,74,152,175,203,204,224

Design and implement comprehensive family curriculum that really works in the clinical setting/daily rounds 9,24,47,50,51,74,84,94,96,101,109,117
121,12-3,160,170,193,195,196,203,204,205,210,212,219,227-8,230

The effect of residency training on the resident's family
10

How to use videotaped family counseling sessions in group review 11,163,175

Overcoming resident resistance to family therapy/family systems thinking 13,40,101,112,157,160,175,204

Designing a family therapy elective (good teaching videos?) 13,28,163,175

Integrating family therapy principles into residents' busy practice 23,75,152,160,193,204,214,218,219,228,230

Workshop/seminar for residents to present specific families to each other 38

Exhibit A/V resources for teaching family concepts and interventions 39,50,67

How to orient interns/students to family thinking and interventions? 48,180

Family counseling by residents: depth/duration/frequency/supervision 55,98,208

Teaching via physicians' own families and families of origin 55,72,78,94,113,119,181

Keys to providing in-service "family" training to M.D. faculty 58,71,76,88,102,112

Demonstrate role-playing for teaching family interventions 60,135

Demonstrate viable MD/Beh.Sc.collaborative teaching of "family" 63,83,98,175,208

Examining residency itself as a family 78

Teaching about families in the hospital setting 79

Use of small group, direct supervision as a teaching context 96

Teaching from the physician's own marriage (or relationship) 119

Teaching "family" on in-patient rounds 163,219

How "soft sciences" can impact "hard sciences" 166

How to include yet one more element (family systems) in our teaching 188

Home visits: content and effectiveness/how to get started 204

Senior faculty: role models/working with families? 204

Designing a resident 1-day or weekend retreat on "family" 219

Strategies for teaching faculty family systems and getting them to use family concepts in their own practices and teaching 224

Getting program directors, FPC directors, and other policy-makers to promote family-centered medicine 226

Too specialized; none of us go/ need counseling/psychotherapy in F.M. don't care for STFM 191,192
WORKING WITH FAMILIES

How to deal with the family's 'seven most common problems' (not itemized) 6
Recognizing family problems/steps to help 6,122,163
How to cope with step-families/divorce 6,16,179,221
Prevention of family problems through preventive medicine:
no smoking/ no alcohol/ no other drugs/ no abuse 6,163,166
Brief family counseling techniques
10,33,58,67,80,88,92,117,122,125,127,129,152-3,175,196,205,214,218,227-8
Dealing with "absent"/sabotaging family members/resistance 12,13,40,112,105,126,163,182

Using Family Circle/Family APGAR/Genogram 209
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Section 2:
Sample Programs
Sample Programs
Family Content Curricula

This section of the report presents examples of family content in 16 of the programs that responded to the survey. This compilation collects, in one place, written descriptions of what several programs intend to teach about family. (Then, of course, as we all know, the actual, daily work of patient care and teaching unfolds, and the need for flexibility and modification to practical reality takes over.) So, these examples are offered not as prize-winning ideals, but more as stimulating conversations about what can be thought of, what needs to be thought of, and what can be done to prepare family doctors as specialists true to their name. In their intentional approach to their work, in their understanding of the crucial importance of family issues in the medical context, in what they will actually be doing with patients and their families, family doctors trained in these ways may well be found working with families as they take care of their patients.

Some of these outlines are clearly the work of sophisticated educators; some breathe the vitality of working clinicians. Some are crisp, logical, and lean, like good road signs, while others suggest brainstorming and gut feelings. Thus, they must represent a pretty good selection of what one needs to learn and to teach about real family practice, they way the real world is both now and after residency.

The Task Force on the Family in Family Medicine lives because of and in order to encourage this continuing conversation among teachers of all styles and backgrounds who contribute to the teaching or emerging family doctors. We hope that these brief notes will be simply signals along a network that can be like an old-fashioned country party line, spreading news like wildfire from house to house.

Let your interest be piqued. Pick up pearls. Be encouraged by what you are already doing well as you compare notes—theirs with yours. And use this collection as an address book/telephone directory to keep in touch.
Sample Program from
Akron General Hospital
Department of Family Practice
400 Wabash Avenue
Akron, OH 44307
1. Curriculum

1.0 General Purpose - Behavioral Science

The purpose of behavioral science in family medicine training is to maximize residents' skills to care for patients. Emphasis is placed on caring for people as opposed to caring for diseased organs. Furthermore, behavioral science teaching will stress the importance of considering family dynamics in the treatment of the individual patient. An ultimate goal of behavioral science program is the treatment of "diseased"/dysfunctional families: "to care for the patient in the context of the family is one thing; to turn the family into the object of care is another."*

Effective therapy for behavioral medicine problems (actually, this is very true for more strictly physical problems as well) requires understanding, acceptance and respect for the behavior, lifestyles and values of others even when these contrast to the physician's personal views.

2.0 Major Objectives

The Family Practice Resident will be able to understand and analyze:

2.1 The family as a system
2.2 The patient as a part of the family system
2.3 The interaction between the physician and the family system and the individual patient
2.4 The issues in interpersonal relationships
2.5 The interactions between the physician his/her values and its impact on the patient
2.6 The impact of illness and disease upon family functioning

3.0 Progression of Curriculum

The progression of the curriculum will involve the resident in:

3.1 Being able to communicate with patients to gain essential information
3.2 Becoming aware of personal values and feelings that impede effective work with the patient
3.3 Understanding his/her own reactions to problems and behavior and how that impacts the patient system
3.4 Learning approaches to manage a wide variety of problems and behavior and understanding how to evaluate the interventions
3.5 Utilizing these treatment procedures in his/her role of family physician in a manner that is effective

* Family Practice: Foundations of Changing Health Care, Geyman, J.P. Appleton Century Crofts Publishers, Chapter 12, pg. 222
II. Overall Objectives for Behavioral Science Curriculum

1.0 First Year Residents

1.1 The resident will be able to:

1.11 Recognize problems in psychosocial functioning
1.12 Consult with behavioral science faculty
1.13 Assess level of functioning
1.14 Refer as appropriate

1.2 The resident will develop appropriate interviewing and communication skills

1.3 The resident will be able to present hard data about patients, state the reason for treatment or referral, identify and clarify emotional problems as they relate to individuals and family

1.4 The resident will be able to identify "actual reason for coming"

1.5 The resident will be able to identify patient at risk (suicide, depression, crisis management)

2.0 Second Year Residents

2.1 The resident will be able to:

2.11 Recognize problems in psychosocial functioning
2.12 Assess level of functioning
2.13 Consult with behavioral science faculty
2.14 Treat and/or refer

2.2 The resident will demonstrate understanding of family systems and structures. The resident will be able to interview entire families when this approach is indicated.

2.3 The resident will be able to establish an appropriate physician/patient relationship in order to facilitate the patient's utilization of the health care system.

2.4 The resident will be aware of and able to utilize ancillary helpers to promote a more effective and efficient system for behavioral/emotional problems.
3.0 Third Year Residents

3.1 The resident will be able to:

3.11 Recognize problems in psychosocial functioning
3.12 Assess level of functioning
3.13 Treat alone or as co-therapist
3.14 Consult and/or refer

3.2 The resident will demonstrate assessment of family functioning, and family counseling skills focused towards problem resolution.

3.3 The resident will be able to demonstrate strategies that will promote greater personal awareness and more efficient management of one's time, energy, professional, and personal lives.

3.4 The resident will demonstrate appropriate leadership and interpersonal skills in dealing with patients, staff, faculty and peers.

4.0 Specific content areas of our behavioral science curriculum are the following:

4.1 The Life-Cycle - developmental
4.2 The Individual - cognitions, behavior and affect
4.3 The Family - systems
4.4 Physician and Patient Interaction
4.5 Special Management Problems
4.6 Psychiatric Interventions
4.7 Professional Adjustment

5.0 Specific goals and objectives relating to the family are:

5.1 Recognize stages of development throughout the family life cycle.

5.11 Newly Married
5.12 Birth of Children
5.13 The Family with Young Children
5.14 The Family with Adolescents
5.15 The Launching Years and Parents Alone
5.16 Retirement and Later Years

5.2 Objectives:

5.21 Identify potential for stress at various stages of family development.

5.22 Record family's previous reactions to past developmental crisis situations.

5.23 Utilize anticipatory guidance to alleviate or reduce amount of stress experienced by family or individual.
5.3 Goal II. Recognize dynamics of family life and the effect on family members.

5.4 Objectives:

5.41 Assess family interactions (between family members), relationships, etc.

5.42 Identify support systems within the families of individual members.

5.43 Utilize strengths of family and individuals in the group during crisis of development, or illness.

5.5 Goal III. Recognize the family as patient.

5.6 Objectives:

5.61 Identify the impact of the family on the health of the individual.

5.62 Identify the impact of the individual on the family during health and illness.

5.63 Utilize skills of short term "family counseling."

5.631 patient education
5.632 crisis intervention

6.0 Specific seminars on the family have been:

6.1 The family as patient
6.2 The family life cycle
6.3 Interviewing the family
6.4 Dysfunctional family relationships
6.5 Impact of disability on the family
6.6 The battered child and his family
6.7 Family's reaction to the abnormal child
6.8 Helping parents help their children - practical tips for the family physician
6.9 The adoptive family
6.10 Working with parents and children in divorce
6.11 Family dynamics
6.12 Family violence
OVERVIEW OF THE
BEHAVIORAL SCIENCE ROTATION

Throughout their three years in residency, our residents are exposed to ongoing Behavioral Science material presented in a variety of formats, from weekly conferences to individual weekly supervision and periodic videotape reviews. Covered during this time are the cycle of normal human growth and development, viewed in the context of the family, social issues and their impact on the family, and the relationship of physical illness to the psychosocial aspects of the family. Within these broad guidelines, self-awareness and interviewing skills are taught. This curriculum provides the foundation on which the Behavioral Science Rotation is built. During this rotation, the educational focus is on the acquisition of family counseling skills.

In June of the residents second year, all second year residents have one month behavioral science rotation, in which their only other patient care responsibilities are to provide ambulatory care two half days a week at the West Side Family Practice Center. The remainder of the time is dedicated to behavioral science education. There are several reasons why the rotation is structured this way. All second year residents are scheduled for the rotation at the same time in order to provide opportunity for group learning, both didactic and experiential, as well as individual learning through direct field placement. Additionally, with all second year residents meeting together, the opportunity builds for these residents to develop good working relationships with one another, so that as they enter their third year and carry on their responsibilities as senior residents, they will have developed the sophistication in their relationships with one another to handle the responsibilities of senior residents in much the way that partners in group practice learn to work and negotiate with one another. Additionally, by not having other pressing patient care responsibilities, the residents are able to dedicate themselves more fully to learning and developing their counseling skills.

Since our program is a Family Practice Residency, the teaching of counseling skills focuses on assisting the residents in learning how to counsel and help families in crisis, and families through short-term problem solving. Consequently, the conceptual framework from which counseling skills is taught is that of a family systems model, employing the techniques and concepts of a number of family theorists, both strategic and structural.

From this program's seventeen years of development in meeting the educational needs of residents, our experience has been that one of the best ways for residents to develop and practice these skills is by placement in community agencies where the resident has the responsibility of being the primary therapist to families in trouble. In placing our residents in community agencies and de-emphasizing their physician status, the residents find that clients relate to them as counselors rather than physicians, and that they in turn feel more comfortable attending to the nonmedical aspects of the client's problems and concerns.

From our experience we have found that having had this field placement in the third year, our residents are far more comfortable in dealing appropriately and effectively with the psychosocial and emotional components that patients bring to them. Through their field placement experience, residents develop
the belief that many of the psychosocial problems are indeed the business of the resident, and consequently the resident feels far more comfortable collecting appropriate psychosocial data and being able to use it with the patient in a way that is helpful to the patient family.

Just as a resident will be exposed to experiences in their surgery rotations which they will not likely do as practicing physicians, or will only do with supervision, the behavioral science rotation serves to stretch the resident to performing and trying out skills, under professional supervision, which they may not choose to do in actual practice later on. The following then is a list, not in any particular priority, of objectives to be achieved during the behavioral science rotation:

1. To develop a sense of cohesiveness with other residents in order to facilitate good working relationships in the third year, and to prepare residents for possible group private practice later.

2. To expose the resident to a variety of short-term psychotherapies, for example, behavioral and rational-emotive, which can be used in treating individuals or whole families.

3. To be exposed to and learn several theories and concepts within the family systems model for assessing the treating family problems.

4. To learn what the resident feels he can treat on his own, what he can treat with consultation, and what it is best for him to refer.

5. To learn major psychiatric categories.

6. To become familiar with psychotropic agents, particularly antidepressive agents and feel comfortable using them appropriately in practice and to be familiar with the psychiatric and emotional side effect of psychotropic medications.

Most of these above-stated objectives will be achieved through the small group learning process, when the residents are scheduled to meet at the Family Practice Center with the Behavioral Science Faculty. There are some additional objectives which are hoped to be achieved through the residents placement in a community counseling agency. Some of these specific objectives are as follows:

1. For the resident to learn to appreciate how counseling agencies operate, in order to be able to use these agencies appropriately in referral processes later.

2. For the resident to be able to develop an ecological assessment of the family.

3. For the resident to be able to assess a family in crisis.

4. For the resident to be able to manage short-term crisis intervention.

5. For the resident to know when individual and family therapy is appropriate, and to be able to choose or refer patient for other therapies as indicated.
6. For the resident to be able to understand problems within the context of the family.

7. For the resident to be able to assist the family in defining problems, and making problem-centered contracts, which include specific goals and how to measure when they have been met.

8. For the resident to be able to assist families in solving problems and improving their level of functioning.

9. For the resident to be able to control the family interview and stimulate interaction as appropriate.

The resident will benefit from the combination of direct ongoing supervision from an experienced field instructor in the agency, as well as from group supervision when he brings particular family situations to the group for general discussion.

The Behavioral Science Rotation is an intense one month experience where the focus is directed toward the development and acquisition of behavioral science skills and knowledge. However, in assisting families in problem-solving, one month in generally insufficient to work with families to the point of goal attainment. Therefore, one half day a week will be available to the resident for a subsequent three to six month period in order for the resident to complete the contract he has negotiated with the clients assigned him in community agencies. Whether the resident goes to this agency to continue meeting with these clients or whether he brings them back to West Side Family Practice Center will be based on the agreements that our Center has with the participating community agency and the client's choice.

Also expected of the resident during the Behavioral Science rotation is that he will designate some time each week to develop his own behavioral science research project, focusing on a significant behavioral science problem that relates to the role of family practice physician. These projects then will later be developed into presentations to other faculty and residents during the third year behavioral science conference schedule.
4.0 Format

The formats that will be used to facilitate the resident's learning will be:

4.1 The behavioral science rotation
4.2 Behavioral science weekly conference and scheduled workshops
4.3 Individual weekly supervision
4.4 Semiannual family practice weekend retreats
4.5 Community seminars and workshops
4.6 Residents meetings
4.7 Team meetings
4.8 Tape review sessions
4.9 Papers and resident presentations

5.0 Faculty

There are two behavioral scientists responsible for planning, implementing, and evaluating the Behavioral Science program.

Their functions are to:

5.1 Establish educational objectives, and review and modify as indicated
5.2 Develop and utilize effective educational resources and materials
5.3 Teach the major portion of the curriculum
5.4 Select the consultants who will provide additional expertise
5.5 Assess the residents' progress in their development of behavioral skills

The Behavioral Scientists share the responsibility for assessing resident performance with the Medical Faculty.

6.0 Evaluation and Assessment

On-going evaluation and assessment are seen as integral to the Behavioral Science Curriculum. Verbal and written feedback are provided to the residents in order to help them better understand their behavior and to set further individualized goals for learning. Residents are encouraged to provide feedback on the behavioral science curriculum to help adapt and change the program to meet resident needs.
III. Program Explanation

1.0 Introduction to Behavioral Science

During the month of July, new residents are introduced to the residency in general, as well as receive specific orientation to behavioral science. This introduction to behavioral science is presented through a number of formats. The overall objectives of orientation are to assist the residents in becoming comfortable with one another and working within the residency, and to begin to identify his/herself as a family practice physician. Some of the ways in which these objectives are achieved are through getting acquainted exercises, learning to become comfortable with the videotape process, sharing ones work with other first year residents through reviews of videotapes, and socializing with other residents and faculty. There is also specific topical material on developing interviewing and assessment skills, understanding the patient and his/her family in terms of his/her total environment, assessing a patient at emotional risk, and learning basic concepts of crisis intervention. Specifics of recognition of depression and evaluation of suicidal risk are included. Additionally, exercises are performed to assist the residents in beginning to learn to function on a medical team.

The behavioral science schedule for July is contained in the orientation manual.

2.0 Behavioral Science Conferences and Behavioral Science Workshops

The Behavioral Science Conferences are held each Thursday from 12:15 until 1:30 in the Conference Room. Content areas of these conferences focusing on areas relevant to family practice medicine are outlined elsewhere. Primary responsibility for presentation falls to the behavioral science faculty. When appropriate and beneficial to the residents' educational needs, an outside consultant gives the presentation. Additionally, each senior resident is expected to give at least one presentation during the academic year, in which he/she presents a videotaped family in which there are significant behavioral science issues. There is also an expectation that each second year resident will present a behavioral science paper based on research pursued during the behavioral science rotation. These papers are presented at behavioral science conferences.

There are workshops on Fridays, twice a month, focused on skill building for second and third year residents in the family practice program. The workshops provide extensive amounts of experiential learning as a major component and teaching emphasis. Extensive skill building in the area of interviewing, family assessment, family sculpting and activities, and therapy are demonstrated and participants of the seminar are encouraged to participate in role plays in order to develop skills in the topical areas presented.
3.0 Behavioral Science Consultation

The Behavioral Science Faculty members are available to consult with residents about patients before or after the patient's scheduled appointment. The behavioral scientists are also available to monitor during a scheduled appointment, in order to offer immediate supervision. These faculty members are available to see patients with the resident on a short term basis, or to provide ongoing supervision of a resident offering counseling to a patient or patient's family. Behavioral Scientists are also available to review videotapes of patient contacts with the resident, and the resident is expected to have a certain number of patient contacts taped, as outlined in the office procedures manual.

4.0 Behavioral Science Rotation

Core Curriculum is covered in depth during the behavioral science rotation at the end of the resident's second year. During this time, residents practice counseling skills in community family counseling agencies, under the supervision of trained field instructors. This agency experience extends into the Fall of the resident's third year.

5.0 Behavioral Science Involvement in Other Aspects of the Residency Program

The involvement of behavioral science into the 8100 rotation is still being explored. Other areas of behavioral science involvement include tape and chart reviews, as well as weekly individual supervisory sessions.
Sample Program from
Barberton Citizens Hospital
Family Practice Residency Program
155 Fifth Street, NE
Barberton, Ohio 44203
This is a longitudinal rotation consisting of one-half day per month throughout the three years of the residency. While on MTS or outplacement rotations, this requirement is waived.

Methodology

1. Prior to his/her half-day of scheduled home visit time, each resident will choose appropriate patients for visits and will contact those individuals to arrange a specific time for the visit. In those instances where a resident is unable to select an appropriate patient to visit, the rest of the home visit team (medical faculty, behavioral scientist) will suggest a patient who could benefit from a visit.

2. Preceding each visit, the home visit team will meet to discuss the individual who is to be visited and to set goals for the visit. The home visit itself is structured to be holistic in its approach. In addition to dealing with patients' medical problems, psychosocial issues will be examined and any management problems will be addressed. After each home visit, the team will process this and follow through with the appropriate recommendations, if any. Finally, each resident physician will be responsible for filling out the "Family Practice Home Visit Form" and will file the original in the patient's FPC chart and place a copy in the home visit master file. Charts are audited on a regular basis in the FPC and these visits will be included with each review.

3. Many of the patients who are visited in the home need to be seen on a regular basis. It is the resident physician's responsibility to make a note in the master home visit schedule book indicating when each patient needs to be seen again.

4. Presently, as mentioned, the home visit team is composed of the behavioral scientist, a medical faculty member, and a resident physician. As the need arises, nursing personnel and/or the patient educator may be included. It is anticipated that as this part of the residents' training grows, medical students from NEUUCOM will be invited to serve as team members while completing Family Medicine clerkships.

Knowledge

Learn the approach of the Family Physician to diagnosis and management of:

1. Home-bound patients.
2. Patients who are temporarily infirmed and unable to easily go to the physician's office.
3. Chronic diseases of home patients.
4. Community resources.
5. Medical techniques used in the home.
6. Nutritional, occupational therapy, and physical therapy home problems.

Skills

Learn to perform home health assessment exams. Acquire diagnostic and therapeutic techniques for:

1. Assessing the needs of permanently, or temporarily, home-bound patients.
2. Physical examinations in the home.

Attitudes:

a. Assess patients perception of their illness and a reasonable expectation of improvement and/or disability.

b. Identify family and personal problems connected with home-bound illness.

c. Understand continuing comprehensive and compassionate care of home-bound illness.

M. Hendricks-Matthews, Ph.D.
Director, Behavioral Science

L. M. Brown, M.D.
Director, Family Practice

12.11.86
BEHAVIORAL SCIENCE

CURRICULUM

There are four areas that will be emphasized during this rotation:

1) Family Systems
2) The resident as counselor/therapist
3) Psychopathology commonly seen in family physician offices
4) Stress management for the resident

Additionally, time will be spent on reviewing psychiatric questions from past In-training Assessment exams and in preparation for the required psychiatric conference presentation.

GOALS

1. Improvement in the quality of patient care by better appreciation of the interplay of psycho/social factors with organic factors.
2. Improvement in patient care by the resident physician emphasizing psycho-social issues in his office interactions with patients.
3. Improvement in the quality of charting: resident will place greater emphasis on the recording of significant psycho-social issues in the patient's life.
4. The resident physician will have a greater appreciation for the importance of stress management in his/her own life.

OBJECTIVES

A. Family Systems

1. Appreciate the importance of family dynamics as it impacts on the individual patient's health and document this in patient's chart.
2. Demonstrate observational and interview skills with individuals during routine office visits that "get at" family dynamics.
3. Demonstrate a knowledge of and comfort with the use of genograms.
4. Demonstrate a knowledge of and comfort with the family A.P.G.A.R.
5. Learn how to assess clinical "red flags" that are indicative of family dysfunction.
6. Have a rudimentary understanding of how a patient's family dynamics and psychopathology relate.
7. Demonstrate an awareness of one's own family dynamics.

41
B. The Resident as Counselor/Therapist
1. Gain awareness into what types of communications with patients facilitate psychological growth and what tends to retard this.
2. Demonstrate good communication skills with patients.
3. Demonstrate the ability to conduct his/her own short-term problem-oriented counseling with patients.
4. Have an understanding of specific treatment approaches for treating anxiety and depression.

C. Psychopathology
1. Be able to describe and recognize the following:
   - depression
   - psychosomatic disorders
   - anxiety
   - character disorders
   - transient situational reactions
2. Demonstrate a comfort with and knowledge of the Diagnostic and Statistical Manual III.
3. Demonstrate the ability to give a mental status exam.

D. Stress Management for the Resident
1. Analyze self to gain greater awareness of stress in own life.
2. Gain awareness/knowledge about various forms of stress reduction e.g. exercise, meditation, yoga.
3. Walk, meditate, perform yoga exercises, or some other stress reducing activity a minimum of 2 times per week (note: time for this is built into Behavioral Science rotation).
4. Keep a journal describing your experiences with the above. It is up to the resident's discretion as to whether journal entries are shared with Behavioral Scientist.

METHODS

The methods that will be used to facilitate the resident's learning include: observation of the behavioral scientist counseling patients; supervised counseling of the resident's patient(s); genograming; utilization of the family A.P.C.A.R. instrument; assigned readings; conferences; experiential sessions on various forms of stress management; journal keeping; discussion/review sessions with the behavioral scientist; and, instructional audiotapes.

EVALUATION

Evaluation will be based on the attainment of the objectives set by the behavioral scientist for the four component areas. The resident physician will also set objectives for him/herself in each of the four areas and will evaluate him/herself on the attainment of these.
Sample Program from
Cuyahoga Metropolitan General Hospital
Department of Family Practice
3396 Scranton Road
Cleveland, OH 44109
SESSION I.

Expectations of Family Month
Four hours each session, 5 afternoons per month
Required Family Interviews
Final Family Project
Levels of Physician Involvement with Families
When to Gather a Family Together
Review Stages of the Life Cycle
Putting a Patient's Problems in Context
Introducing Background of Family Systems Concepts
The Role of Hypothesis Generation

HAND-OUTS:
Stages of the Family Life Cycle-Froma Walsh
Levels of Physician Involvement with Families-Doherty and Baird
The Structural View of the Family-Allmond, Buckley, Goffman
Preventive Medicine and the Family-Janet Christie-Seely

SESSION II.

Family Role-Play
Introduce Structural and Relationship Dimensions of Family Functioning
Possible Hypothesis Generation Related to Structural/Relationship Dimensions
Live Family Interview
Discussion of Interview and Dimensions 1-10 on FORE
Discussion of Possible Hypotheses for Structural/Relationship--Assessment

HAND-OUTS:
Hypothesizing--Circularity--Neutrality: Three Guidelines for the Conductor of the Session- Selvini, Boscolo
The Family as the Treatment Unit-Virginia Satir
Research Linking Stress, Illness and the Family -Janet Christie-Seely
SESSION III:
Introduce Communication and Adaptability Dimensions
Possible Hypothesis Generation Related to Communication or
Adaptability Dimensions
Live Family Interview
Discussion of Interview and Dimensions 11-23 on FORE
Discussion of Possible Hypotheses for Communication and Adaptability Dimensions
Assessment and Specific Plans for Family Interviewed
Level of Interventions

HAND-OUTS:
A Conceptual Model of Psychosomatic Illness In Children - Minuchin
Levels of Interventions - Cole-Kelly

SESSION IV:
Live Family Interviews or Review of Taped Family Interview
Discussion of Interview and Dimensions on FORE
Discussion of Assessment and Plans of Interviewed Family/s
The Process Of Interviewing--Family Interview Questions
The Stages of the Interview

HAND-OUTS:
The Hindrance of Theory in Clinical Work-Whitaker
Family Interview Questions-Cole-Kelly
Outline of Stages of an Interview - Cole-Kelly

SESSION V:
Final Project Presentation
Follow-up Discussion
Final Video Review, Completion of FORE Packet and Discussion
1. The curriculum on the "Family" is taught in three different formats.

(a). The Behavioral Science curriculum devotes at least one third of its time to this subject. Required and protected Behavioral Science Seminar and workshop time is about six (6) hours, in three-hour blocks, per four (4) week rotation, per resident. There are three (3) Behavioral Science tracks, one for each post graduate resident group. Readings, videotapes, and group discussion are the primary means used to facilitate learning in this forum.

(b). In the post graduate year 2, there is a half-day per week for eight weeks of family assessment clinic. Here, the PG-2 resident conducts a family assessment with the direction and co-leader with one of our family therapy consultants - the Family Systems Group of the Institute for Juvenile Research. There are also didactic presentations preceding this. These sessions are videotaped when the equipment is functioning for review later by the resident, or for use in the next format described.

(c). During 8 of the 50 weekly Monday noon conferences, faculty issues presented and taught, usually using case examples on videotape - performed in (b); (just discussed).

MISC: Hopefully family issues, are addressed by the Family Practice attending during the routine one-to-one clinical supervision during the residents weekly outpatient clinics (PG-1s=2 half days/week, PG-2s=3 half day/week PG-3s=4 half days/one week).

2. Purposes of convening a family are as diverse as the physicians, therapists, and families involved - most commonly discussed issues clinic seem to be: a-c in "Family assessment" and c, d, and e in Family Practice Inpatient Service.

(a). Patient with persistent symptom complex.

(b). Child patient with enuresis, encopresis, or chronic pain ("PPP")

(c). Adult patient with chronic medical problem and difficulty with adherence to advised required, diet or medication.

(d). Terminally - ill patient to discuss "DNR".

(e). Chronically - ill adult patient who needs a lot of home nursing care to avoid frequent rehospitalizations.
3.

(a). Family therapists - (degrees maybe - PhD psychology, MSW, M.A. in psychology, etc.).

(b). Clinical ethicist (degree is D. Min.).

(c). Physician - pediatrician with formal 2 year family therapy training; family physicians with or without further formal training.

4. Current format seems, very good to one consistent attendee.

J. Benson, M.D.

Curriculum Committee Chair
Sample Program from
Forbes Health System
Physicians' Office Building
2566 Haymaker Road
Monroeville, PA 15146-3593
WORKING WITH FAMILIES
CURRICULUM

FIRST YEAR

1. Introduction to Family Studies

A. Bio-Psycho-Social model of health care as an approach to medicine viewing the patient in his context.
   1. Define the bio-psycho-social approach
   2. Contrast it to traditional or other specialty approaches to medicine noting advantages and disadvantages of each approach.
   3. Apply the bio-psycho-social approach to case material.

B. The Family defined as a functional social unit having structure, function, and coping mechanisms.
   1. State three definitions of family.
   2. State five each bio-psycho-social functions of the family.
   3. List five major family tasks.
   4. Define family roles/delineate the roles of family members in a sample case.
   5. Analyze a sample family case (health family) for parameters of coping and function from a live exposure. The hy and pe of the family; subjective (what they say) and objective (what they do).
   6. Describe optimal family function in sample case using at least two models of family coping/function.
   7. Describe six different family structures using own patients.
   8. Demonstrate knowledge of key terms (household, family of origin, family of generation, etc.)
II. Family Life Cycle

A. Developmental Model; developmental tasks, crises, transitions, etc. individual and family development

Child Development
Adult Development

1. Demonstrate understanding of the developmental model through case analysis and comparison/contrast with disease model.

2. Demonstrate knowledge of development throughout the life cycle by identifying life stage and tasks described in case material.

B. Concept of the family life cycle
Phases of the life cycle
Developmental tasks at each phase
Nodal points (crises)/Functional and dysfunctional adaptations
Normal life changes and pathological situations/problems
Major variations in the family life cycle (divorce, etc.)

1. Describe the family life cycle phases

2. Relate family life cycle phases to development of individuals in the family

3. Define crisis in developmental terms

4. List developmental tasks for each stage of family development

5. For at least two (resident's own or patient's) families, characterize the life cycle phase, salient developmental tasks, past crises and their resolution, anticipate potential crises, dysfunctions or possible pathological situations.

6. Hypothesize for at least two families connections between life changes and illness. Demonstrate connections by drawing a time line (Rakel) for each family.

7. Describe potential clinical applications of identifying family life cycle stage in PR care (acute, chronic, continuous, comprehensive, preventive care).

IMPLEMENTATION - Interview a family obtaining data on all of the above concepts and present the family in seminar.
III. Health/Illness Beliefs and Practices in Families

A. The family as a meaning producing unit.

The family as a source of health/illness beliefs: ethnicity, religion, ritual, tradition and their role in healing.

The family as a nurturing/healing unit.

Family healers and family health practices.

1. Interview two patient families and describe health, illness practices and beliefs. Describe a significant illness in the family and how it was dealt with.

IV. Assessing the Family - Part 2

A. Using previous content to examine relationships within the resident (FP) family of origin. To develop a concept of health in families. To begin assessing families seen in practice.

1. Be able to conduct a family study using a genogram.

2. On one's own family being able to bring some insight to discussion of it.

3. Demonstrate knowledge of characteristics of a "healthy family" using own family as source of examples of:

   Olson circumplex model
   Beavers model
   Energized family

4. Assess normal families in normative crisis (on videotape and in resident's practice) e.g. post partum home visit, at hospital discharge of elderly relative to nursing home, etc. using the members' self report, compared responses among members, structure of power and communication patterns, interaction, PRACTICE method.

5. Begin to differentiate family health and coping - optimal, marginal, impaired in patient and taped families.

V. Basic Interviewing Skills

A. Joining

B. Data Gathering

C. Integrating
SECOND YEAR

Skills and Assessment Level Two

- Problem definition
- Intervention
- Family problems

Family Crisis and Coping Model

THIRD YEAR

Family Problems Continued
Practicum

INDEX OF METHODS

Readings
Short Presentations
Case Discussions
Unstructured Family Interview and Observation
Seminars
Role Plays
Sculpting
Videotape Review
Family Circle, Family Studies
Family Interview
Individual and Group Supervision
Simulations
Joint Interviews
Live Observations/Demonstrations
Sample Program from
North Colorado Family Medicine
1650 16th Street
Greeley, CO 80631-5399
MAJOR GOALS AND OBJECTIVES

CORE COMPETENCY OBJECTIVES IN BEHAVIORAL SCIENCE EDUCATION:
Family Awareness and Family-Oriented Care

GOAL: TO HELP FAMILY PRACTICE RESIDENTS DEVELOP THE COGNITIVE, AFFECTIVE, AND BEHAVIORAL SKILLS NEEDED TO EFFECTIVELY CARE FOR PATIENTS WITHIN THE CONTEXT OF THEIR FAMILIES.

OBJECTIVE I
After completing a family practice residency program resident physicians will demonstrate knowledge of the role of the family in health and illness maintenance.

GOAL: TO HELP FAMILY PRACTICE RESIDENTS DEVELOP THE COGNITIVE, AFFECTIVE, AND BEHAVIORAL SKILLS TO EMPLOY A FAMILY SYSTEMS APPROACH IN THE ASSESSMENT AND MANAGEMENT OF PATIENT'S HEALTH CARE PROBLEMS.

OBJECTIVE I
After completing a family practice residency program, resident physicians will demonstrate the ability to use record keeping and assessment tools which facilitate knowledge of the family system.

GOAL: TO HELP FAMILY PRACTICE RESIDENTS DEVELOP THE COGNITIVE, AFFECTIVE, AND BEHAVIORAL SKILLS TO INTEGRATE A KNOWLEDGE OF FAMILIES AND THE FAMILY LIFE CYCLE INTO MEDICAL PRACTICE.

OBJECTIVE I
After completing a family practice residency, resident physicians will be able to formulate and implement patient care plans which utilize the resources of the family system.

OBJECTIVE II
After completing a family practice residency, resident physicians will be able to shape plans for the management of patient problems according to the organization and function of patients' families.

OBJECTIVE III
Resident physicians will recognize and manage issues involving healthy family development and normal life transitions.
CORE COMPETENCY OBJECTIVES IN BEHAVIORAL SCIENCE EDUCATION:
Family Awareness and Family-Oriented Care

GOAL: TO HELP FAMILY PRACTICE RESIDENTS DEVELOP THE COGNITIVE, AFFECTIVE,
AND BEHAVIORAL SKILLS NEEDED TO EFFECTIVELY CARE FOR PATIENTS WITHIN
THE CONTEXT OF THEIR FAMILIES.

OBJECTIVE I

First Level Obectives)

After completing a family practice residency program resident physicians will demonstrate knowledge of the role of the family in health and illness maintenance.

(Second Level Objectives)

A. Resident physicians will demonstrate knowledge and understanding of the family's role in health behaviors and attitudes.

1. Resident physicians will demonstrate skills in facilitating family factors which promote good health.

(Third Level Objectives)

a. Assist families to develop programs which encourage illness prevention.

1) Resident physicians will work under supervision of behavioral science faculty to modify at least three of the following lifestyle behaviors which are risk factors for the development of health problems.
   a) smoking
   b) obesity
   c) high stress with low stress management skills and weak social support systems
   d) poor coping style
   e) poor nutrition
   f) excessive use of alcohol and/or drug abuse
   g) unsafe household/neighborhood environment

2) Resident physicians will work under supervision of behavioral science faculty to assist at least three families to establish and/or maintain adaptive lifestyle behaviors by implementing organized wellness programs which include attention to:
   a) nutrition
   b) exercise
   c) communication skills
      (1) stress management
      (2) coping skills
      (3) conflict prevention and management
      (4) self-esteem enhancement
   d) negotiation of the family life cycle

*For an explanation of First, Second and Third Level Objectives, see Preface.
3) Resident physicians will work under supervision of behavioral science faculty to facilitate adaptive interaction patterns between family members in at least three families in their practice.
   a) encouragement of individual autonomy and growth for all family members
   b) appropriate level of emotional connectedness, without excessive distancing or overinvolvement
   c) clear delineation of generational boundaries (spouse/parent/child)
   d) cooperative spouse-parent alliance
   e) flexibility of attitudes and behavioral options
   f) negotiation and conflict resolution
   g) problem solving and decision making
   h) health habits and lifestyle; self care

6. Resident physicians will demonstrate knowledge and understanding of the family's role in illness behaviors and attitudes.

   1. Resident physicians will demonstrate skills in dealing with family factors which contribute to the occurrence of illness via family case conferences on behavioral science faculty supervision.

      a. Family stress and symptom development

      b. Family factors exacerbating the course of illness

         1) acute illness
            a) severity and recuperation
            b) after effects--disability (physical or psychological)
            c) recurrent episodes of same, similar, or different illnesses

         2) chronic illness
            a) severity
            b) relapse/remission periods
            c) effects on functioning during active illness
            d) long-term effects on functioning/disability

   c. Effects of illness on the family

      1) alteration of family structure--boundaries, control, role expectations
      2) changes in family atmosphere--mood, communication, problem solving, decision making
      3) impact on family functioning
         a) the negotiation of family life cycle transitions and phases
         b) autonomy of individual family members
         c) emotional closeness between members
         d) nurturance of self-esteem of individuals
         e) intimacy and sexuality
         f) role expectations
d. Assist families with family histories that suggest increased risk of health problems that involve family dynamics prominently.

1) problems with alcohol and/or drugs
2) depression
3) "bad nerves"/anxiety
4) physical violence between family members
5) unwanted/unplanned pregnancies
6) suicide
7) psychiatric hospitalization/nervous breakdown
8) difficulty with the issues involved in life cycle transitions/phases (e.g., adolescence, parenthood)

f. Identify and deal appropriately with families whose interactional patterns are contributing to illness behaviors.

GOAL: TO HELP FAMILY PRACTICE RESIDENTS DEVELOP THE COGNITIVE, AFFECTIVE, AND BEHAVIORAL SKILLS TO EMPLOY A FAMILY SYSTEMS APPROACH IN THE ASSESSMENT AND MANAGEMENT OF PATIENT'S HEALTH CARE PROBLEMS.

OBJECTIVE 1

After completing a family practice residency program, resident physicians will demonstrate the ability to use record keeping and assessment tools which facilitate knowledge of the family system.

A. Resident physicians will have knowledge of at least 3 of the following evaluation methods to elicit information selectively about patient's families:

1. Genogram (Family Tree) (Jally)
2. Family Circle Drawing (Thrower, et. al.)
3. Family APGAR
4. Family Inventory of Life Events
5. Family Inventory of Resources for Management
B. resident physicians will demonstrate knowledge of the use and/or design of medical records that facilitate family-oriented care.

1. Chart information in patient's medical records by making entries on the problem list, in the progress notes, and on special forms or flow sheets about:

   a. The composition of the family
   b. The history of the development of the family
   c. Family dynamics (psychosocial interior)
   d. Relationship of the family to society
   e. Family history of medical and psychological problems
   f. Significant family problems, past or present
   g. Health education about family health issues
   h. Counseling of one or more family members

C. Resident physicians will demonstrate skills in interviewing an entire nuclear family, with or without members of the extended family present, and assess the structure and function of the family with respect to a particular problem or illness of a family member.

1. Resident physicians will be supervised by behavioral science faculty in calling for and conducting family interviews in at least five of the following instances:

   a. Treatment failure
   b. Symptom recurrence
   c. Confusing complexity of symptoms without a clear explanation of nature of problem (likely psychosomatic or psychophysiological problems)
   d. Chronic illness
   e. Serious acute illness
f. Problems requiring major lifestyle changes

h. Death
   1) anticipatory grieving
   2) appropriate mourning
   3) adjustment to the loss and planning for the future

i. Crisis
   1) accident
   2) natural disaster
   3) crime
   4) any event so defined by the patient

j. Child care and child care problems

k. Marital problems

l. Psychosocial problems especially persistent depression, anxiety, and somatization

m. Making a referral

2. Elicit enough information during a family interview to assess.
   a. The history, nature, and severity of the presenting problem
   b. The structure/organization of the family
   c. Communication patterns of the family
   d. Family expectations for therapeutic outcome

3. Manage the time available for the family interview effectively, with a well-organized closure phase.

GOAL: TO HELP FAMILY PRACTICE RESIDENT DEVELOP THE COGNITIVE, AFFECTIVE, AND BEHAVIORAL SKILLS TO INTEGRATE A KNOWLEDGE OF FAMILIES AND THE FAMILY LIFE CYCLE INTO MEDICAL PRACTICE.

OBJECTIVE 1

After completing a family practice residency, resident physicians will be able to formulate and implement patient care plans which utilize the resources of the family system.

A. Resident physicians will establish treatment strategies which best serve the patient and their family. Resident physicians will demonstrate the capacity to:

   1. Develop an alliance with different family members who can support treatment.
2. Involve family members in increasing patient's compliance with treatment regimen.
   a. Medications
   b. Lifestyle changes
      1) bedrest
      2) exercise
      3) diet
      4) emotional expression
      5) work habits

3. Evaluate the impact of treatment on the family at such times as:
   a. Hospitalization
   b. Chronic illness
   c. Nursing home placement
   d. Major surgery or other invasive procedures

4. Conduct family counseling with supervision of behavioral science faculty for at least three families with a minimum of 4 sessions each.

5. Acknowledge personal limits in assessing and treating families and refer when appropriate.

6. Coordinate care as the primary physician.
   a. Ability to develop a relationship with a therapist such that treatment plans are shared and coordinated
   b. Developing a plan for consistent communication between professionals during the period of shared treatment

7. Utilize community resources
   a. Agencies
   b. Other physicians
   c. Therapists
   d. Schools
   e. Religious institutions
   f. Community groups
   g. Employers
8. Utilize influence to increase the likelihood of a referral will be successful.
   a. Calling the consultant or therapist
   b. Convening the family or relevant subsystem to discuss the referral
   c. Framing the reasons for referral around the patient's chief complaint
   d. Experiencing confidence in the consultant
   e. Using a follow up appointment with the patient or family to support the referral and assess progress

B. Resident physicians will demonstrate skills in serving as an advocate for the patient and family in medical settings including

   1. Maintaining involvement with the patient and family as the coordinator of health care, regardless of the level of care.
      a. Health problems for which the family physician is responsible for providing definitive care (primary responsibility)
      b. Health problems which require shared support from other health care resources, in addition to help from the family physician (shared responsibility)
      c. Health problems which require referral to another health care professional, and for which the family physician only needs to support the referral process (supportive responsibility)

**OBJECTIVE II**

After completing a family practice residency, resident physicians will be able to shape plans for the management of patient problems according to the organization and function of patients' families.

A. Using family conferences appropriately in follow-up care and management of health problems.

   1. Use family conferences effectively to manage
      a. Stress-related disorders
b. Informed cooperation of patient and the family with management recommendations (adherence, as well as the even-worse term, compliance, implies patient passivity vs. activated participation in the care)

c. Marital and sexual problems

d. Parent-child problems

e. Chemical dependency

f. Depression

g. Anxiety disorders and problems

h. Somatoform disorders

F. Managing various health problems with a family-oriented approach.

1. Manage health problems of certain types by assessing the family situation carefully and forming management plans that incorporate family factors integrally

a. Problems associated with the family having difficulty with a life cycle transition or phase

b. Problems or recent origin that appear to be situational in nature, related to family factors

c. Illness or illness-related problems that stem from how the family interprets illness and provides support for its members

OBJECTIVE III

Resident physicians will recognize and manage issues involving healthy family development and normal life transitions.

A. Resident physicians will demonstrate ability to link the presenting problem to the patient's and family's current life cycle issues.

1. Understand the problem in context

2. Communicate an understanding of the patient and family's current difficulties

3. Activate the family's resources to help with the problem

B. Resident physicians will demonstrate knowledge and understanding of specific aspects of the family life cycle including:

1. Changes over time
a. Resident physicians will demonstrate skills in identifying healthy family functioning

1) sharing of power
2) high level of individuality
3) intimacy
4) problem solving ability (no scape goating)
5) openness to feelings of others (empathy)
6) clear patterns of communication (avoiding hidden agendas, mixed messages, etc.)

2. Sequential stages
a. Leaving home
b. Coupling/marriage
c. Family in the making
d. Family with young children
e. Family of adolescents
f. Mid-life and the empty nest
g. Retirement
h. Old age

3. Developmental tasks - Resident physicians will demonstrate skills in assessing and assisting families achieve stage-critical family developmental tasks.

a. Married couple
   1) establishing a mutually satisfying marriage
   2) adjusting to pregnancy and the promise of parenthood
   3) fitting into the kin network
   4) renegotiation of relationship with parents

b. Childbearing
   1) having, adjusting to, and encouraging the development of infants
   2) establishing a satisfying home for both parents and infant(s)
   3) negotiation of grandparent roles

c. Pre-School age
   1) adapting to the critical needs and interests of pre-school children in stimulating, growth-promoting ways
   2) coping with energy depletion and lack of privacy as parents
d. School-Age

1) fitting into the community of school-age families in constructive ways
2) encouraging children's educational achievement

e. Teenage

1) balancing freedom with responsibility as teenagers mature and emancipate themselves
2) establishing postparental interests and careers as growing parents

f. Launching center

1) releasing young adults into work, college, marriage, etc. with appropriate rituals and assistance
2) maintaining a supportive home base

g. Middle-aged parents

1) rebuilding the marriage relationship
2) maintaining kin ties with older and younger generations

h. Aging family members

1) coping with bereavement and living alone
2) closing the family home or adapting it to aging
3) adjusting to retirement

4. Normal and unexpected crises - Resident physicians will demonstrate skills in assisting families through both normative and non-normative family life cycle events.

a. Crisis of status change

1) normative
   a) moving to another school/town, etc.
2) non-normative
   a) physical or emotional handicap, etc.

b. Crisis of demoralization

1) normative
   a) adolescence, etc.
2) non-normative
   a) delinquency, etc.

c. Crisis of addition

1) normative
   a) birth, adoption, etc.
2) non-normative
   a) assimilate step-father, step-mother, step-siblings into the family, etc.
d. Crisis of abandonment
   1) normative
      a) elderly friend or elderly family member dies, etc.
   2) non-normative
      a) child banished from family or runaway, etc.

5. Anticipatory guidance - Resident physicians will demonstrate skills in providing anticipatory guidance based on family life cycle events and developmental tasks.
   a. Premarital examination
      1) thoughts on marriage
      2) finances
      3) sexual relationship
      4) family planning
      5) in-laws
      6) role responsibilities
   b. First pregnancy
      1) planned?
      2) feelings about pregnancy
      3) expectations regarding infant care
      4) common changes in pregnancy (physical & psychological)
      5) increase fathers involvement
   c. Other pregnancies
      1) sibling rivalry
      2) mutual feelings of both parents
   d. Child development
      1) expectations
      2) learning
      3) socialization
      4) school
      5) poison
      6) accidents
   e. Adolescence
      1) adolescent tasks
         a) separation
         b) sexuality identity
         c) individual identity
      2) changing role relationships
   f. Marital problems
      1) role relationships and expectations
      2) allow ventilation of expressed affect
g. Empty nest
   1) explore concepts of loss  
      a) children  
      b) aging  
      c) expectations  
   2) facilitate discussion of past mutuality  
   3) encourage adoption of new joint ventures  

h. Aging parents  
   1) promote discussion with family members  
   2) inoculate family against possible feelings of guilt  
   3) help mobilize support resources
Sample Program from
McKeesport Hospital
Family Practice Residency
1500 Fifth Avenue
McKeesport, PA 15132
FAMILY EVALUATION OUTLINE

I. Patient-Family Name

II. Identifying Information
   a. Age, race, sex, marital, occupation

III. Family Composition
   a. Those living in the home, significant family members outside home

IV. Presenting Complaint and Their History
   a. The patient's complaint, the family's complaint, the physician's complaint
   b. How long has problem existed
   c. What has been done to alleviate the problem
   d. How does it interfere with patient/family lifestyle or Dr.'s practice

V. Psychiatric History
   a. Patient(s)
   b. Family members
   c. History of psychiatric services - outpatient therapy and/or hospitalizations
   d. Social Service contacts

VI. Pertinent Medical Data

VII. Family Genogram-Family History
   a. Size of family of origin, patients ordinal position among siblings, parent's relationship and parenting styles
   b. Significant events
      1. Deaths, illnesses, divorces, remarriages, family alliances and splits

VIII. Present Life Situation - Sources of Stress and Sources of Support
   a. Health, work, sex, neighborhood, religion, social networks, recreation, social service involvements, extended family

IX. Assessment of Family Dynamics
   a. Subsystem functioning
      1. Spouse - support, accommodation, independence
      2. Parental - nurture, guide, control children
      3. Sibling - negotiate, cooperate, compete
b. Boundaries - rules defining who participates and how clear and flexible
   1. Disengaged - rigid, distancing
   2. Enmeshed - diffuse, overinvolvement, intrusiveness

   c. Life cycle transitions
      1. Newly married couple
      2. Family with young children
      3. Family with adolescents
      4. Launching children
      5. Family in later life

   d. Interactions external to the family
      1. Extended family
      2. Neighborhood, community groups
      3. Health care professionals

   e. Strengths and Weaknesses
      1. Adaptability
      2. Conesiveness
      3. Coping Mechanisms

   f. Meaning of illness to family

X. Formulation of Problem Areas

XI. Strategies of Intervention and Goals

*Some examples of dysfunctional family patterns: (no. IX above)

1. One parent repeatedly allies with a child against other parent.
2. "Parental child" has inappropriate responsibilities for other children.
3. One parent closer to grandparent than co-parent.
4. Unsatisfactory marriage leads one parent to derive too much emotional support from child.
5. Children are able to play one parent off against another.
6. Family physician gets into coalition with one family member against another.
The Family Curriculum in Family Practice Residency Training

I. Review of Other Curricula

II. A Curriculum Model

III. Series of Topical Presentations for the Faculty

IV. Annotated Bibliography
I. Review of Other Curricula

Based on a review of available literature (e.g., "The Family in Family Medicine", STM, 1981) the development of a family curriculum for Family Practice Residents remains an ongoing process and reflects the varying needs of individual residency programs (i.e., rural vs. urban, community vs. university settings). In general, a review of other ongoing programs' philosophies, teaching methods and faculty reflects the same issues which have been discussed at our own Faculty Development Meetings. Programs could be placed on a continuum from the more pragmatic, specific "family and illness management" approach to the more global family systems approach involving more intensive experience and training in doing family therapy. Differences between the programs appear to be related to the specific orientations of the family faculty involved and it is often difficult to tell whether the stated objectives are being met or whether they remain ideas on paper.

In general, however, there seems to be a trend away from an initial effort which was geared toward emulating family therapists toward the development of subject matter and methods of intervention more pragmatically related to the practice of family medicine. As a corollary to this, it is recommended that M.D. faculty should play a primary role in teaching on the family with faculty of other disciplines enhancing and reinforcing the family curriculum objectives. A recent survey of 100 residency programs revealed that the majority use similar teaching methods - lectures (70%), AV reviews (45%), case/family conferences (45%), co-therapy/counseling (37%), support/Balint groups (21%), consultation/precepting (20%) with other methods (chart reviews, readings, outpatient mental health rotations, hospital rounds, home visits, inpatient mental health rotations, films, simulated patients, two-way mirrors, role playing, seminars, and resident recruitment) being used by less than 20% of the programs.

The same survey also established for what purposes family interviews were scheduled: impact of illness on family (39%), family functioning, data base (33%), teaching tool (20%), family counseling (21%), multiple problems in family (19%), treatment/discharge planning (18%), chronic illness (15%), crisis intervention (15%), and other (less than 15%), sexual/marital counseling, terminal illness, childhood behavior problems, first encounter, substance abuse, health education, child abuse, annual health review, family request, patient compliance.
A number of teaching tools have been developed by family practitioners (based on adaptations from family therapy methods) and appear to be quite useful by providing concrete devices by which to evaluate and record data and develop realistic goals for a family. Of those most commonly used (The family APGAR, Genogram, Life Line; Family PGMR, Family Circle, Home visit, Family interview) examples are provided in this report. (We are waiting to receive the family-oriented intake form from Ardogast in Maryland but have included his Family Assessment Schema). The family Apgar, developed by Smilkstein, Seattle, Washington; measures whether the family is a resource for the patient or the source of the patient’s pathology (based on a family member’s perception) and seems to be regarded not only as a utilitarian clinical device but a reliable research tool. It has demonstrated a positive correlation between low Family APGAR scores and high family clinic utilization, a correlation between high APGAR scores and a family’s motivation to cooperate with “ostomy” care (compliance), as well as differentiating family function between groups of school children who were “maladjusted” and those who were not. (see Smilkstein, The when and why of the family APGAR, The Family in Family Medicine, STM, 1981).

While a number of different conceptual frameworks are used to teach family dynamics, including family role and structural analyses, communication analyses, behavioral analyses, and family goals and value orientations, the conceptual schema which seems most relevant to the family physician and which is included in nearly all the family curricula is that of the Family Life Cycle. The Family Life Cycle can serve an important orienting and organizing function for the family practice physician by delineating stages of family development, necessary changes family members must adjust to and the stress inherent in “normative” changes as well as explaining stress related illnesses and the capacity of a family to cope with an illness at a particular stage. (see for example, Horby, C., The family life cycle. J. Med. Ed. 46:198-203, 1971).

The teaching of skills in family management techniques of intervention or how to “work” with a family is a much more complex issue. In part it is related to the overall goals of the family curriculum; that is, whether the training is focused on assessment and management of specific illness situations related to family life or whether family dysfunction and therapeutic efforts to change family interactions are the focus. While the latter is certainly a noble goal, it is questionable as to whether it is realistic to consider this under the aegis of the Family Physician. Obviously, it is not
an either/or situation and the understanding of the family system's impact on illness and vice-versa necessitates a core group of skills, but it is a matter of focus. As Nathan Epstein, M.D. (Brown) psychiatrist and teacher of family physicians recently wrote "For beginning students, engagement (with the family) is much more effectively achieved... when the student therapist respects his patients and his craft and learns how to take a good history of the family problems and to formulate and carry out carefully thought-out diagnostic procedures and treatment plans. In the process of learning how to do these well, the student will develop enough confidence in himself to be able to relate to his patient families in a natural way in line with his own style and personality". (p. 98, International Journal of Family Therapy, 2 (2), 1980, commentary on Wells, R.A. Engagement Techniques in Family Therapy). Geyman reflects this view in his book, Family Practice.

The variety of specific skills or intervention techniques that are taught in other programs often reflects the training of the behavioral scientist who is doing the teaching - be it Rogerian empathic listening, facilitative skills, Behavior Modification's positive reinforcement and behavioral contracting skills or family systems interventions Allen Murray Bowen or Salvador Minuchin. Many programs seem to recognize the value of and include techniques of crisis intervention: reducing stress through direct problem-solving, providing support and structure, and building on strength within the family.


Most residencies report an examination of specific problem situations (e.g. terminal illness, child abuse) through either lecture series or seminar type presentations. In general purely didactic lectures seem less useful than those related to a specific case or videotape presentation. This problem oriented approach seems quite useful in that it allows for the teaching of specific types of situations which the resident may encounter while at the same time examining underlying dynamics of family life and a variety of intervention skills which could be generalized to other situations. A series of such topical presentations has been prepared for the Family Practice Faculty making use of materials available locally through the University Health Center libraries (videotapes and literature).
A number of the programs have integrated a home visit program requiring 1 or 2 home visits during each year (Guidelines are included in this report - see Medalie) some programs make use of a "Family Study" requiring the resident choose 1 or 2 families to follow on a long term basis, including an extensive family assessment, the role of illness in their lives and changes over time with reports to and conferences with a faculty advisor. Some programs have introduced support groups for the spouses but as in any support group the mandate or impetus for this to be carried out successfully needs to come from the recipients. A few programs have instilled research in the area of family dynamics and illness behavior (e.g., Smilkstein at the U. of Washington, Seattle) and although this is in fact recommended by the STEP, it seems it would be most feasible if there are skilled researchers willing to work along with the clinical faculty as it is a most difficult task to combine clinical and research work. Finally, a number of programs have made available to the interested resident a clinical rotation in a mental health center with a focus on family therapy (Virginia has even developed their own Family Stress Center) and it is possible that such an arrangement could be worked out locally also in Pittsburgh.

In summary then, while there is a wide variety of teaching philosophies and formats available the following recommendations are made for a Family Curriculum which is at once easily adaptable into ongoing residency training but which adds a new content focus on the family as a unit.
II. Curriculum Model

A. Goals for Residency Training in Family:

1. Capacity to listen to family members as an active process
2. Ability to observe and interpret interactions among family members.
4. Ability to communicate clearly and facilitate communication between family members.
5. Ability to avoid entangling alliances with individual family members.
6. Appreciation of sociocultural and environmental influences on family life.
7. Recognition of the family life cycle as the evolving milieu for health and illness.
8. Capacity to integrate care of family problems into the traditional care of individual patients.
9. Awareness of oneself as a therapeutic agent with a family.

Adapted from Geyman, The Family in Family Practice

B. Family Case Presentations to the Family Therapist, Behavioral Specialist and Family Physician Faculty.

C. Making of videotaped family interviews with resident/faculty terms (possible use of the McGill University Evaluation Form).

D. Topical subject presentations by Family Practice Faculty:

1. Dementia and the Family
2. Chronic Illness and the Family
3. Terminal Illness, Loss and the Family
4. Evaluation of Early Parent-Infant Relationship: Competency of Parents and Children at Risk
5. Incest
6. Adolescent Problems and the Family
7. Marital and Sexual Problems in the Adult Couple
8. Child Abuse
9. The Family Life Cycle
10. Relationship between Illness and Family Life
11. Single Parent Family
12. The Family of the Physician
13. The Black Family
14. Alcohol and Drug Abuse and the Family

E. Availability of Annotated Bibliography

F. Clinical Elective in Family Therapy
III. TOPICAL PRESENTATIONS

Following is a prepared set of presentations, based on suggestions made by Family Practice Physicians. Each presentation takes about one hour and is based on a brief (generally) videotaped segment, one or two recommended articles and a list of significant points to be covered. The material should generate discussion of family dynamics and individual illness and the role of the physician and can easily be presented by Family Practice Faculty.

Videotapes are all available at no cost through the W.P.I.C. librarian, Mrs. Pat Revis. If your hospital does not have borrowing privileges, you might speak to your hospital librarian about arranging for them or have Dr. M. Block obtain the tape for you. It is suggested that the presenters review the article(s) selected beforehand to orient themselves to the "family approach".
DEMENTIA AND THE FAMILY
Subject: Dementia and The Family

Materials: Videotape: "Helping the Helpers" 27½ minutes.

In three vignettes, Dr. Monica Blumenthal interviews family members (two sisters, a wife, and husband (patient)) about the experience of taking care of the elderly demented family member. No commentary.


Endorfer, C. and Cohen, D. Management of the Patient and Family Coping with Dementia Illness. JFRP 10(5) 131-137, 1985

Videotape: "Age Related Sensory Deprivation" 15 minutes.

Following a brief review of the significance of reduction in vision and hearing, there is a simulated family dinner scene demonstrating the experience of sensory deprivation and its impact on the aged and family members.
Discussion Points: Dementia

1. Educate the family re. usefulness of keeping an orderly house, structured day with familiar surroundings to communicate directly and clearly, and to view suspiciousness as an effort to explain loss and not get entangled in useless battles. Keeping patient active during the day, avoiding naps may help patient sleep better at night.

2. Make sure other medical conditions (e.g., diabetes or urinary tract infection) are not exacerbating condition. Overmedicating may cause delirium.

3. Emotional Support to other family members: in day to day management, decision - to send patient to nursing home, planning about wills and money, expression of negative feelings, and awareness of physical strain.
CHRONIC ILLNESS AND THE FAMILY
Subject: Chronic Illness and The Family

Materials: Videotape "Sybil's Plight. A Family's Adjustment to Catastrophic Illness" -20 minutes

Excerpts from family interview and commentary regarding a case in which the father suffers ESRD and is on heme-dialysis, emphasizing the impact on marital relationship, parent-child relationships (hereditary factors), necessary role adjustments and the stress of living with chronic illness.


Steindl, J.H. et al. Medical condition, adherence to treatment regimens and family functioning. Arch Gen Psychiat 37, 1980, 1025 - 1027.
Discussion Points: Chronic Illness

1. Help family discuss and adapt to changes in roles and responsibilities.

2. If it is a large family, meet with all once to discuss illness and management and get them to appoint a contact person to avoid getting a lot of calls. Meeting with all of them together also avoids them getting mixed messages.

3. If the family is doing the caretaking, suggest that the caretakers build in relief time - vacations, help from others, respite care if possible.

4. Encourage family to talk about negative feelings, to avoid them being acted out (eg. buying improper foods, "forgetting" medications or doctors' appointments).
Harley J. Racer, M.D.
STFM Task Force on the Family
Society of Teachers of Family Medicine
1740 West 92nd Street
Kansas City, Missouri  64114

March 30, 1988

Dear Harley:

The following is a brief response to your request for information about how we attempt to teach the "family in family medicine" at the Fairview/St. Mary's Family Practice Residency Training Program (an affiliate of the University of Minnesota Department of Family Practice and Community Health).

In the first year of residency training, family teaching is accomplished in three major ways:

1) Attached is a description of our "Basic Clinical Psychiatry" course which meets weekly through much of the first year. As you can see from the goals and objectives, the attempt is made to discuss family stresses and resources with each particular problem area that is discussed. This course is co-taught by a psychologist, a family physician, and a hospital social worker, who all work to stress how to involve family and community resources. In addition to this integrated way of discussing the family, this year we added two didactic sessions on how to do a family conference. This is done in the context of dealing with the family about DNR/DNI issues because this has consistently been the area where interns desire family skills.

2) All interns are required to do a three-week Chemical Dependency rotation at the St. Mary's Rehabilitation Unit. One entire week of this rotation is called "Family Week," and residents are required to sit through all lectures and group and family sessions as if they were a family member of the chemically-dependent person. This experience has consistently raised awareness about the power of families and is usually the first time that interns think about their own family of origin.

3) As part of our orientation to the model Family Practice clinic, all interns are observed and videotaped by a family physician. Although the focus of these sessions is on their generic doctor-patient skills, this preceptor is family-therapy trained and works actively to give feedback about how they related to family members and how they can incorporate a family focus into day-to-day family medical care.
In the second year, we offer a monthly seminar entitled "Family Systems in Family Medicine" (course description attached). Two psychologists have primary responsibility for teaching this course, but Family Practice faculty are strongly encouraged to attend and help integrate the didactic principles into family medicine practice. Thus far, three different preceptors have taken the course, including the powerful first session in which families of origin are explored and their impact on us as caregivers is discussed. Although residents respond most to case discussions, experiential exercises and videotapes are used strategically during this course.

The bulk of integrated family teaching occurs, as it should, in day-to-day precepting. We are fortunate to have several medical preceptors who are sophisticated about psychosocial and family issues and who have been actively encouraged to make this a part of their precepting. We are also fortunate to have psychological preceptors with a family systems orientation. When we are asked to consult, we always question family issues and use the chart as a way of raising resident awareness about how to find clues and how to communicate about critical family variables. As psychological preceptors, we prefer to do most of our teaching by actually doing co-counseling with residents. Although a small percentage of our work is with couples and/or families, we have a family-oriented focus with the individual patients. Residents seem to develop a sophistication about family issues after working with us.

For residents who have a particular interest in family counseling, we have been able to develop a working relationship with a local mental health center that actively does family therapy with live supervision. Two of our residents have happily done a rotation in this center. One of those residents did further work with me using some of my own prepared videotapes and doing some family counseling here with videotaped and live supervision. In the future, we hope to develop a variant of a family stress clinic, which will have the dual purpose of service and teaching. If I can be more detailed about particular areas of teaching, please let me know. Thank you for your continuing interest in raising awareness and developing materials with which to teach the family in family medicine.

Sincerely yours,

Leatrice Mankin Sherer, Ph.D.
Clinical Assistant Professor
Licensed Consulting Psychologist

LMS:rab
Basic Clinical Psychiatry
A Course for First-Year Residents

I. Goals and Objectives

1. That residents will understand the impact of illness, disability, or trauma on a patient and his/her family and, conversely, will understand how the patient and family's resources affect recovery and/or coping.

2. That residents will become familiar with assessment procedures and therapeutic options available for the psychiatric problems commonly encountered in family medicine.

3. That residents learn how to work with other health care professionals. This includes understanding how the work context influences relationships among caregivers and how group dynamics can affect the therapeutic alliance of patient, family, and caregivers.

4. That residents become more aware of their own skills, attitudes, and values and that they recognize that these partly determine the choice of treatment plan and role for the family physician.

5. That residents will be able to formulate a treatment plan that will include the family physician's role with the patient, the family, other professionals, and community resources.

II. Course Format

1. Seminar sessions will meet weekly on Fridays from 12:15 pm-1:30 pm. Meeting place will be announced.

2. A calendar, with reading assignments, is attached. Faculty will develop their presentations and lead discussions based on the assumption that residents will have read the relevant material prior to each session.

3. Initial sessions will focus on acute presentations of psychiatric problems and psychological crisis. Teaching format will be lecture and discussion, with residents expected to actively question and provide brief clinical examples.

4. Later sessions will focus on chronic problems and normative crises, with emphasis on care provided in an ambulatory setting. Teaching format will be discussion based on resident case presentations, two cases per topic. The format for these presentations follows.

III. Format for Case Presentations

1. Choose a case which illustrates a particular topic.

2. Indicate in advance when you will present the case.

3. Dictate a summary of the case which will include:
A profile of the patient (demographics, plus a characterization)
Present concerns
A significant problems summary (for both patient and family)
Significant medical interventions
Related family and social data
A characterization of the doctor-patient and doctor-family interactions thus far
Current assessment and management plan—include resources used
Some comments (these can be verbal, at the time of presentation) about your
personal reactions to the case, especially about unresolved issues with the
patient, family, and/or other professionals involved

IV. Text: Clinical Psychiatry in Primary Care (3rd Edition)
Steven Dubovsky, MD, and Michael Weissberg, MD
Williams and Wilkins, Baltimore, 1986.

Residents will be asked to make a payment to cover 1/2 the cost of the textbook.
Payment should be made promptly by writing a check to Smiley’s Point Clinic.

V. Faculty
Leatrice Mankin Sherer, PhD
Patricia M. Cole, MD
Joseph Clubb, Fairview Social Service Department
Consulting Psychiatrists
Allied Health Care Professionals
Course Description

The goal of this course is to help physicians appreciate how family attitudes and behavior affect every aspect of health care. Family variables influence when a person decided to consult a physician, how the patient complies with medical regimens, and what rapport develops between the physician and an individual patient. In turn, medical interventions with an individual patient have the capacity to affect the lives of others in the family. A family physician must constantly grapple with questions of assessment, intervention, role, responsibility, and confidentiality, and these questions are greatly complicated when "the family" is included as an object of concern. This course provides a forum for each resident to challenge his/her answers to these questions.

This seminar meets monthly during the second year of residency. Faculty consists of psychologists and family physicians. Basic principles of family systems are presented by faculty lecture and required readings. Most sessions focus on residents' case presentations. These discussions are clinically oriented and end with a management plan and decision about "family charting."

Objectives

1. Residents will understand the family life cycle, including "normative crises."

2. residents will appreciate the range of functional styles of coping with change and illness.

3. residents will understand how family issues affect common problems seen in family medical practice. Problems covered in the course are: depression, anxiety, stress-related medical disorders, substance abuse, patient noncompliance, marital and sexual problems, and parent-child problems.

4. residents will explore various ways to elicit, assess, and communicate family data significant to patient care. This includes learning how to record family data, make family assessments, and develop plans, using a problem-oriented record format.

5. residents will develop family skills appropriate to primary care medicine:
   - The ability to simultaneously engage two or more family members in discussions about health care.
   - The ability to empathize with disparate family members.
   - The ability to support the family in its efforts to cope with a situation.
   - The ability to assess when a family is dysfunctional and to make an appropriate referral.

6. residents will increase their awareness of being "situationally ineffective" as care providers. They will learn to ask whether a dysfunctional relationship with a particular patient can be credited to the patient's and/or the physician's unresolved family-of-origin issues.

Expectations

1. Prior reading, thinking, and preparation.
2. 75% attendance and active involvement in discussion.
3. 2 case presentations from each resident (suggested format attached).

Readings

Family Systems in Family Medicine
Course Outline
1987-88

Basic Readings: These will inform discussions of family intervention and should be read by the November 17th session:

Text:  
Chapter 2  A Model for the Primary Care of Families  
Chapter 3  Family Systems Theory and Family Therapy  
Chapter 5  Forming a Therapeutic Contract that Involves the Family  
Chapter 6  Guidelines for Referring or Treating  
Chapter 7  Counseling Families

Handouts:  
"Life Cycle and Tasks" Chart  

August 18  
Learning about families from the inside out.  
Reading: Thinking and drawing instructions, under separate cover.

September 15  
Family Assessment: Historical Data  
Reading: Handouts  

October 20  
Family Assessment: Observational Data  
Reading: Text, Chapter 4, "Observing and Assessing Families in Family Practice"

November 17  
Family Intervention: Depression  
Reading: Text, Chapter 14, "Treating Depression in a Family Context"

*December 15  
Family Intervention: Patient Compliance (and Levels of Physician Involvement—presentation by William J. Doherty)

January 19  
Family Intervention: Stress-Related Disorders  
Reading: Text, Chapter 8, "Family Therapy and Family Medicine"

February 16  
Family Intervention: Anxiety  
Reading: Text, Chapter 15, "Treating Anxiety in a Family Context"

March 15  
Family Intervention: Substance Abuse  
Readings: Text, Chapter 12, "Treating Chemical Dependency in a Family Context," and Chapter 13, "Two Interviews for Chemical Dependency Problems"

April 19  
Family Life Cycle: The New Couple  
Family Intervention: Marital and Sexual Problems  
Reading: Text, Chapter 10, "Primary Care Counseling for Marital and
Sexual Problems
Handouts: "Low Self-Esteem and Mate Selection" and "Different-ness and Disagreement", *Conjoint Family Therapy*

May 17
Family Life Cycle: Parenting, Childhood and Adolescence
Family Intervention: Parent-Child Problems
Reading: Text, Chapter 11, "Primary Care Counseling for Parent-Child Problems"
Handouts: "Marital Disappointment and Its Consequences for the Child" and "What All Children Need in Order to Have Self-Esteem" in *Conjoint Family Therapy*

June 21
Family Life Cycle: Launching Children, Moving On and On
Reading: Handouts
Sample Program from
SUNY-Stony Brook
Department of Family Medicine
Health sciences Center
Stony Brook, NY 11794-8461
1. How do you teach (implement) the curriculum on the family? (strategies, use of A-V resources, where and when, etc.)

- At the medical student level: Med III
  During the primary care clerkship, 5 x 1/2 hour sessions are scheduled to discuss the family life cycle and its implications on primary care intervention. Sessions are conducted by a family physician and behavioral scientist.

- At the resident level:
  Introduction to the Family (See accompanying memorandum)

- Grand Rounds:
  One Grand Round was done on the Family in Family Medicine

- Genogram use is encouraged and its relevance discussed when precepting residents

2. For what purposes do you schedule a family conference or family interviews? (Where? How often?)

Mostly scheduled for inpatients, especially when a drug or alcohol problem, recurrent hospitalizations, or terminal illness. On average, one conference/month.

Outpatients: Motivated physicians and residents hold family conferences to have more insight on "recurrent illness patient", "non-compliant patient". This is rarely done, however, and only by the few who are motivated.

3. What disciplines or professionals do you use to help in teaching curriculum on the family?

Dr. Gerald A. Green, Ph.D., Clinical psychologist
Edward Feldman, M.A.M.S.W.
Raja Jaber, M.D. - planning to start training in family therapy July 1986.

4. What workshop topics would you like to see presented at the annual workshop on "The Family in Family Medicine?" (Sponsored by the Task Force each February or March.)

- Family assessment interview for the family physician
- Family health (functionality ?)
- Illness behavior in families
- Boundaries between family medicine and family therapy
- Difference in fee distributions for counseling between therapists and family physicians: how can we surmount it?
MEMORANDUM

To: Residents and Faculty

From: Raja Jaber & Jerry Green

Subject: Introduction to the Family

Date: September 15, 1987

The faculty have agreed that it should be useful to devote a series of noon conferences to a discussion of the family life cycle, team-taught by a family physician and a behavioral scientist. The first of a series of six such conferences will occur this coming Thursday, and we are attaching a series of readings that will be useful bases for discussion not only then, but throughout the series. Obviously, the more who have read these articles, the more useful in our discussions they will be. In contrast to our team-teaching these topics with the third-year clerks, our sessions with residents should be greatly enriched by their ability to include in the discussions clinical examples from their own practices.

September 17  Green & Jaber--The Family I: Family Life Cycle; Stress and Illness
concept of the family life cycle; Holmes and Rahe: stress and illness model; definition of families; when does a family begin?: the concept of family developmental tasks in the cycle

October 29 Feldman & Valdini--The Family II: Fairing and First Parenting
Couples adjusting to each other; pregnancy -- as a decision and as a fact; the family physician's participation in pregnancy, delivery, and the newly-constituted family.

November 19 Shephard & Robbins--The Family III: Launching
letting go: parenting younger kids after there is an "adult" child in the family; relating to an offspring's new independence.

December 17 Green & Froom--The Family IV: The "Empty Nest"
living together without children as a concern on which to focus a couple's efforts; grandparenthood; increase in sorotic concerns.

January 15 Rose & Schwartz--The Family V: The Aging Family
geriatrics: loss; widowhood; death of a partner; the healthy elderly: the circularity vs. linearity of family development and function; extended families.

February 19 Feldman & Trilling--The Family VI: "Abnormal" Families
family APDR: concept of family pathology, diagnosis and treatment in family practice; appropriate time and resources for referral; family dynamics; generational roots of pathology.
Sample Program from
University of Toronto
Department of Family and Community Medicine
1 King's College Circle
Toronto, Ontario, Canada M5S 1A8
People to People Marriage and Family Delegation
Dr. W. Robert Beavers, Delegation Leader

Title of Presentation: Working with Families: A Training Program for Family Physicians

Name of Delegate: Edward Bader

Approximate Time Length: 10 minutes

Visual Equipment Required: Overhead Projector

ABSTRACT

John Evans, M.D. is one of Ontario's best known medical educators. In 1967, he became Dean and founder of McMaster University's new Medical School. From 1972 to 1978, he was President of the University of Toronto. It was therefore no surprise the Premier, David Peterson, asked him to head a panel to review the health care system in Ontario.

In 1987, the Panel released its report. It recommended increased emphasis on care in medical offices and community settings, and an improved cooperation between health services and social services. Dr. Evans explained: "We want young doctors to realize that treating acute incidents in hospitals is only a small part of the health care challenge".

Over the past decade, the Department of Family and Community Medicine at the University of Toronto has established several innovative programs which have been implementing many of the Panel's recommendations. Among these programs is the Working with Families Institute which provides interdisciplinary training in family assessment and family counselling for residents in Family Medicine. The goal of this training is not to produce family therapists, but to enable family physicians to develop some of the skills of the family therapist so that they will be more helpful when working with families who come to them in their practice of medicine. Also,
working together with family therapists and sexual therapists as part of their training prepares the family physicians to understand the perspectives and goals of social services and to work cooperatively with social service providers in the future.

The Institute received funding from the Ontario Ministry of Health on April 15, 1986 for a two year period, with a third year of funding dependent on an evaluation of the program. I act as Coordinator of the Institute and offer eight half-days of training each week at the Flemingdon Health Centre in Don Mills, a residential area near downtown Toronto. Four Toronto hospitals also offer at least one half-day of training in family or sexual counselling each week.

At all sites, the training is interdisciplinary, i.e. social workers, family therapists and sexual therapists work together in a team. On each team there are two trained family therapists, one of whom is always a family physician. The two therapists divide roles during each counselling session so that one co-counsels the couple or family with a trainee, usually of the opposite sex. The other therapist supervises the counselling session through a one-way mirror and, while supervising, also acts as a teacher for other residents observing the session (see accompanying room map). Thus, on a half-day in which three couples or families are seen by the team, each resident will usually co-counsel during one session and observe the other two sessions. The residents ordinarily come for twelve half-day sessions and counsel or observe an average of twenty families, often seeing the same family two or three times during their training.
People to People Marriage and Family Delegation
Dr. W. Robert Beavers, Delegation Leader

Name of Delegate: Edward Rader

Abstract Page 3

In addition to the training in family assessment and family counselling, the Working with Families Institute asks all residents to be involved in preventive, educational programs. At the Flemingdon Health Centre, special attention has been placed on two key family transition points, the transition to getting married and the transition to having the first child. Residents act as co-leaders in a series of educational sessions that "bracket" the event, i.e., they co-lead four pre-wedding and three post-wedding classes for engaged couples. A similar "bracketing" takes place around the birth of the first child, with six pre-natal classes and four post-natal classes (see attached brochures).

Evaluation

Second year residents in Family Medicine are tested on their counselling skills and attitudes at the beginning of their training period, with particular focus on empathy and appropriateness of advice. Then, as each resident completes his or her training, a post-test measure is used. Finally, after the residents have completed their training and established their own medical practices, a third test is given, including questions on how extensively they are now using their counselling training. Preliminary findings were encouraging, and the Ontario Ministry of Health has now approved not only the third year of funding but also given approval in principle for a fourth year. The Ministry has also agreed to give financial support to establishing similar programs for the Family Medicine Training Programs in New Zealand and Australia in 1989.
1) No lectures are given. Instead video-tape films are used, followed by free-wheeling discussions.

2) The course is divided into two sections:
   (a) Before the marriage, four evenings devoted to:
       (1) Communicating in Marriage
       (2) Family Backgrounds
       (3) Finances
       (4) Sexuality
   (b) One Year following the wedding, three evenings devoted to:
       (1) Resolving Conflicts
       (2) Changing Roles in Marriage
       (3) Building a Better Relationship

WHY IS IT?

Research has shown that people who take pre-marriage courses handle conflict better, and if problems do arise they seek help more readily. LEARNING TO LIVE TOGETHER improves your chances of having a more satisfying and more enduring marriage.

WHO LEADS IT?

The course is co-led by the Flemingdon Health Centre's Marriage Counsellor (Mr. E. Bader) and either a physician, nurse practitioner or theological student.

WHEN IS IT?

A new course starts each month and is held one evening a week from 7:30 to 9:30 p.m.

WHERE IS IT?

The course is held on alternating months at either St. Andrew's Church, 117 Bloor Street East, (just east of Yonge-Bloor Street subway station) or at Flemingdon Health Centre, 10 Gateway Blvd, Don Mills (just east of Don Mills Road, three lights south of Eglinton).

HOW MUCH IS IT?

Fees are $70.00 a couple for the seven sessions. This fee will be waived at the Minister's request.

For further information please telephone Cathy Cooper at 429-4991.
early bird

EARLY PREGNANCY: Given by nutritionist and physiotherapist
- Growth and development of baby
- Special exercises during pregnancy (e.g., back care)
- Food habits assessment for future mom and dad
- Prenatal nutrition (e.g., weight gain, foods to eat or avoid)

late bird

STARTING AFTER 5TH MONTH OF YOUR PREGNANCY:

The next five late bird classes will be devoted to learning and practising the breathing techniques for the labour and delivery as well as discussions on special topics of parenting.

LABOUR AND DELIVERY: Given by doctor and physiotherapist
Changes that occur in your last month of pregnancy
Preparing for the trip to hospital; signs of early labour
Delivery; stages and what's happening
Sample Program from
University of Medicine and Dentistry of New Jersey
School of Osteopathic Medicine
301 S. Central Plaza, Suite 2300
Stratford, NJ 08084
The hallmark of family medicine is its focus on continuous, as opposed to episodic, care. Working with the same patients over a period of time provides the physician with the opportunity to observe the complex interaction of physical, psychological and familial aspects of illness, and to make interventions in all these areas.

The goal of the Family Social Science Program of the Family Practice Residency is to teach the resident how to integrate the psychosocial and medical aspects of medicine in the course of treating families. In order to achieve this goal, the program consists of two, two week (part time) rotations with the Family Social Scientist during which residents have individualized programs designed to help them achieve competency in working with patients and their families.

The goal of the Geriatrics Program in the residency is to teach the resident how to provide appropriate care to the elderly population. Caring for an elderly person is complex, with many medical as well as psychosocial issues that must be addressed. The geriatrics program provides the resident with a panel of elderly persons and their families who are cared for over time. It also exposes the residents to community resources that may help with psychosocial dilemmas. During the resident's first year, s/he takes part in a two week geriatric rotation. In the second year, the resident is assigned a panel of nursing home patients who are cared for using the team approach. The resident also cares for homebound patients. Included in the didactic portion of the overall program are seminars concerning geriatric issues.

Components of Programs

A. Seminars--Tuesday and Wednesday mornings, 7:30 - 8:30 Chiefs' Conference Room.

B. Resident Case Presentations: during seminars' time, twice monthly. See attached protocol. Brief summaries of upcoming presentations are to be distributed a week prior to the presentation. Ideally, case presentations' subject matter will correlate with topics being discussed during didactic seminars.

C. Precepting with Family Social Science Program Director - Periodically FSSPD will join residents as they see patients in the ambulatory care centers and on hospital rounds.

D. Two-week family psychosocial rotations (one each year)

E. Evaluations - quarterly with Dr. Ross & Ms. Yudin; self-evaluations pre- and post-program; seminars will be evaluated by residents (see
attached evaluation form).

F. Two-week geriatric rotation.

G. Providing long term care for panel of nursing home patients.

H. Precepting with the Geriatric Nurse Practitioner. The GNP will make initial home visits as appropriate. The GNP will also make recap rounds in the nursing home with the residents.

I. Evaluations: The resident evaluates the two week geriatric rotation; J. Yudin evaluates the resident after the two week rotation and triannually while caring for nursing home patients. (see attached form)

Requirements

A. Case Presentations: see enclosed format protocol.

B. Family Social Science Tasks: see enclosed.

C. Nursing home Inservice.

D. Geriatric Tasks: see enclosed.
Family Social Science Curriculum: Experiential Component

Goals and Objectives:

1. Develop ability to recognize, evaluate and deal with psychosocial problems.
2. Develop ability to deal with psychosocial problems with confidence and skill.
3. Develop integrated biopsychosocial approach to medical problems.
4. Improve patient satisfaction and follow-up skills.

Precepting:

The Family Social Scientist precepts with the Family Practice residents in two settings: the Family Practice office and in the hospital during rounds. In the office, the Family Social Scientist sits with the resident while s/he is seeing patients, then meets with the resident afterwards to discuss the patients and the resident’s interviewing style and skills.

Interviews and Self-Evaluation:

At the beginning of the residency program, each resident will meet with the Family Social Scientist who will interview the resident about his/her interest and skills in the psychosocial aspects of medicine. The residents also will complete a self-evaluation questionnaire at the beginning, and at the end of the residency in order to evaluate their improvement in dealing with the psychosocial aspects of medicine.

Family-Oriented Treatment Plans:

During the Family Social Science Precepting, the residents will be encouraged to develop family-oriented treatment plans which incorporate evaluating the family situation and helping the family improve its overall health and health behaviors.

Reference:
FAMILY SOCIAL SCIENCE ROTATIONS

Purpose:
1. to learn basic family dynamics as they apply to family medicine practice.
2. to learn counseling skills and anticipatory guidance strategies useful in working with patients and their families.

Time:
Each year of residency: two weeks, part time, concurrent with the residents' "heart station", endoscopy and/or surgery rotations.

Curriculum:

Year II
Human Development throughout the Life Cycle
Family Dynamics
The Fifteen Minute Hour (assigned reading)
Levels of Physician Involvement and Families
Human Sexuality (tapes)
Precepting in the office
The Family in Medical Practice
(assigned reading)

Year III
Chronic Disease and the Family
Family Therapy, and Family Medicine (assigned reading)
Family Therapy Techniques for Family Physicians
Family Assessment
Family Meeting—videotape if possible
How to find and Refer to Mental Health Professionals
FAMILY SOCIAL SCIENCE CORE COMPETENCY OBJECTIVES

J. Ross, Ph.D.

(Adapted from Core Competency Objectives in Behavioral Science Education -- Task Force on Behavioral Science Education, Society of Teachers of Family Medicine, 1986)

FAMILY ASSESSMENT AND TREATMENT SKILLS

1. Resident physicians will demonstrate the ability to use record keeping and assessment tools which facilitate knowledge of the family system, i.e. the genogram and one other family assessment tool.

1.b. Resident physicians will be aware of which biopsychosocial issues they are most comfortable handling and the influence of personal values and beliefs on patient interaction.

2. Resident physicians will help patients modify at least three of the following lifestyle behaviors which are risk factors for the development of health problems: smoking, obesity, high stress with low stress management skills and weak social support systems, poor coping style, poor nutrition, excessive use of alcohol and/or drug abuse, unsafe household and/or neighborhood environment.

2.b. Resident physicians will assist at least three families to establish and/or maintain adaptive lifestyle behaviors by implementing organized wellness programs which include attention to: nutrition, exercise, communication skills (stress management, coping skills, conflict prevention and management, self-esteem enhancement), negotiation of the family life cycle.

3. Resident physicians will facilitate adaptive interaction patterns between family members in at least three families in their practice. E.g. encouragement of individual autonomy and growth for all family members, appropriate level of emotional connectedness without excessive distancing or overinvolvement, clear delimitation of generational boundaries (spouse/parent/child), cooperative spouse-parent alliance, flexibility of attitudes and behavioral options, negotiation and conflict resolution; problem solving and decision-making, health habits and lifestyle.

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1. Resident physicians will demonstrate skills in dealing with family factors which contribute to the occurrence of illness via family case conferences and/or family social science supervision. Residents will assist families with family histories that suggest increased risk of health problems that prominently involve family dynamics, identify and deal appropriately with families whose interactional patterns are contributing to illness behaviors, identify key characteristics of families that promote the development of physical symptoms as a coping style and consequently tend to induce psychosomatic illnesses in their members.

4.a. Resident physicians will demonstrate the ability to manage health problems of certain types by assessing the family situation carefully and forming management plans that incorporate family factors integrally. E.g. problems associated with difficulty with life cycle transition or phase, problems of recent origin that appear to be situational and related to family factors, illness or illness-related problems that stem from how the family interprets illness and provides support for its members.

4.b Resident physicians will demonstrate ability to link the presenting problem to the patient's and family's current life cycle issues, i.e. to understand the problem in context, to communicate an understanding of the patient and family's current difficulties, and to activate the family's resources to help with the problem. Furthermore, resident physicians will demonstrate knowledge and understanding of specific aspects of the family life cycle, including: changes over time, sequential stages, developmental tasks, normal and unexpected crises, and anticipatory guidance.

4.c. Resident physicians will demonstrate the ability (1) to develop an alliance with different family members who can support treatment, (2) involve family members in increasing patient's compliance with treatment regimen, (3) evaluate the impact of treatment on the family at stressful times (e.g. hospitalization, chronic illness, nursing home placement, major surgery or other invasive procedures).

5. Resident physicians will call and conduct family interviews in at least five of the following instances: treatment failure, symptom reoccurrence, confusing complexity of symptoms without a clear explanation of nature of the problem, chronic illness, serious acute illness, problems requiring major lifestyle change, hospitalization, death, crisis, child care and child care problem, marital problem, psychosocial problems (depression, anxiety, somatization), making a referral. The resident physician will elicit enough information during the interview to assess: the history, nature and severity of the presenting problem; the structure/organization of the family; family communication patterns, family expectations for therapeutic outcome. The resident physician will manage effectively the time available for the family interview, with a well-organized closing.
5.a. Resident physicians will demonstrate the ability to use family conferences effectively to manage two of the following problems: stress-related disorders, compliance, marital and sexual problems, parent-child problems, chemical dependency, depression, anxiety disorders and problems, somatoform disorders.

6. Resident physicians will conduct family counseling for at least two families with a minimum of 3 sessions each, AND/OR resident physicians will acknowledge personal limits in assessing and treating families and refer when appropriate, coordinate care as the family physician, utilize community resources, utilize influence to increase the likelihood of referral's being successful, and maintain involvement with the patient and family as the coordinator of health care.
1. Genograms are present in all ambulatory patients' charts.
   A. Genograms are present on all hospitalized patients' charts.
   B. Genograms are present on all nursing home patients' charts.

2. Three patients have been helped to modify lifestyle behaviors (see Objective #2). Indicate patients' first names.
   1. 
   2. 
   3. 

3. Three patient families have been helped to modify lifestyle behaviors (see Objective #3). Indicate patients' first names.
   1. 
   2. 
   3. 

4. Three patient families have been helped to modify their maladaptive interaction patterns and/or they have been encouraged by facilitating adaptive interaction patterns (see Objective #3). Indicate patients' first names.
   1. 
   2. 
   3. 

5. Two families in which maladaptive patterns contribute to the maintenance of health problems have been helped to improve their health (see Objective #4). Indicate patients' first names.
   1. 
   2. 

6. Family conferences have been used to manage six of the following problems (see Objective #5): (Indicate patients' first names.)
   1. Treatment failure
   2. Symptom recocurrence
   3. Confusing complexity of symptoms without a clear explanation of the nature of the problem
   4. Chronic illness
   5. Serious acute illness
   6. Problems requiring major lifestyle changes
   7. Hospitalization
   8. Death
   9. Crisis
   10. Child care and child care problem
   11. Marital problem
   12. Psychosocial problems (depression, anxiety, somatization)
7. Family interviews have been used to manage three of the following problems (see Objective #1): Indicate patients' first names:

1. stress-related disorders
2. compliance problems
3. marital and sexual problems
4. parent-child problems
5. chemical dependency (includes PTSD)
6. depression
7. anxiety disorders and problems
8. somatoform disorders

8. Family counseling has been conducted with at least two families, and/or two families have been referred successfully for counseling to a qualified professional (see Objective #6). Indicate patients' first names.

1.
2.

9. Via precepting, the following has been demonstrated: the ability to establish rapport, use attending skills such as pacing and leading, establish a therapeutic contract, facilitate, reframe and reinforce, set goals, and close interviews.

10. Common children's school age problems have been evaluated and treated (two). Indicate patients' first names.

1.
2.

11. A family crisis situation has been assessed and the resident has successfully intervened. Indicate patient's first name.

1.

12. One family/marriage assessment has been completed. Indicate patient's first name.

1.

13. Appropriate, non-pharmaceutical course of treatment has been undertaken with three patients with common mental health problems (e.g. depression, anxiety). Indicate patients' first names.

1.
2.
3.

14. All patients are screened routinely for alcoholism, and appropriate referral sources are known. Extra points: attend an AA meeting.
Awareness of one's own family's mental health needs is demonstrated regularly.

PGI-1 year:
PGI-2 year:
BEHAVIORAL SCIENCE TASKS - DESCRIPTION

Using a biopsychosocial approach to medicine requires that the physician utilize interviewing and assessment skills which are somewhat different from those used in a more traditional medical setting.

Residents are challenged to improve their skills in using the biopsychosocial approach. In order to help residents develop these skills, they are asked to complete Behavioral Science Tasks which incorporate a variety of skills and behaviors.

Residents are expected to maintain a record of their achievement of the tasks. Residents' progress in achieving the tasks is reviewed tri-annually with the Behavioral Scientist.

The Behavioral Science Tasks, with explanation, are as follows:

1. Consultations with Behavioral Scientist - 6 per year

   The Behavioral Scientist is able to help residents help their patients with psychosocial problems. Consultations may be either "curbstone" or with the Behavioral Scientist joining the resident in meeting with a patient and/or the patient's family.

2. Evaluate and carry out treatment of common children's school age problems (2).

   Family practitioners frequently encounter children who are suffering stomach aches, headaches, school and other functional problems. For this task, the resident is to analyze the problem, and then to develop and carry out a treatment plan resulting in the successful resolution of the problem.

3. Have completed genograms in each ambulatory patient's chart.

   Residents are expected to complete genograms for each patient they see.

4. Assess and intervene in a family crisis situation (1).

   Family physicians often are the first called when a family feels they are in crisis. The resident will demonstrate the ability to assess the crisis, and to determine whether to intervene or refer.

5. Complete family and marriage assessments - 6 families

   The Behavioral Scientist has a schema to help in assessing families and marriages. Residents are to meet with the Behavioral Scientist to discuss in depth the dynamics and organization of six families/marriage.

6. Arrange and conduct family interviews - 8 total

   This task is part of the residents' work with the Chronic Illness Consultation Center. Interviews can be conducted in order to help with ambulatory and/or hospitalized patients. The resident is to
identify the goal(s) in having the meeting and then to determine whether the meeting(s) outcome is consistent with the goal.

7. Demonstrate ability to assess and diagnose patients (3) with depression and anxiety and to decide whether to treat or to refer.

8. Demonstrate the ability to address the emotional aspects of general medical illness (10).

   Residents are to discuss with the Behavioral Scientist 10 patients for whom they have provided integrated biopsychosocial care. Residents will identify the different components of their treatment and how, together, they resulted in integrated care.

9. Demonstrate the ability to assess patients (2) with problem behaviors such as smoking and/or over-eating (obesity) and to decide whether to treat or refer.

10. Complete alcoholism screenings on all ambulatory care patients, and make the appropriate notation in the charts.

11. Demonstrate competence in referring drug-dependent patient (1) for appropriate treatment, and attend one AA meeting.

12. Have completed genograms for all hospital patients when on hospital services.

13. Show awareness of own family's mental health needs and demonstrate attention to these needs.

   Residents are to live lives which include both work and play. Regular recreation and entertainment are mandatory, as is involvement with significant others.

14. Have one ethics consultation with Dr. Erde.
FAMILY & MARRIAGE ASSESSMENT

3 Generation Genogram: Note medical problems including, ETOH/drug abuse, by each family member; use arrow to indicate family health expert.

1. Significant problems & stresses?

2. Problems are acute, episodic, or chronic?
   How does family explain them?

3. Coping ability: How cohesive is the family? How flexible? What is typical coping pattern?

4. Life cycle stage: Recent transitions? Conflict between individual and familial developmental needs?
5. Ethnic/cultural/socioeconomic group(s) to which family belongs?

6. Leisure/community/religious activities?

7. How do parents get along? Is couple viable as a unit?

8. Is there appropriate hierarchical organization in family? Defined boundaries between individuals and generations?

9. For couple: A. What is each person's definition of a good marriage? Of a good husband and wife? Do these definitions agree?

B. How satisfactory is their sexual relationship?

C. How do they play together? Do they have adult friends?
THESE SYMPTOMS MAY INDICATE THAT THE PATIENT IS EXPERIENCING STRESS IN EITHER THE FAMILIAL OR EXTRAFA M I L I A L (SOCIAL, COMMUNITY) SETTING.

HEADACHES

BACKACHES

CHRONIC PAIN

MUSCLE SPASMS

NERVOUSNESS

VAGUE SYMPTOMS

ABDOMINAL PAIN

LOSS OF APPETITE

BOWEL CHANGES

URINARY CHANGES

SLEEP DISTURBANCES

BEHAVIOR DISTURBANCES IN CHILDREN
SOME MANAGEMENT PROBLEMS MAY INDICATE POSSIBLE DYSFUNCTION (TEMPORARY) OR CHRONIC IN THE FAMILY. THEY ARE:

A. FREQUENT ATTENDANCE WITH MINOR ILLNESS.

B. SYMPTOMS PRESENT FOR A LONG TIME.

C. COMPLAINTS OUT OF PROPORTION TO PHYSICAL FINDINGS.

D. FAILURE TO RECOVER IN THE EXPECTED PERIOD OF TIME.

E. FAILURE OF SUPPORT, GUIDANCE AND EDUCATION TO SATISFY THE PATIENT FOR MORE THAN A SHORT PERIOD OF TIME.

F. FREQUENT VISITS BY A PARENT WITH A CHILD WITH MINOR PROBLEMS.

G. ATTENDANCE OF AN ADULT PATIENT WITH AN ACCOMPANYING RELATIVE.

H. IMPROVEMENT IN SYMPTOMS IN ONE FAMILY MEMBER IS FOLLOWED BY DEVELOPMENT OF SYMPTOMS IN ANOTHER.

I. DIFFERENT FAMILY MEMBERS PRESENT TO YOU WITH DIFFERENT SYMPTOMS OVER A CLOSE PERIOD OF TIME.
Twice monthly the Family Medicine Seminars will feature residents giving case presentations. Residents will choose a case from their ambulatory, hospital and/or nursing home patient panels; ideally, the case will correlate with what is being discussed during the didactic seminars.

The case presentation format includes:

A. Presenting problem
B. Medical and psychosocial history
C. Genogram
D. Treatment plan, with rationale
E. Article relevant to case
F. Discussion of medical problem/topic, with attendant psychosocial and ethical issues.

A brief outline/summary of the presentation should be distributed to faculty and other residents a week prior to the presentation.

The goals of the presentation are for the resident (1) to demonstrate a clearly conceptualized treatment plan which integrates medical and psychosocial issues; (2) to obtain feedback on the treatment plan from a multi-disciplinary panel; and (3) to educate colleagues about a family medicine problem.

Before making the presentation, the Behavioral Scientist will meet with the resident to discuss the presentation. The resident also may choose to meet with experts relevant to the case (e.g. geriatric, ethical, medical specialist) prior to the presentation. Relevant experts always are welcome additions to the conferences.

Residents are to allow 30 minutes (minimum) at the end of the presentation for discussion of treatment plan and goals.
FAMILY PRACTICE PSYCHOSOCIAL FORM

NAME: ____________________________ COMMUNITY: ____________________________

AGE: ______ ETHNIC/RELIGIOUS: ____________________________

MARITAL STATUS: ____________________________ LIVING IN HOME: ____________________________

EDUCATION: ____________________________ OCCUPATION: ____________________________

BIOMEDICAL PROBLEMS: ____________________________

SOCIAL PROBLEMS/STRESSORS: ____________________________

MENTAL STATUS: ____________________________

Indicate with an arrow which person is most responsible for the patient's care.

JR/1985
Figure 3. Completed genogram for Barbara
I. Today's presentation's subject matter was:
   a. Interesting
      1 2 3 4 5
      No  Very
   b. Relevant
      1 2 3 4 5
      No  Very
   c. Useful
      1 2 3 4 5
      No  Very

II. Teaching Skills:
   a. Was the presentation well organized?
      1 2 3 4 5
      No  Very
   b. Was the group discussion good?
      1 2 3 4 5
      No  Very
   c. Did the presenter demonstrate the ability to balance dissemination of information with audience participation?
      1 2 3 4 5
      No  Very

Resident's Signature __________________________
Sample Program from
University of Tennessee
College of Medicine
800 Madison Avenue
Memphis, TN 38163
BEHAVIORAL SCIENCE CURRICULUM FOR U.T. FAMILY PRACTICE RESIDENCIES
FAMILY LIFE CYCLE

Instructional Goals

   A. The Unattached Adult
      1. Differentiation of self in relation to family of origin
      2. Development of intimate peer relationships
      3. Establishment of self in work
   B. The Newly Married Couple
      1. Formation of marital system
      2. Realignment of relationships with extended families and friends to include spouse
   C. The Family with Young Children
      1. Adjusting marital system to make space for child(ren)
      2. Taking on parenting roles
      3. Realignment of relationships with extended family to include parenting and grandparenting roles
   D. The Family with Adolescents
      1. Shifting of parent-child relationships to permit adolescent to move in and out of system
      2. Refocus on mid-life marital and career issues
      3. Beginning shift toward concerns for older generation
   E. Launching Children and Moving On
      1. Renegotiation of marital system as dyad
      2. Development of adult to adult relationships
      3. Realignment of relationships to include in-laws and grandchildren
      4. Dealing with disabilities and death of parents (grandparents)

Behavioral Objectives

The resident will:
1. View the family in a developmental framework as a dynamic unfolding of generations in response to normal predictable life transitions.
2. Identify where the family is in the life cycle sequence.
3. Assess how well the family has negotiated previous stages of the life cycle.
4. Collect family historical (inter generational) information to discover family themes and patterns by use of genogram and interview.
5. Determine whether current life cycle issues are primary or secondary to the presenting problem.
6. Record pertinent data in medical record.

Implementation and Evaluation

1. Didactic conferences/reading
2. Consultation with behavioral science faculty
3. Videntape review
4. Chart review
5. Genogram

Faculty Setting
Instructional Goals

F. The Family In Later Life
1. Maintaining own and/or couple functioning and interests in face of physiological decline, exploration of new familial and social role options.
2. Support for a more central role for middle generation.
3. Making room in the system for the wisdom and experience of the elderly; supporting the older generation without overfunctioning for them.

Behavioral Objectives

II. Family Adaptation/Coping Responses
The resident will:
1. Assess the resources and strengths of the family to adapt to life transitions and to perform their associated tasks.
2. Recognize the cumulative effect of the successful or unsuccessful negotiation of tasks by the family throughout the life cycle.
3. Look for intergenerational patterns of adaptation and successful task completion.

III. Family Structure
A. Generational boundaries
B. Roles of family member-hierarchy
C. Degree of enmeshment disengagement
The resident will:
1. Solicit structural information through interview and/or use of assessment instrument (inventory)
2. Assess structural information in light of presenting problem
3. Record pertinent data in medical record

Implementation and Evaluation
1. Didactic conferences/readings
2. Consultation with faculty
3. Videotape review
4. Chart review
5. Genogram
### Instructional Goals

IV. Family Dynamics  
   A. Degree of rigidity-flexibility  
   B. Interactional patterns among sub-systems  
   C. Degree of conflict resolution ability  
   D. Triangulation patterns  
   E. Open and closed boundary systems respect to environment

### Behavioral Objectives

- The resident will:
  1. Solicit information about family dynamics through interview and/or use of assessment instrument  
  2. Assess family dynamics in light of presenting problem  
  3. Record pertinent data in medical record

### Implementation and Evaluation

1. Didactic conferences/readings  
2. Consultation with behavioral science faculty  
3. Videotape review  
4. Chart review  
5. Genogram

### Faculty Setting

**REFERENCES:**


BEHAVIORAL SCIENCE CURRICULUM FOR U.T. FAMILY PRACTICE RESIDENCIES
FAMILY LIFE CYCLE - ATYPICAL CRISIS AND VARIATIONS

Instructional Goals

The resident, after viewing individuals and the family in a developmental framework, will identify the following "crises" or atypical variations in family dynamics.

I. Parent-Child Attachment Problems
   A. Failure of one or both parents to effectively form appropriate attachments with their infant/child

II. Problems With Pre-School Children
   A. Inappropriate toilet training (i.e. too rigid, demanding or structured)
   B. Difficulty or inability to set behavioral limits
   C. Aggression with peers or family members
   D. Excessive sibling rivalry
   E. Prolonged separation anxiety

Behavioral Objectives

The resident will:

1. Observe parent and infant interaction.
2. Assess how parents are providing for infant's expressed, as well as hidden needs.
3. Be able to evaluate failure-to-thrive infants for biomedical or psychosocial causation.
4. Utilize other members of multidisciplinary staff for observation and assessment when necessary (i.e. nurses, social workers, psychologist, etc.).
5. Make appropriate referrals to psychiatry and child protection workers when necessary.

Implementation and Evaluation

1. Clinical observation
2. Consultation with faculty
3. Videotape review
4. Didactic conferences
5. Home visit

Faculty Setting

1. Clinical observation
2. Chart review
3. Multi-disciplinary planning group
4. Consultation with faculty and preceptors
5. Didactic conferences
6. Regular rounds
7. Individual counseling
III. Problems with middle age and adolescent aged children.
   A. Making a decision to "hold a child back in school."
   B. School refusal
   C. Mental retardation
   D. Learning disabilities
   E. Eating disorders
      1. Anorexia nervosa, bulimia
      2. Pica
      3. Rumination disorder
      4. Obesity
   F. Sleep related problems
      1. Functional enuresis
      2. Enuresis
      3. Sleepwalking
      4. Sleep terrors
      5. Insomnia
   G. Depression and suicide
   H. Substance abuse
   I. Adolescent pregnancy
   J. Sexually transmitted disease
   K. Behavioral problems
      1. Adolescence
      2. Runaway
   L. "Latch-key" children

IV. Adult crises
   A. Communication problems
      1. Indirect
      2. Masked
      3. Closed
      4. Excessive arguing; peer conflict resolution
   B. Loss of job, income
   C. Disability-loss of health with subsequent early retirement.
   D. Marital/family dynamic problems
      1. Enmeshed
      2. Disengaged
      3. Triangulation

Behavioral Objectives

The resident will:
1. Identify symptoms of listed childhood disorders.
2. Use appropriate diagnostic tests and consult with professionals if necessary.
3. Be able to conduct family counseling sessions to elicit communication and plan appropriate treatment.

Implementation and Evaluation

1. Clinical observation
2. Chart review
3. Multi-disciplinary planning
4. Consultation with faculty
5. Didactic conferences
6. Regular rounds
7. Individual counseling
### Instructional Goals

#### V. Separation/Divorce
- A. Death of "fantasy" marriage and end of marital relationship
- B. Shifting of roles and relationships
- C. Re-structuring of family boundaries
- D. Effects of divorce on individuals involved:
  1. Parents
  2. Children
  3. Extended family

#### VI. Stepfamily issues
- A. Born of loss i.e. death or divorce
- B. Incongruent family history
- C. Incongruent stages in family cycle
- D. Children may visit or reside with other parents
- E. Many expect "instant love": few guidelines for new roles

#### VII. Family violence
- A. Spouse abuse
- B. Child abuse
  1. Emotional
  2. Physical
  3. Sexual

### Behavioral Objectives

#### The resident will:
1. Identify the emotional stages of divorce and/or remarriage
2. Assess how each family member will cope with divorce
3. Recognize destructive and self-defeating patterns among families experiencing divorce and make treatment plan.
4. Determine if each family member is working through the developmental tasks of grieving when divorce occurs.

#### The resident will:
1. Monitor development of stepfamily and make supportive interventions, if necessary, to include:
   a. Psycho-educational input
   b. Reading material
   c. Family conferences
   d. Family counseling

### Implementation and Evaluation

1. Role play
2. Video tapes
3. Case discussions
4. Individual counseling
5. Selected bibliography
6. Didactic conferences
7. Review/feedback with preceptor/behavioral scientist

### Faculty Setting

1. Role play
2. Video tapes
3. Case discussions
4. Individual counseling
5. Selected bibliography
6. Didactic conferences
7. Review/feedback with preceptor/behavioral scientist
REFERENCES:


Children in Crisis, 1986.

Common Childhood Behavioral Disorders. Tape
Appendix A

Directory/Survey Respondents
<table>
<thead>
<tr>
<th></th>
<th>Name</th>
<th>Address</th>
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<tbody>
<tr>
<td>1</td>
<td>Family Practice Center</td>
<td>Greenwood, SC 29646</td>
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<tr>
<td>2</td>
<td>Family Practice Residency Program</td>
<td>Carraway Methodist Medical Center 3001 27th Street North</td>
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<tr>
<td></td>
<td></td>
<td>Birmingham, AL 35207</td>
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<tr>
<td>3</td>
<td>Eastern Carolina Family Practice Center</td>
<td>PO Box 1846</td>
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<tr>
<td></td>
<td></td>
<td>Greenville, NC 27834</td>
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<tr>
<td>4</td>
<td>Iowa Lutheran Hospital Family Practice Residency</td>
<td>University at Pennsylvania Avenue</td>
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<tr>
<td></td>
<td></td>
<td>Des Moines, IA 50316</td>
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<td>5</td>
<td>Department of Family Medicine</td>
<td>St. Elizabeth Hospital Medical Center 1053 Belmont Avenue</td>
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<tr>
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<td></td>
<td>Youngstown, OH 44501</td>
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<tr>
<td>6</td>
<td>Area Health Education Center Family Practice Residency</td>
<td>100 South 14th Street</td>
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<td></td>
<td>Fort Smith, AR 72901</td>
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<tr>
<td>7</td>
<td>Department of Family Medicine Mayo Clinic</td>
<td>200 SW First Street</td>
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<td></td>
<td></td>
<td>Rochester, MN 55905</td>
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<td>8</td>
<td>Family Practice Residency</td>
<td>McKeesport Hospital</td>
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<tr>
<td></td>
<td></td>
<td>1500 Fifth Avenue</td>
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<td></td>
<td>McKeesport, PA 15132</td>
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<td>9</td>
<td>Underwood Memorial Hospital Family Practice Center</td>
<td>Woodbury, NJ 08096</td>
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<tr>
<td>10</td>
<td>Madigan Army Medical Center Box 828</td>
<td>Tacoma, WA 98431</td>
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<tr>
<td>11</td>
<td>Lynchburg Family Practice</td>
<td>3300 Suite A Rivermont Avenue</td>
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<td></td>
<td>Lynchburg, VA 24503</td>
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<td>2600 Seventh Street, SW</td>
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<td>13</td>
<td>St. Joseph's Medical Center</td>
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<td>Los Angeles, CA 90024</td>
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<td>Department of Family Practice</td>
<td>Rockford School of Medicine</td>
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<td>Rockford, IL 61101</td>
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<td>Seattle, WA 98104</td>
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<td>St. John's Mercy</td>
<td>615 S. New Ballas</td>
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<td>St. Louis, MO 63141</td>
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<td>Phoenix, AZ 85015</td>
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<td>12 East Chestnut Street</td>
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<td>Augusta, ME 04330</td>
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<td>3341 East Livingston</td>
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<td>1601 Owen Drive</td>
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<td></td>
<td>Fayetteville, NC 28304</td>
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<tr>
<td>22</td>
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<td>PO Box 1881</td>
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<td></td>
<td></td>
<td>4801 South Grand Street</td>
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<td></td>
<td></td>
<td>Monroe, LA 71202</td>
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<tr>
<td>23</td>
<td>Department of Family Medicine</td>
<td>Kennedy Medical Center</td>
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<td>James Street</td>
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<td></td>
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<td>Washington, PA 15801</td>
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| 26 | Family Practice Center  
Presbyterian Intercommunity Hospital  
12401 E Washington Boulevard  
Whittier, CA 90602 |
|---|---|
| 27 | Department of Family Practice  
San Jose Hospital  
25 North 14th Street  
San Jose, CA 95112 |
| 28 | Family Practice Center  
Toledo Hospital  
2051 West Central Avenue  
Toledo, OH 43606 |
| 29 | Saint Francis Medical Center  
Family Practice Residency  
530 NE Glen Oak Avenue  
Peoria, IL 61637 |
| 30 | Montgomery County Medical Education  
Foundation—Family Practice Center  
500 Med Center Blvd., Suite 175  
Conroe, TX 77304 |
| 31 | University of Alabama College of Community  
Health Sciences  
Tuscaloosa Family Practice Residency  
PO Box 6331  
University, AL 35486 |
| 32 | Family Practice Residency  
400 Memphis Street  
Bogalusa, LA 70427 |
| 33 | Family Practice Center  
76 High Street  
Lewiston, ME 04240 |
| 34 | Family Practice Residency  
223 E. Jackson Street  
Jonesboro, AR 72401 |
| 35 | Kline Family Practice  
Polyclinic Medical Center  
2601 N. Third Street  
Harrisburg, PA 17105 |
| 36 | Department of Family Practice  
Merced Community Medical Center  
301 E. 13th Street  
Merced, CA 95340 |
| 37 | First Colonial Family Practice Center  
1120 1st Colonial Road  
Suite 100  
Virginia Beach, VA 23454 |
| 38 | Northridge Hospital Medical Center  
Family Practice Residency  
18406 Roscoe Blvd.  
Northridge, CA 91325 |
| 39 | Midland Hospital Center  
4007 Orchard Drive  
Midland, MI 48670 |
| 40 | Goppert Family Care Center  
Baptist Medical Center  
6601 Rockhill Road  
Kansas City, MO 64131 |
| 41 | Naval Hospital  
Department of Family Practice  
(Code 104)  
Charleston, SC 29408 |
| 42 | St. Francis Family Practice Residency  
925 North Emporia  
Wichita, KS 67214 |
| 43 | Kaiser Foundation Hospital  
9961 Sierra Avenue  
Fontana, CA 92335 |
| 44 | Ball Memorial Hospital, Inc.  
2300 Gilbert St.  
Muncie, IN 47303 |
| 45 | St. Lawrence Family Practice Residency  
1210 West Saginaw  
Lansing, MI 48915 |
| 46 | Family Practice Residency Program  
Naval Hospital  
Camp Pendleton, CA 92055 |
| 47 | Department of Family Medicine  
University of Cincinnati  
234 Goodman Street, ML 782  
Cincinnati, OH 45267 |
| 48 | Family Practice Office  
Arizona Health Science Center  
1450 North Cherry St.  
Tucson, AZ 85719 |
| 49 | Family Practice Residency  
University of Alabama in Huntsville  
201 Governors Drive, SE  
Huntsville, AL 35801 |
| 50 | Siouxland Medical Education Foundation  
2417 Pierce  
Sioux City, IA 51104 |
| 51 | St. Joseph Family Practice Residency  
200 North 16th Street  
Suite 100  
Reading, PA 19604 |
| 52 | Department of Family Medicine  
Geisinger Medical Center 14-00  
Danville, PA 17822 |
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<td>1200 Old York Road Abington, PA 19001</td>
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<td>PO Box 32861 Charlotte, NC 28222</td>
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<td>PO Box 3281 Modesto, CA 95353</td>
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<td>7703 Floyd Curl Drive San Antonio, TX 78284</td>
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<td>73</td>
<td>St. Mary Corwin Hospital Southern Colorado Family Medicine</td>
<td>1038 Minnewa Avenue Pueblo, CO 81004</td>
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<td>Department of Family Practice Mountain AHEC</td>
<td>491 Biltmore Avenue Asheville, NC 28801</td>
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<td>75</td>
<td>William M. Simpson, Jr., MD</td>
<td>49 Montague Street Charleston, SC 29401</td>
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<tr>
<td>76</td>
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<td>4660 McWillie Drive Jackson, MS 39216</td>
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<td>82</td>
<td>University of Rochester School of Medicine</td>
<td>885 South Avenue, Rochester, NY 14620</td>
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<tr>
<td>83</td>
<td>J Mack Worthington, MD</td>
<td>899 Madison Avenue, Suite 850-M, Memphis, TN 38103</td>
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<td>229 S. Morrison Street, Appleton, WI 54911</td>
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<td>91</td>
<td>Michael J. Wanderer, MD</td>
<td>503 18th East, Seattle, WA 98112</td>
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<td>Family Practice Residency Program</td>
<td>St. Michael's Hospital, 2400 West Villard Avenue, Milwaukee, WI 53209</td>
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<td>Youngstown Hospital Association, 500 Gypsy Lane, Youngstown, OH 44501</td>
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<td>Department of Family Practice, 9000 Franklin Square Drive, Baltimore, MD 21237</td>
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<td>2300 So. Dakota Avenue, Sioux Falls, SD 57105</td>
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<td>1224 Doctor's Lane, Fort Collins, CO 80524</td>
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<td>99</td>
<td>Hassler Center—Family Medicine</td>
<td>Fairview General Hospital, 18200 Lorain Avenue, Cleveland, OH 44111</td>
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<td>Santa Monica Hospital Medical Center, 1225 Fifteenth Street, Santa Monica, CA 90404</td>
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<td>102</td>
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<td>St. Elizabeth Hospital, 2209 Genesee Street, Utica, NY 13501</td>
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<td>Department of Family Medicine</td>
<td>10060 Rushing, El Paso, TX 79924</td>
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<td>105</td>
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<td>Brookhaven Memorial Hospital Medical Center, 101 Hospital Road, Patchogue, NY 11772</td>
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<td>Family Practice Residency Program</td>
<td>San Bernardino Medical Center, 780 E. Gilbert Street, San Bernardino, CA 92415</td>
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<td>107</td>
<td>Department of Family Medicine</td>
<td>Scott White Memorial Hospital, 2401 South 31st Street, Temple, TX 76508</td>
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<td>108</td>
<td>Family Practice Residency</td>
<td>1500 South Main Street, Fort Worth, TX 76104</td>
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109 Department of Family Practice
University of California
2221 Stockton Blvd.
Sacramento, CA 95817

110 Family Practice Residency
University of California-Irvine
101 City Dr. So., Bldg 28A, route 81
Orange, CA 92668

111 Department of Family Medicine
Medical College of Ohio
CS 1008
Toledo, OH 43699

112 Family Practice Group
Albany Medical College
TS 112
Albany, NY 12208

113 Family Practice Center
Glendale Adventist Hospital
801 South Chevy Chase Drive
Glendale, CA 91205

114 Ghost Family Practice Center
Eastern Virginia Medical School
130 Colley Avenue
Norfolk, VA 23510

115 Family Practice Residency Program
Tallahassee Memorial Regional Medical Center
1301 Hodges Drive
Tallahassee, FL 32308

116 Family Practice Center
7th & Clayton Streets, Suite 309
Wilmington, DE 19835

117 East Tennessee State University
Bristol Family Practice Center
100 Bristol College Drive
Bristol, TN 37620

118 Family Practice Residency Program
Florida Hospital
2501 North Orange, Suite 235
Orlando, FL 32804

119 Family Practice Residency Program
Niagara Falls MC
501 Tenth Street
Niagara Falls, NY 14301

120 University of California-San Diego
225 West Dickinson Street, H-809
San Diego, CA 92103

121 Family Practice Residency Program
The Williamsport Hospital
699 Rural Avenue
Williamsport, PA 17701

122 Unavailable

123 Duluth Family Practice Residency Program
Duluth Family Practice Center
330 North 8th Avenue East
Duluth, MN 55805

124 Department of Family Medicine
Lancaster General Hospital
555 North Duke St.
Lancaster, PA 17604

125 Department of Family Medicine
Texas Tech University Health Science Center
1400 Wallace Blvd.
Amarillo, TX 79106

126 Department of Family Practice
University of North Carolina
Trailer 15, 2691
Chapel Hill, NC 27514

127 R.L. Thompson Strategic Hospital
SCHF
Carswell AFB, TX 76127-5300

128 Family Physicians Health Center
579 Wells
St. Paul, MN 55101

129 Department of Family Practice
University of Kansas
Kansas City, KS 66103

130 Family Practice Center
1600 Providence Drive
PO Box 3276
Waco, TX 76707

131 Eastern Virginia Medical School
Portsmouth Family Medical Center
2700 London Blvd.
Portsmouth, VA 23707

132 Unavailable

133 Unavailable

134 Department of Family Medicine
California College of Medicine
University of California-Irvine Medical Center
101 City Drive South
Orange, CA 92668

135 Unavailable

136 Smiley's Point Clinic
2200 Riverside Avenue South
Minneapolis, MN 55454
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177  SUNY-Buffalo
Department of Family Medicine
1001 Humboldt Parkway
Buffalo, NY 14208
178  Unavailable
179  Unavailable
180  Unavailable
181  Scenic General Hospital
Family Practice
900 Scenic Drive
Modesto, CA 95350
182  Selma Family Medicine Center
429 Lauderdale Street
Selma, AL 36701
183  Family Practice Center
Akron City Hospital
525 East Market Street
Akron, OH 44309
184  Unavailable
185  Unavailable
186  Unavailable
187  Unavailable
188  University of New Mexico School of Medicine
2400 Tischer Avenue, NE
Albuquerque, NM 87131
189  Family Practice Center
6036 N. 19th Avenue
Phoenix, AZ 85015
190  Unavailable
191  Karen Kingsolver, PhD
Chin Hills Building, #300
3915 Talbot Road South
Renton, WA 98055
192  University of Oklahoma College of Medicine-Tulsa
2808 South Sheridan
Tulsa, OK 74129
193  Deaconess Hospital
600 Mary Street
Evansville, IN 47747
194  Unavailable
195  Unavailable
196  Unavailable
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200  Unavailable
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202  Unavailable
203  Fayetteville AHEC
1601-B Owen Drive
Fayetteville, NC 28304
204  University of Texas Health Science Center-Houston
Memorial Family Practice Center
777 SW Freeway
Houston, TX 77074
205  Saint Vincent Family Practice
232 West 25 Street
Erie, PA 16544
206  Unavailable
207  Unavailable
208  West Suburban Family Practice
100 Lake Street
Oak Park, IL 60302
209  Unavailable
210  Leo W. Rotan, PhD
1301 Hodges Dr.
Tallahassee, FL 32308
211  Pontiac General Hospital
Family Practice Center
Seminole Center, First Level
Seminole at West Huron
Pontiac, MI 48053
212  Unavailable
213  Unavailable
214  San Pedro Peninsula Hospital
Family Practice Program
PO Box 5306
San Pedro, CA 90732
215  Unavailable
216  Department of Family Practice
Southern Illinois University School of Medicine
Springfield, IL 62708
219 Silas B. Hays Army Community Hospital
HSXT-FP
Fort Ord, CA 93941-5800

220 Unavailable

221 Unavailable

222 Unavailable

223 Family Practice Residency
Floyd Medical Center
#7 Professional Court
Rome, GA 30161

224 UMDNJ
School of Osteopathic Medicine
301 S. Central Plaza, Suite 2300
Stratford, NJ 08084

225 Family Practice Residency
7th Street & Park Avenue
Minneapolis, MN 55415

226 Unavailable

227 Unavailable

228 Unavailable

229 Unavailable

230 University of Kansas
Residency Program at Wesley
3243 E. Murdock, Suite 303
Wichita, KS 67208

231 Unavailable

232 Department of Family Medicine
The Community Hospital at Glen Cove
St. Andrew's Lane
Glen Cove, NY 11542

233 Montefiore Medical Center
Department of Family Medicine
3412 Bainbridge Avenue
Bronx, NY 10467-2490

234 Department of Family Practice
St. Clare's Hospital
600 McClellan Street
Schenectady, NY 12304
Appendix B:

Reading Lists/Bibliography
Behavioral Science Reading List
Submitted by Barberlon Citizens Hospital, Barberton, Ohio

Family Systems


Gerber L. Married to their careers: career and family dilemmas in doctors' lives. Tavistock Publications, 1983.
The Family and Larger Systems: Selected Bibliography


Behavioral Science in Family Medicine

Submitted by Howard F. Stein, PhD, and William D. Grant EdD*

Books


Journal Issues

Comprehensive Psychiatry, 1966; Vol. 7, No. 5 (October)


5. Ackerman, Nathan W. Family psychotherapy today: some areas of controversy, pp. 375-88.


9. Boszormenyi-Nagy, Ivan. From family therapy to a psychology of relationships: fictions of the individual and fictions of the family, pp. 408-23.


11. Main, TF. Mutual projection in a marriage, pp. 432-49.


Individual Articles/Chapters


Barnhill, Laurence R. Healthy family systems. The Family Coordinator, 1979; Jan.:94-100.


Jackson, Don D. the question of family homeostasis. Psychiatric Quarterly (supplement), 1957; 31:79-90.


Litman, Theodor. The family as a basic unit in health and medical care: a social behavioral overview. Social Science and Medicine, 1974; 8:495-519.

Mead, Margaret. The contemporary American family as an anthropologist sees it. The American Journal of Sociology, 1948; May:453-459.


Schwenk, TL and CC Hughes. The family as patient in family medicine: rhetoric or reality. Social Science and Medicine, 1953; 17:1-16.


A Selected Bibliography

The following bibliography was published in The Family in Family Medicine: Graduate Curriculum and Teaching Strategies. It was prepared for that edition by Donald M. Cassata, PhD, University of North Carolina, Chapel Hill, North Carolina.


* MOST FREQUENTLY MENTIONED IN SURVEY


31. Boszormenyi-Nagy I. From family therapy to a psychology of relationships: fictions of the individual and fictions of the family. 408-423.


118. Howard J. All happy clans are alike: in search of the good family. The Atlantic 1978; (241) 5:37-42.


129. Keller R. Family ill health—an investigation in general practice. New


149. Litman TJ. The family as a basic unit in health and medical care: a social-behavioral overview. Social Science and Medicine 8:495-519.


156. Mauksch H. A social science basis for conceptualizing family health. Social Science and Medicine 1974;8:521-528.


*198. Richardson HB. Patients have families. New York: Commonwealth Fund, 1945.


220. Sluzki CE. On training to 'think interactionally'. Social Science and Medicine 1974;8:483-485.


232. Stein J et al. The family as a unit of study and treatment, region IX. Rehabilitation Research Institute, University of Washington, 1969.


237. Talmadge JM. Psychiatric residents, medical students, and families: teaching family dynamics to the uninitiated. Family Therapy 1975:11-16.


