The Residents' JOURNAL

a publication of
The American Journal of Psychiatry

November 2009 Volume 4 Issue 11

Inside

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This Issue

Introduction

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As psychiatry residents, we are in the unique position of examining and comprehending the importance of families. Many of us are beginning families of our own while simultaneously working with the families of our patients. We also are learning to understand family dynamics through our work with patients in psychotherapy. In this issue, we closely investigate issues surrounding families. In a case report, the importance of involving families in patient care is discussed. Also, a resident mom describes the challenges faced by many residents with families. In another article, the importance of working more effectively with families of patients with borderline personality disorder is assessed. The lessons outlined in these articles may help us professionally as well as in our personal lives with our own families.

Interview With Dr. William G. Kronenberger

The following is a brief interview with William G. Kronenberger, Ph.D., on "Family Therapy in Child Psychiatry," conducted by Logan Kristen Wink, M.D. Dr. Kronenberger is an Associate Professor of Clinical Psychology and Psychiatry at Indiana University School of Medicine, Department of Psychiatry, where he teaches courses in family therapy to both psychiatry residents and psychology interns. Dr. Kronenberger also employs family therapy in his practice at the Riley Hospital for Children, Child and Adolescent Psychiatry Clinic. Dr. Wink is a third-year psychiatry resident at Indiana University School of Medicine and the Editor for this issue.

Dr. Wink: Why is studying family therapy important for psychiatry residents?

Dr. Kronenberger: Medical care and symptom improvement in children take place within a family context, whether the treatment involves medication or nonmedication therapy. In the case of medication, parents are important for adherence and for the child's attitude toward the medication. In the case of psychotherapy, the family can act as a system to perpetuate the child's symptoms or to encourage change. A background knowledge of family therapy can be very valuable for working with families and with individual children, particularly when resistance or avoidance is encountered in the course of clinical care. Whether the resident is actually doing family therapy or is using her or his knowledge of family therapy to promote better communication and care, it is important to have an understanding of how families change and how individual symptoms operate within a family system. Another reason to include family therapy in resident training is to facilitate communication and coordinated care between psychiatrists and professionals who are doing family therapy. It is important for the psychiatrist to have an understanding and appreciation for the goals and techniques of work being done by the family therapist.

Dr. Wink: What do you enjoy about working with families?

Dr. Kronenberger: Working with families is challenging, complex, and stimulating. I most appreciate the willingness of the families to engage with me in attempting to make a change in their system. Typically, several family members (for example, parents) are already trying to make changes, so they are motivated to work with a clinician to meet this goal. However, change is usually stressful for the family, so family therapy calls for a considerable amount of effort and flexibility in responding to new challenges. I also enjoy facilitating new ways of communication and interaction among family members and seeing how these changes result in improvements in their relationships.

Dr. Wink: How is working with the family unit beneficial for the child patient?

Dr. Kronenberger: The family is a powerful agent of change for the child because of many factors, including attachment, behavioral contingencies, social support, modeling behavior, teaching coping skills, environmental influences on behavior, and group motivation for change. Being able to work with such a positive and powerful force in a child's development greatly enhances the possibility of success in therapy.

Dr. Wink: What difficulties are encountered in family therapy?

Dr. Kronenberger: Communication and emotion can become very complex in treatment when more than one person is working with a clinician. It is challenging to keep track of the communication and to respond in a way that works toward therapeutic goals. Using family therapy theories, strategies, and techniques can help to meet these challenges without becoming overwhelmed. More basic challenges to family therapy are limited insurance coverage for family therapy and difficulty scheduling a time that multiple family members can attend.

Dr. Wink: What are some resources you suggest for residents working with families?

Dr. Kronenberger: If you want to read some of the original sources, I'd suggest books by Minuchin, Haley, and Satir. They are excellent writers who describe their theories and techniques in their books and articles. For a basic text, I'd recommend *Family Therapy: An Overview* (by Herbert Goldenberg and Irene Goldenberg) or *Theory and Practice of Family Therapy and Counseling* (by James Robert Bitter). It is also important to remember that there are many theories of family therapy and many ways in which family therapy can be used in a treatment plan. Sometimes, only a few members of the family can attend sessions, and family therapy is designed to address only that subset of family members. Family therapies come in many types, from systemic to behavioral, and some types of family therapy are better suited to certain situations. Becoming familiar with several basic theories and adapting these concepts to each individual family is most likely to be beneficial to the patient.

Dr. Wink: Okay. So can you help me apply family therapy theory to a difficult patient encounter? I am seeing a [patient] who has been diagnosed with oppositional defiant disorder and mood disorder not otherwise specified. [The child] has tantrums so prolonged and significant that she has yet to attend school regularly, and hospitalization has been considered on multiple occasions. She presents to each appointment with her mother, maternal aunt, and maternal grandmother, all of whom live together. They generally present as helpless and exhausted and frequently imply that they wish I could "fix it" for them. Medications have been unhelpful and are often stopped within days of initiating due to perceived side effects. The grandmother raises medical concerns about the patient at each visit, none of which have yielded answers upon

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further investigation. My experience with this family has brought forth my own feelings of helplessness and exhaustion, as I have yet to relieve the patient's suffering in any way. Any ideas?

Dr. Kronenberger: Approaching this type of family using family therapy techniques requires looking at the family unit structurally and strategically. In a complex family with multiple "mothers," structural family therapy would focus on who is "in charge." In this family there seems to be conflict between several "mothers," essentially resulting in the child having all the power. One method of working with this family would include helping the family see this misalignment of power, and working with them to choose a "boss." The family as a whole must then learn to defer to the rules set by the "boss" when working with the child. Working with this family from a strategic perspective requires understanding that despite the suffering of the family unit, it will be resistant to change. With this in mind, the importance of forming an alliance with the family unit becomes incredibly important. When working strategically, the therapist issues challenging directives to provoke the family to change, which requires a strong connection between therapist and family.

In this case, medications have not been effective (apparently due to a combination of side-effects and noncompliance), and yet the family is looking to the physician for answers. This puts you in a bind, with the family asking you to help but not appropriately implementing the type of help (medication) that you are providing. In a medication management appointment you are limited by time constraints. However, you can begin to address family power structure by talking about who is responsible for making sure the child gets the medication. Is it the child who is in charge? Do you have a strong enough alliance with the family to help them see this? Furthermore, appropriate therapy referrals for both the child individually and the family as a whole will be important with this family. Working closely with the therapist to understand the techniques being used, and reinforcing this work in brief medication management appointments can be beneficial in working toward long term healing.

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A Family Disease: Case Exploration

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Being a resident involved with the formation of a new child and adolescent psychiatry addictions clinic has been both a challenging and rewarding experience. Shortly before the first new patient evaluation, a valued friend, mentor, and colleague admonished me to "be careful, addiction is a family disease." I had no idea how true that warning was.

The first complete evaluation was of a young man, aged 17 years and 9 months. He was accompanied to the appointment by his mother. Once his mother was excused from the interview room, he was friendly, cooperative, and appeared to answer questions honestly. He gave a long history and eventually endorsed symptoms consistent with polysubstance dependence, including for prescription drugs, marijuana, cocaine, and alcohol. He stated that some of the drugs he abused he obtained by stealing them from his mother. Unfortunately, he also indicated no desire for treatment or change, and his future plans included moving to a state where he could grow medical marijuana legally when he turned 18 years of age.

The interview progressed longer than anticipated, and I was summoned out of the room by the office staff. The patient's mother had been alternating between asking when we would be finished with our session and passing out, appearing clinically intoxicated. When she was brought into the room, I calmly explained that, given her son's age and lack of desire for treatment, medical and psychotherapeutic interventions would likely be unsuccessful. When she became upset, her son began to actively castigate her, despite redirection. She soon expressed suicidal ideation. As might be expected, the procedures for the evaluation and treatment of a suicidal adult in a child and adolescent clinic located in a children's hospital without a psychiatric inpatient unit or emergency department were not well developed.

As the interview moved toward a crisis evaluation, the teenager was removed from the room and supervised in another area of the clinic. When my attending and I determined that the mother's constellation of risk factors were depression, chronic pain, substance dependence, age, and race, we decided that transfer to an affiliated hospital with an adult inpatient unit was warranted. The policy at that time required that the patient, now the mother, be transported by security and with a clinic provider. Unfortunately, no nursing staff or other team members were readily available. As we waited for security, I tried to remain as supportive as possible while simultaneously trying to minimize exacerbation by the teenager, who had since returned to the interview room. No adult or other guardian could be contacted, and we could not release him on his own because he was a minor.

The security officers were pleasant and of significantly large stature. The transport vehicle was a suburban utility vehicle, with only one row of seating in the back. After several unsuccessful attempts by one of the officers to fit into the back seat with the mother and child, I was forced to sit in an uncomfortably close proximity to the crying, nearly hysterical mother and her defiant teenage son. Throughout the trip, the son continued to make comments to his mother as well as the security officers, threatening to leave the car at a stop sign so that he could visit his girlfriend. The mother was crying, the teenager was arguing alternatively with his mother and the officers, and I was wondering if I had chosen the right medical specialty. The situation continued upon arrival to the affiliated hospital, and we were forced to notify their security of both the suicidal status of one patient and the flight risk of the other.

I learned a lot during this encounter. Addiction is subject to complex gene-environment interactions (1)—or said another way, addiction is a family disease. Successful treatment of substance abuse problems, including among adolescents, will undoubtedly require cooperation between providers and families as well as family members among themselves. Literature reviews have shown that interventions involving social contacts (family and otherwise) have the potential to improve outcomes when compared with approaches that target only the individual patient (2). If the mother and teenage son in the present case, or similar family, were to present to a substance abuse clinic, the family should be involved in group therapy and also referred for individual substance abuse evaluations. While all family members may not meet criteria for direct intervention, the impact of any substance use among them on the individual patient, even if not problematic, must be addressed. In some cases, it may be better to consider the whole family unit (biological or otherwise) as "the patient." However, in the crisis situation involving the mother and teenage son, clinical focus was maintained on the individual in crisis while attempting not to jeopardize the clinical relationship with the teenage patient.

Dr. Plawecki is a third-year resident and recipient of the American Psychiatric Institute for Research and Education (APIRE)/ Janssen Psychiatric Resident Scholars Fellowship. He has received travel support to the 2009 APA annual meeting and will receive support during the Fellowship to assist in research career development. His final project has yet to be determined but will involve the clinic discussed in this article.

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Resident Mom

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It's Sunday night, and I'm looking at my calendar for next week: Monday—complete a master treatment plan; Wednesday—find an item for kindergarten show and tell and write a psychodynamic formulation; Thursday—test on U.S. capitals; Saturday—birthday party (remember to buy present). I am a psychiatry resident and a mother.

Ten years ago, I was expecting my first child. She was born 10 weeks prematurely, and I left residency to care for her. Then, after going through a series of unexpected circumstances called "life," I found myself back in residency, 10 years older with two school-aged children. While my situation of returning to residency after 10 years is unique, creating a family during residency is not. Erik Erickson, known for his theory on psychosocial development, believed that the task of young adulthood is to establish intimate relationships. Consistent with Erickson's theory, it is not unexpected that many residents marry and become parents during their postgraduate training.

According to a study by Dr. Matthew Lewin (1), during the time between the start of medical school and the end of residency/fellowship, 90% of male physicians and 70% of female physicians marry. Of these female physicians, 90% will marry professional men, and almost one-half will marry another physician (i.e., dual-physician marriages). Marital stress during residency is often the result of long work days, frequent overnight calls, and preparation for board examinations, all of which require time away from spouses and children. Additionally, a demanding work schedule can result in sleep deprivation, which can cause a decrease in mental alertness, irritability, anhedonia, and lowered interest in sexual activity, leading to feelings of loneliness for one or both partners (2). Other problems that may contribute to marital stress are isolation from family and loss of friendships, established during medical school, due to relocation for residency. Many residents also report financial worries, largely due to educational debt. Last, there are primary psychiatric illnesses, such as mood, anxiety, and substance abuse disorders, that can arise in residents or spouses of residents. These illnesses can cause martial stress and may be exacerbated by marital distress (2).

Pregnancy is another challenge faced by physicians beginning a family during training. Women, particularly those in dual-physician marriages, often defer advancement of their careers as they take primary responsibility for child care and other domestic issues (1). Often, the first career change occurs with maternity leave, which may delay graduation. Most women will take much less than 10 years for family leave; however, nearly all residents will take some time away from residency during the early months of parenting. This interruption in the continuity of residency often presents significant obstacles. According to the American Board of Psychiatry and Neurology (3), "to ensure continuity of training, the Board requires that two of the three years of residency training, excluding the PGY-I, be spent in a single program. The 36 months of full-time specialized residency training must be completed in no more than two blocks. If completed in two blocks, the blocks must not be more than ten years apart."

Residents who begin families during training report difficulties with breast-feeding, childcare, and role strain as their greatest concerns (4). Role strain is the difficulty in fulfilling multiple role obligations. Trainees often report the conflicting responsibilities of being a parent, student, and physician as causes of anxiety and/or tension. Frequently, resident-parents may face the additional stress of hostility from other program trainees, since they might feel as though they must "pick up the slack" for residents who are on bed rest during a high-risk pregnancy or at home with a sick child.

Expecting residents to defer marriage and parenting until after their training is unrealistic. Program directors and trainees should remember that psychiatry is a science that promotes healthy relationships, and thus they should support adaptations to training that encourage spousal and parental bonds.

The challenges of beginning a family during postgraduate training are many. However, the personal and professional benefits most certainly outweigh the stressors. The unconditional love offered by a spouse and child can improve any day. In addition, having a family offers one a new appreciation of the life cycle and can enrich one's understanding of his or her patients.

It's 7:00 p.m.—time for a bedtime story. Tonight, it's *The Little Engine that Could*.

Dr. Gill is a fourth-year resident.

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Borderline Personality Disorder: The Family Connection

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Borderline personality disorder. Many residents, faculty, and practicing clinicians cringe when they hear this diagnosis. Patients with borderline personality disorder have historically been labeled "problematic" and "difficult." For years, the disorder has been studied in hopes of understanding how it develops and finding effective treatment for those afflicted. Unfortunately, little of this research has directly helped providers manage this patient population. Individuals with borderline personality disorder have spouses, children, parents, and other loved ones who also get ensnared in the chaos and drama caused by the disorder. In traditional treatment and research, a tremendous amount of attention was focused on the patient only, but in recent years, attention has been given to the family as well. Subsequently, the role of family dynamics in the perpetuation of bipolar disorder has been studied in addition to the necessity of family support in treatment. The purpose of the present article is to examine this diagnosis in a biopsychosocial manner, to discuss the effect of treatment on the patient and family, and to review the efficacy of supportive therapy for family members.

Borderline personality disorder is a complicated, multidimensional diagnosis. Research examining the biological basis of this disorder has resulted in the development of multiple theories, including the presence of an overactive amygdala, reduced serotonergic activity inhibiting modulation of impulsive behavior centers, chronic elevation of cortisol leading to an exaggerated and sensitive stress response, and poor connectivity between the limbic system and executive cortex (1). Numerous studies have shown genetic predisposition for emotional dysregulation and impulsivity to be common in families of individuals with borderline personality disorder (2). The psychological hypotheses of the development of the disorder are diverse. Temperament, trauma, and neglect, coupled with an invalidating emotional environment with poor modeling of effective coping strategies, are discussed in many psychological theories (1). Interestingly, there seems to be a common theme of "the perfect storm" that must occur in order for a person to develop DSM-IV criteria for the diagnosis. The majority of patients share a predisposition for emotional sensitivity and reactivity and a slow return to baseline arousal. Typically, patients have suffered some sort of traumatic event, such as childhood sexual abuse or other forms of abuse or neglect. These patients often had caregivers who were unable to validate their emotional experiences (1). This biopsychosocial perspective demonstrates that family dynamics directly influence the development of the disorder.

Family also plays an integral role in the perpetuation of the disorder. The relationship between mothers with borderline personality disorder and their offspring has been examined in many studies. Literature focusing on parents with the disorder consistently reports that the offspring of these individuals are at high risk for developing symptoms in adult life. A mother who was raised in an environment lacking emotional availability and responsiveness may be impaired with regard to feelings of empathy. Inconsistency and the tendency toward separation on the part of the parent have been shown to predict the emergence of borderline personality disorder symptoms in children. Treating the borderline personality disorder parent seems to be critical in preventing the continuation of unhealthy interpersonal traits (3). One study examined the relationship between mothers with the disorder and their children after the mothers received psychotherapy. The treatment focused on helping the mother with emotional attunement and the ability to interpret, respond to, and validate her child. Results showed that mothers in treatment reported improved quality of their relationships with their children and felt far less hostile and more confident in their parenting skills. Engaging with the child in a healthier manner and the improved perception of this relationship will likely have a direct impact on the psychological well-being of the child (3).

The relationship between parents and children has been studied from the adult patient perspective as well. A family-process study that focused on finding target intervention points discovered a marked discrepancy in the perception of the family environment between the bipolar disorder patient and his or her parents (4). The patient's view was typically far more negative than that of the parents. The parents, especially if one exhibited borderline personality disorder traits, tended to join together against the patient, invalidating the patient's emotional response to what he or she perceived as a hostile environment. Working with the patient and family with the intention of improving interpersonal relationships and the family atmosphere seems to be a constructive course of action.

Historically, families of borderline personality disorder patients have had limited resources for support. The behaviors commonly observed in the disorder (suicide attempts, self-injurious behavior, labile emotions, rage) can be very stressful for both the patient and their family. Frequently, loved ones of the patient are neglected. Many family members experience various forms of distress, including depression, burden, guilt, loss, and grief. Support groups focusing on psychoeducation and family education are often available for families of patient's with other psychiatric illnesses. Mental healthcare professionals facilitate these psychoeducation programs, and family members run the family education programs. Both have been found to be helpful for families with members suffering from mental illness. Recently, one particular family program, Family Connections, has concentrated on providing support for borderline personality dis-

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order families. A 12-week study of this program showed that participants experienced significant changes in their sense of burden and grief (5). They also gained a supportive network and learned valuable emotion and coping skills. Unfortunately, family support groups for borderline personality disorder are scarce, and many families continue to feel isolated and alone in their struggles.

In conclusion, when treating patients with borderline personality disorder, it is imperative to also consider the patients' family. Treatment for the disorder may begin with the patient only but will likely involve the family in the end. More research devoted to this topic needs to be done, not only to help those in practice but also to establish resources for the families who experience the emotional turmoil related to this disorder.

Dr. Bonham is a fourth-year resident.

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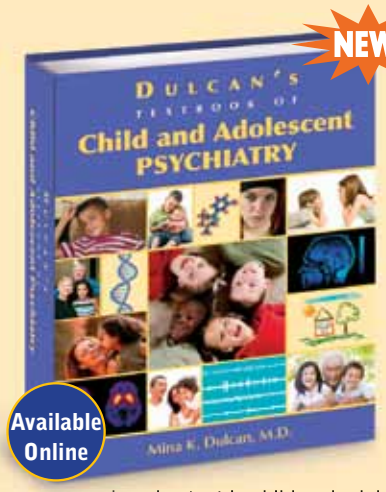

Dulcan's Textbook of Child and Adolescent Psychiatry

Edited by Mina K. Dulcan, M.D.

Dulcan's Textbook of Child and Adolescent Psychiatry supplants the previous textbook edited by Jerry Wiener and Mina Dulcan—not with a new edition, but rather a new book that offers a fresh look at the field of child mental health. It preserves Wiener's vision of a clinically focused textbook useful to trainees and practitioners in a variety of specialties, providing the most up-to-date and comprehensive text in child and adolescent psychiatry as presented by more than 110 contributors who distill their knowledge and expertise into a single authoritative volume.

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Book Review

Coloring by Numbers: *Satir Step by Step: A Guide to Creating Change in Families*

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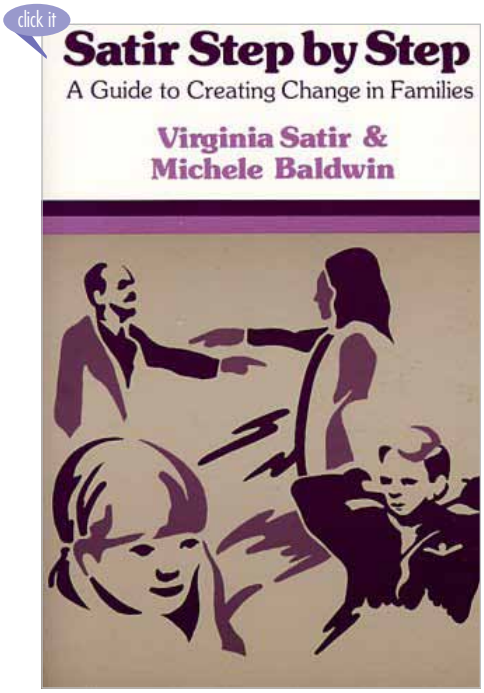
Virginia Satir (1916–1988) is known for her work in defining the art of family therapy. *Satir Step by Step*, which she authored in collaboration with Michele Baldwin, is a consolidation of her popular works (*Conjoint Family Therapy*, *The New Peoplemaking*, *Satir Model: Family Therapy and Beyond*). While this book is not exactly as simple as "coloring by numbers," the authors do an excellent job of showing how to build family rapport and trust with very clear, concise dialogue as Satir sculpts a session.



Satir Step by Step: A Guide to Creating Change in Families, *by Virginia Satir and Michele Baldwin. Palo Alto, Calif., Science and Behavior Books, 1984, 282 pp., $21.95*

Part I is a verbatim transcription of an interview with a family undergoing long-term therapy, which includes specific observations and comments. From the transcription, a reader can easily gain a better appreciation of the family in the context of "the patient." There are rich examples of parental messages in early childhood and the important role these messages play in molding behaviors. All the while, one can see how Satir keeps putting herself on "an equal human plane with family members," with the use of personal metaphors, reframing techniques, and humor.

In Part II, the conceptual framework, Satir expands on her contrasting views of the world by drawing on Eastern philosophies. Specifically, the threat and reward model and the seed model, which she uses to describe the following four areas: the definition of a relationship, the definition of a person, the explanation of events, and people's attitudes toward change. The threat and reward model is described as a punitive top-down hierarchical model in which those on top (doctors, teachers, and parents) know what is best for those on the bottom (children, students, and patients). The social commentary supports that many civilizations, including many Western societies, have evolved around this model. It becomes apparent that families seek help when individuals struggling with this model are uncomfortable with feeling compelled to behave in a certain way simply to satisfy others' expectations. In the seed model, every person is unique—the individual's strength is based on an acceptance of inherent underlying differences. This model, in contrast to the linear "do as I say" approach of the threat and reward model, is espoused as one that is more fluid. It allows for change to occur on multiple levels that contribute to an individual's growth. The overt rules in a family (such as bedtime, curfews, and household responsibilities) as well as the hidden rules (such as, for example, never speaking about father's drinking or the oldest son who drowned when he was 4 years old) are explored with regard to how they apply to the family system.

I found myself flipping back and forth between the sample interview and commentary to see how communication patterns between parents and children evolved and how the self-worth of each family member was reinforced. Conceptually intriguing and filled with applicable clinical examples, Satir and Baldwin have created a work that can bring techniques of family therapy to the therapist's repertoire.

Dr. Prasad is a fourth-year resident.