

## Inside

- 2 New Residents and the Residents' Journal  
Joseph M. Cerimele, M.D.
- 3 Preventing Family Conflict at the End of Life  
Stephen J. Warnick, Jr., M.D.
- 6 Defiant Behavior and Delayed Puberty: A Family Therapy Approach  
Ruxandra Carp, M.D.
- 9 Effective, Long-Term Couples Therapy for a Patient With Severe and Persistent Mental Illness  
Elie Isenberg-Grzeda, M.D.; Jeffrey Kerner, M.D.
- 13 The Utility of Family Inclusion in the Care of the Psychiatric Patient  
Michael Ascher, M.D.
- 14 Book Review  
Michael Ascher, M.D.; Jonathan Avery, M.D.
- 15 Book Review  
David Hsu, M.D.
- 16 Test Your Knowledge
- 17 Residents' Journal Info

## In This Issue



This issue of the *Residents' Journal* features articles on the theme of family psychiatry. Stephen J. Warnick, Jr., M.D., discusses four key areas that can aid in preventing family conflict in end-of-life care. Ruxandra Carp, M.D., outlines a family therapy approach involving psychoeducation, skills building, and intrapsychic work in addressing problematic family dynamics. Elie Isenberg-Grzeda, M.D., and Jeffrey Kerner, M.D., present a treatment model for long-term couples therapy for a patient with severe mental illness. Next, Michael Ascher, M.D., provides us with information on the utility of family inclusion in the care of psychiatric patients. Last, a review of a book on helping family members of individuals with alcohol dependence is presented by Dr. Ascher and Jonathan Avery, M.D.

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## New Residents and the *Residents' Journal*

Joseph M. Cerimele, M.D.  
Senior Editor

The 2011–2012 academic year ends on June 30th. Many regular readers, authors, and reviewers will complete residency or fellowship training at that time. Our journal only considers manuscripts authored by trainees, limiting our pool of potential authors to medical students, residents, and fellows. Each June, part of this pool moves on, and each July a new group enters the pool. We successfully managed the transition during July 2011. We hope to again rebuild our team of readers, authors, and peer reviewers by recruiting many new students, residents, and fellows during the changeover this summer.

The *Residents' Journal* is published monthly on the website of the *American Journal of Psychiatry* and e-mailed to residents who have signed up on our listserv. You can help us in the summer transition by telling other residents and fellows about the journal and by encouraging others to sign up for the monthly

e-notice. Also, don't forget about discussing the *Residents' Journal* with the medical students rotating with you on the wards. Despite our journal's name, we have actively encouraged medical student authorship (1).

Why tell others about the journal? Many residents have told me that it is encouraging to know that readers who have never before written a manuscript can work with the editors to submit one. The editors are glad to help trainee authors move through the academic writing and publication process. Telling another resident about the journal could help him or her move into the pool of regular readers, and at the *Residents' Journal*, we believe that regularly reading of journals is the first step in the writing process.

I often joke with colleagues about the "*Residents' Journal* progression." As an editor, I am pleased to hear from readers who have thought about writing and

submitting a manuscript. I can watch the trainee's idea develop into a published article. That same author could then be invited to peer review a manuscript, a task that most residents enjoy and can do very well (2). Some peer reviewers remain interested in learning editing skills as well as the mechanics of journal production and, subsequently, apply to become guest section editors. Many trainees have moved through this progression. We feel that telling your new colleagues about our journal could send someone down this path of learning important academic skills.

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# Preventing Family Conflict at the End of Life

Stephen J. Warnick, Jr., M.D.  
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## Case

“Ms. C” was a 79-year-old African American woman who presented to a community hospital for progressive weight loss, jaundice, and fatigue. The patient had no reported history of these symptoms. She had not seen a physician in more than 30 years due to her dislike of doctor’s offices and only came to the hospital in response to her son’s urging. She was independent in her activities of daily living and resided with her son, although she had been living in another state with her daughter until 3 months prior to presentation. Her initial examination revealed that she was cachectic but not in distress. She had scleral icterus and thrush, with a palpable liver edge. Her liver function tests revealed an alkaline phosphatase level of 1435 U/L, an aspartate transaminase level of 94 U/L, an alanine transaminase level of 43 U/L, total bilirubin concentration of 14.3 mg/dL, and a carbohydrate antigen 19-9 level of 81,444 U/ml (normal range <37 U/ml). Computed tomography results of her abdomen demonstrated a pancreatic head carcinoma, with lymphadenopathy and metastases to the liver and lungs. Pertinent mental status examination findings revealed that the patient appeared ill and withdrawn. She had a restricted affect and stated that her mood was stable, denying depression. She demonstrated organized thought processes and had no delusions, paranoia, or hallucinations. She was alert and oriented with intact attention and able to process information with an average cognition. She had poor insight into her health and recent health decline, but her judgment was intact.

Ms. C was diagnosed with metastatic pancreatic cancer, and she did not seem surprised or upset by the diagnosis. The departments of oncology, gastroenterology, and palliative care were consulted, and after discussing that surgery, radiation, and chemotherapy were not viable op-

tions, both the patient and her son agreed to a biliary stent to relieve her jaundice. They were initially interested in palliative care, but on further discussions with the daughter, the son insisted upon aggressive care. This change in plan occurred partially because the daughter wanted the cancer to be cured. When the daughter arrived from out of state, she was fixated on hyperalimentation, since she believed that nutrition could make her mother strong enough to undergo chemotherapy or surgery. This led to anger when intravenous fluids were discontinued, as the daughter felt that her mother was being starved. The family then requested tube feedings to maintain nutrition as well as a liver biopsy so that the patient’s care could be transferred to a cancer treatment center. The daughter also asked for medical information regarding her mother’s prognosis and test results to be withheld because she felt that this made her mother feel worse. Throughout the process, Ms. C was passive but comfortable with her family members making medical decisions, although she maintained decision making capacity. When asked about her preferences, she stated that it was “all in God’s hands” and that “miracles can happen.” Eventually, she was transferred to the local tertiary care center for a second opinion after the primary medical team, departments of oncology and palliative care, and the ethics committee determined that further treatment consisted of futile care.

## Discussion

End-of-life decisions can be difficult for patients and their families, creating a main source of conflict in the hospital, which can be prevented by better understanding family dynamics and establishing evidence-based communication (1). Analyzing the present patient’s care reveals four key areas that can aid in making end-of-life conflicts less trouble-

some for the patient, family, and medical team: assessment of readiness to accept terminal diagnosis, identification of sociocultural influences on end-of-life care, examination of the physician’s beliefs regarding end-of-life care, and recognition of warning signs of family conflict.

## Assessment of Readiness to Accept Terminal Diagnosis

Assessment of the stages of grief experienced by a patient and his or her family aids in setting realistic goals in the patient’s care. The patient in the present case was not ready to discuss death initially, despite presenting with end-stage cancer. In such circumstances, Weiner and Roth (2) have proposed asking the patient and the family questions such as “What do you understand about your illness?” and “Where do you see things going with your illness?” These types of questions can prevent communication from shutting down. Such dialogue can also help the primary medical team and family start a discussion regarding the goals of care. Weiner and Roth proposed using the stages of change model and motivational interviewing to help patients and families increase their readiness to discuss death and dying, rather than forcing the physician’s agendas on them.

## Identification of Sociocultural Influences

In addition to assessing readiness to discuss death, early identification of important cultural beliefs that affect end-of-life decisions is vital to preventing family conflict. In the present case, the use of surrogate decision makers, strong religious beliefs, the question of withholding medical information, and cultural attitudes toward end-of-life care were relevant. The patient’s most influ-

continued on page 4

continued from page 3

ential decision maker was her daughter, and evidence has shown that many African American patients tend to rely more on family members, close friends, and clergy in end-of-life decision making rather than using formal documents, such as do not resuscitate orders or formalized durable powers of attorney (3). There is also evidence that African American families are less satisfied with end-of-life care, particularly regarding communication with physicians (4). Our team may have avoided conflict by having the patient's daughter, instead of her son only, involved early in the decision making, either through telephone or videoconference. Inquiring about surrogate decision makers can build trust, which is important because family members and patients often doubt physicians' judgments regarding futile medical care (5). Knowing patients' religious beliefs can also help in end-of-life care planning in that this enables doctors to focus less on medical jargon and more on spiritual issues. Patients who use spiritual means as coping are more likely to implement aggressive end-of-life care and less likely to have do not resuscitate orders (6). This is counterintuitive and can be partially explained by a reluctance to plan for death, leaving decisions about life and death "in God's hands" (3). Involving religious figures early in decision making builds rapport and can foster discussions about the goals of care.

Withholding medical information is another cultural issue to explore. The patient's daughter requested that information be withheld, but our team never asked the patient about her own preferences regarding being informed of her diagnosis or prognosis, which was a potential missed opportunity to build trust. Western cultures generally value respect for autonomy as one of four major principles of medical ethics, and autonomy includes the right for a patient to not know his or her diagnosis and to defer decision making to others (7, 8). A discussion of cultural values pertaining to end-of-life care also extends to the broad literature on racial and ethnic differences in care, with multiple studies demonstrat-

ing that even though African American patients have less access to medical care during their lifetime, at the end of life, these same patients are more likely to have aggressive care (4, 9–11). There are many theories as to why this difference exists, such as persistent mistrust of the medical establishment in the wake of the Tuskegee syphilis experiments, less education regarding do not resuscitate orders and the role of powers of attorney, and religious beliefs suggesting that end-of-life decisions should be left to a higher power. We provide respectful and appropriate care to patients when we better understand cultural issues in caring for dying patients.

## Examination of the Physician's Own Belief System

There are at least two validated scales designed to assess comfort with topics on end-of-life care, with one scale targeting physicians-in-training and the other focusing on palliative care physicians and nurses (12, 13). These scales, however, fail to take into account physicians' cultural beliefs about the dying process, such as shared decision making and withholding medical information. For instance, our team had not considered that our patient might have wanted her medical information withheld, potentially because of personal biases and beliefs regarding sharing medical information among the medical team. Our cultural assumption that patients should be told their diagnosis and prognosis may have harmed our relationship with the patient and her family.

## Recognition of the Early Warning Signs of Family Conflict

An additional learning point highlighted in our patient's case involved poor familial communication. While there was never overt conflict between the patient, her son, and her daughter, there were signs of strain, such as the siblings never being in the hospital at the same time, changes in the management plan depending on whether the son or daughter

made decisions, and the persistent hostility toward the medical team despite frequent communication with the family. King and Quill (14) have provided many tips for recognizing familial issues and minimizing conflict, such as regular communication among the medical professionals in order to prevent sending mixed messages, avoiding mirroring the family conflict, and setting ground rules for each family meeting regarding what will be accomplished and what behaviors will be tolerated.

## Conclusions

End-of-life care is a time in which to engage with patients and their families, and anticipating situations with the potential for conflict can improve care. Awareness of different styles of communication and decision making, especially when different from those with which the physician is comfortable, builds trust with family members. Keeping the focus of end-of-life care on the goals of the care, rather than spending time on how to deal with a "difficult" family member, helps the medical team and the patient's support system collaborate toward a positive outcome.

*Dr. Warnick is a fifth-year resident in the Family Medicine and Psychiatry Residency Program, University of Cincinnati. The author thanks Jeffrey D. Schlaudecker, M.D., Assistant Professor of Family Medicine, University of Cincinnati, for providing invaluable assistance.*

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continued from page 4

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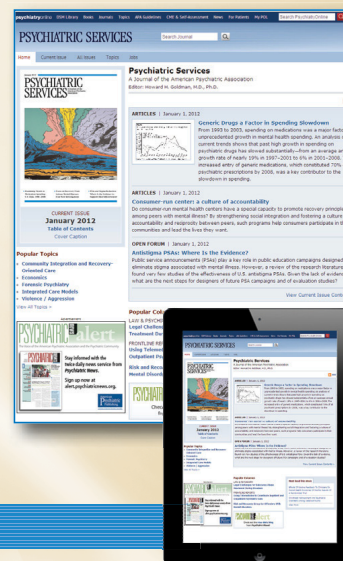
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# Defiant Behavior and Delayed Puberty: A Family Therapy Approach

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Postdivorce families and stepfamilies with multi-problems are common in clinical practice. Like many families, they frequently enter treatment focusing on one individual as the source of their distress. A careful assessment often reveals problematic family dynamics, which become the target of treatment. In the present report, a range of family therapy interventions, including parenting practices and alliances across two households, are discussed as they relate to the behavior problems of an adolescent boy with delayed puberty.

## Case

“Peter” was a 14½-year-old Caucasian boy who was referred to family therapy for hitting his twin 7-year-old half-brothers and disobeying his mother and stepfather. He had previously received 18 months of individual therapy. He was reportedly well behaved whenever he was at his biological father’s house, and he had an uneventful childhood until 2 years prior to his referral when he started to become irritable and aggressive toward his twin brothers. Concurrently, his interest in athletics, socializing, school, and family suddenly decreased. About 1 year ago, the family’s pediatrician expressed concern about his slow growth.

His parents divorced when he was an infant because of his father’s alcoholic rages. The mother remarried when he was 3 years old. His brothers were born 4 years later. In addition to parenting three boys, Peter’s mother was the primary caretaker for her ailing father. The mother and stepfather reported having a loving marriage. Over time, Peter’s father achieved sobriety and forged an amicable coparenting relationship with his ex-wife. Interestingly, Peter’s father and stepfather became friends as well as tennis partners.

Peter presented for family therapy evaluation with his mother, stepfather, biological father, and half-brothers. The adults appeared to be amiable toward each other and somewhat detached from the children. Peter’s rambunctious brothers frequently interrupted the conversation. They also teased Peter. The parents did not intervene. When Peter finally demanded that his brothers stop teasing him, the adults chastised him.

The mother complained that Peter “tried to parent” his brothers and “talked back” when told to stop. She added that she often called his biological father for help in disciplining him. The stepfather complained that Peter never listened to him. His biological father responded apologetically that his son most likely took after him, describing himself as a rebellious teenager.

Peter became tearful and said that the twins were exhausting and often invaded his room, took over his computer, and refused to leave when he asked them nicely. “I ask Mom to help, but they don’t leave, so I push them out of my room. Then Mom screams at me. Why am I the one to blame?” Peter stated that his stepfather was harsh with him and that in contrast, he spoiled his own sons. He added that at his father’s house, he felt peaceful, as though he were on vacation.

The mother responded to this poignant plea by stating, “How can you be so rude? I am just one person. I don’t have only you to take care of. I also have to take care of my sick father.” Peter’s father added, “Be nice to your mother. You should be more grateful for all she does for you.”

Peter (4 ft, 3, in) and his brothers (4 ft, 1 in) were almost equal in size. Because he never mentioned his physical immaturity, the adults assumed that he was not con-

cerned about it. When I inquired about his size, he replied, “I don’t want to talk about it,” hinting that perhaps seeming disinterest might actually hide painful concern.

At the end of the evaluation session, I expressed appreciation for the adults’ cooperative postdivorce relationship. I empathized with the couple’s challenge of raising children with different developmental needs while juggling work and care for an ailing parent. I suggested weekly family therapy sessions in various configurations (the whole family, the married couple, the mother and Peter, etc.) to address specific dynamics (1). I encouraged an endocrinology referral for Peter and an evaluation for the hyperactive twins.

The parents agreed with the plan. We subsequently met for 10 sessions. During the course of treatment, Peter was diagnosed with idiopathic delayed puberty and began receiving treatment. In addition, the twins were diagnosed with attention deficit hyperactivity disorder (ADHD) and also received treatment. I collaborated with Peter’s individual therapist, who explored the effect of his medical condition with him and provided consistent support.

In family therapy, we focused on psychoeducation, increased parental empathy, firmer limit setting, and attention to the effect of Peter’s medical condition and the twins’ ADHD on the family dynamics. Gradually, Peter’s behavior and that of his brothers improved. Additionally, his interaction and communication with his mother and stepfather improved. Eventually, the family chose to terminate the sessions.

continued on page 7

continued from page 6

## Family Therapy Interventions

The interventions applied to this case were drawn from Papernow's (2) three-level model, which weaves together psychoeducation (level 1), interpersonal skills building (level 2), and intrapsychic work (level 3). Psychoeducation enabled the parents to understand the developmental needs of the children, set more realistic expectations, and learn about effective parenting practices. Furthermore, they also needed to develop parenting skills that would enable them to empathize with their children's feelings and to become alert to the underlying motives of the children's difficult behaviors. In turn, children tend to become more cooperative when they feel that their parents understand them. The intrapsychic work was necessary whenever the parents were triggered by the children's behavior and had difficulty responding empathically, despite having made consistent progress in the areas of psychoeducation and interpersonal skills building. The clinician enabled the parents to explore the connection between the present situation and a child's experience growing up in their family.

At the psychoeducational level, researchers recommend an authoritative parenting style that is warm, empathic, and responsive yet firm (3, 4). The Parenting Styles Chart (2-4), which illustrates these strategies, helped Peter's mother and stepfather

to recognize that harsh, authoritarian parenting triggered increased defiance and withdrawal from him. Meanwhile, permissive parenting left the twins undisciplined. Like many stepparents, Peter's stepfather was unaware that he was more accepting of his own children's behavior than of Peter's (2).

We focused on Peter's normal adolescent need for more autonomy and separation (5) from his family in order to solidify his own identity. The parents needed to understand that his delayed puberty significantly affected his self-concept, exposed him to peer rejection, and precipitated changes in his behavior. Eventually, they were able to understand his vulnerability given that in adolescence, self-esteem is closely related to body image. We also worked on helping all the adults to become aware of Peter's need for protection from the twins' intrusiveness and teasing.

At the interpersonal skills level, it appeared that no one in Peter's environment empathized with his position. I introduced a rule that helped everyone to feel safe enough to voice their opinions and concerns in our sessions. I emphasized that my role was to be equally supportive of each family member and not to take sides. The family learned to set firmer limits and to provide more structure for the twins (6). The adults developed their skills in empathizing (7) with all of their children and remained interested in the underlying motives of difficult behaviors. In addition, they became aware that their

loyalty to each other had trumped their empathy for Peter's needs. They agreed to start speaking up for Peter when any of them were judgmental of him.

## Intrapsychic Work

Despite psychoeducation and skills building, Peter's mother still struggled in being able to respond appropriately to him. We therefore turned to intrapsychic work (2, 8). For example, in response to Peter's worries about his medical condition, his mother had inadvertently flooded him with her own anxiety and helplessness: "I feel helpless too because I can't make you grow!" Exploration revealed that her father's chronic alcoholism often left her feeling helpless during her own childhood, and she was now facing his terminal illness. Realizing that healing her profound personal wounds might help her to better tolerate her children's feelings, she chose to enter her own individual therapy.

## Conclusions

This report illustrates how a family therapy focus that flexibly combines psychoeducation, skills building, and intrapsychic work can improve outcomes in a blended family with children of varying developmental stages and needs. Parenting children of different ages is generally challenging. It is even more difficult when one or more children have special needs (i.e., Peter's delayed puberty and the twins' ADHD). Integrating elements

continued on page 8



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continued from page 7

of bio-psycho-social assessment enables the medically trained family therapist to identify medical problems as well as their contribution to dysfunctional family dynamics.

Postdivorce families pose unique challenges for parents, stepparents, and stepchildren. Although the three adults in Peter's life met the critical challenge of establishing a collaborative coparenting relationship, treatment helped them to deepen their empathy for Peter (9).

*Dr. Carp is a second-year child and adolescent psychiatry fellow at Cambridge Health Alliance/Harvard Medical School, Cambridge Mass. She completed her adult psychiatry residency at Harvard South Shore Psychiatry Program. She will practice in the Boston area beginning July 2012.*

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# Effective, Long-Term Couples Therapy for a Patient With Severe and Persistent Mental Illness

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## Case

“John” was a 50-year-old Caucasian man with schizoaffective disorder. He was unemployed and lived in the community with his 59-year-old wife. They had a 26-year-old son who lived alone.

The patient’s chief complaint was that he wanted to kill himself. He initially presented to the psychiatric emergency department when he was brought in by police after threatening to jump off the roof of his apartment building. He reported waxing and waning depressed mood, anhedonia, guilt, poor concentration, and hopelessness since the death of his mother 5 years prior. He also reported passive suicidal ideation beginning 2 years earlier, after being fired from his job due to repeated careless mistakes. Intermittently over 2 years he heard an unrecognizable male voice repeating demeaning comments, such as “You should kill yourself.” These auditory hallucinations also occurred in the absence of mood symptoms.

John began throwing kitchen knives at trees 1 year prior. He was euphoric when handling knives, falsely believing that he could accurately hit a target without appreciating any physical danger or legal repercussions. He denied other mood and psychotic symptoms. He also denied past psychiatric illness as well as a history of major medical illness.

The patient was raised by both parents and had a younger brother. After completing high school, he joined the Marines. At age 23, he was introduced to “Jane,” then 30 years old, and the couple soon married. He also began work as a parcel delivery man. John and his wife had strong attachments to one another, enjoyed a loving and supportive marriage,

and felt close to family and friends. Three years after they married, their son was born. John’s mother died when he was 37 years old, leading to an unexpected discovery: the man who raised him was not his biological father, and his younger brother was actually his half-brother.

John reported drinking beer socially while he was in his 20s and 30s and denied smoking cigarettes or using drugs. Both he and his wife denied a history of spousal abuse.

He was first admitted to an acute inpatient unit and then transferred to a long-term state psychiatric facility after 4 weeks, since aggressive behavior and poor self-care persisted. At the state facility, a PGY-2 psychiatry resident rotating for 6 months coordinated all aspects of the patient’s care. Clozapine was prescribed and titrated to 500 mg in divided doses, in addition to 200 mg of sertraline. The patient’s wife visited him daily and participated fully in treatment planning.

The wife requested couples therapy, and the patient agreed. The resident led the therapy sessions, which were supervised by the residency training program’s director of family therapy. The sessions occurred weekly for 1 hour. The supervisor also participated, enhancing the continuity of care. The patient initially remained quiet, and the therapy was focused on listening to his wife’s experience of his illness. This in turn built rapport and fostered safe and open communication. His symptoms were perceived as unexpected and frightening, and work was focused on repairing the couple’s attachments. The wife reported feeling guilty for not recognizing the illness, shame and stigma regarding mental illness, and helplessness about her husband’s care. These issues were normalized, relevant information

about the illness was provided, and conflicts arising from the couple’s emotional distress were explored. Couples therapy also provided the patient’s wife with an outlet to discuss her own health and that of their adult son.

Over 3 years of hospitalization, a total of seven residents were involved in couples therapy with John and his wife. He reported progressively fewer symptoms and improved functioning. At the point of discharge, the director of family therapy negotiated with the training program and outpatient services to ensure that residents would continue work with the couple on an ongoing outpatient basis. In 4 years after discharge, John and his wife continued weekly therapy sessions and worked with a total of eight residents. The theoretical model is described elsewhere (1).

## Discussion

Since the 1950s, treatment of chronic mental illness has moved to the community, and an estimated 40% of patients live with their families (2). Day-to-day behavioral management, medication compliance, and patient advocacy often become the responsibilities of patients’ family members (3, 4), who report feeling overwhelmed, frustrated, and hopeless about their loved ones’ recovery (3).

Patients with schizophrenia are typically unmarried, since illness onset commonly occurs during adolescence, before stable partnerships form (4). Among individuals with schizophrenia, marriage rates are lower relative to the rates in the general population, and divorce rates are higher (5). In the majority of cases, parents, specifically mothers, assume caregiver responsibilities, and in a recent sample

continued on page 10

continued from page 9

of schizophrenia patients, only 10.6% of caregivers were spouses (4). Research on spousal burden in schizophrenia is therefore limited (4–7). Spouses of patients with mental illness commonly face unique challenges, including with emotional and sexual intimacy, redefining mutual partnership roles, lost expectations of a shared life with their spouse, and the threat of separation or divorce (6). Couples therapy intervention in the present case preserved and supported the couple's relationship.

Family therapy is an evidence-based treatment (8, 9) and is reflected in the APA guidelines on the treatment of several axis I disorders, including schizophrenia (10). Several models of family therapy exist, and variables can include theoretical approaches (didactic, cognitive-behavioral therapy, systems theory), length of time, location, and single-family versus multiple-family sessions (9). Despite certain differences, evidence-based treatment models of family therapy share common core principles (9).

Working with families is a common clinical scenario encountered by psychiatric residents and is a core competency of the Accreditation Council for Graduate Medical Education. However, residents face obstacles in providing family therapy, including the lack of thorough training in many residency programs (11) as well as the problems of transferring care when changing rotations artificially forces termination. Both obstacles are reflected in the literature by reports from family members of feeling in conflict with treatment providers (12) and families experiencing frustration over issues related to the continuity of care (3).

## Issues Unique to Spouses

In the present case, common problems unique to spouses began to emerge during outpatient treatment. The patient's wife worried about which symptoms indicate impending relapse, and therapy offered an opportunity for both the patient and his wife to talk more openly. The wife noted the burden of rearranging spousal responsibilities with regard to household

chores, parenting, and finances. Therapy enabled her to explore the difficulties that she faced in taking on new tasks that her husband could no longer perform and the sense of loss and failure he must have felt about this. She returned to work as a custodian in order to support the family. Both spouses revealed feelings of extreme social and familial isolation. Therapy provided a platform to discuss the common problem of impairment in sexual interest and intimacy, often caused by medication side effects or iatrogenic weight gain. The residents adapted the therapy to address these problems and new ones over time. For example, explicit crisis plans were provided to address symptoms of recurrent suicidality and aggression, which continued to emerge intermittently over the course of treatment. Problem solving techniques addressed household chores, finances, parenting, and the patient's difficulty with adhering to the treatment plan. A parent-child dynamic emerged, since the wife reported feeling like the patient's "parent," and this was addressed in the sessions. A thorough sexual history was taken to explore the couple's fears and inhibitions. Lack of intimacy remained an ongoing and difficult-to-treat problem, which is consistent with studies reported elsewhere (6).

## Structural Styles of Therapy

Expert recommendations conclude that psychosocial interventions should span at least 9 months, although there are some longer-term and even open-ended family therapy structures (9). Formats have included single- and multiple-family sessions, and location can vary among inpatient, outpatient, clinic-based, family practice-based, and home-based settings. In addition to the theoretical model of therapy, the degree of involvement of the identified patient can vary (e.g., the degree of didactic, cognitive-behavioral, or systems-based approaches to therapy). Dixon et al. (9) reported that little is known about the lowest "dose" of family therapy needed to achieve success, but successful programs have reported lower relapse rates, improvement in the well-being of family members, improved participation in vocational rehabilitation

programs, and decreased overall cost (9). A recent randomized, controlled study of a 2-year family therapy intervention with schizophrenia patients reported relapse rates of 12% with family therapy intervention versus 40% with individual counseling plus standard treatment, which was statistically significant (13).

## Conclusions

The unusual aspect of the treatment in the present case was the sustained improvement and lack of recidivism in a person with serious mental illness by, among other things, weekly couples therapy and significant work with the patient's spouse. Therapy was open-ended, and the couple had a safe holding environment in which to contain all of the challenges faced by a couple dealing with multiple psychiatric and social problems. Residents who worked with this couple found the experience to be rewarding and enlightening and one of professional growth. The model drew on evidence-based treatments, such as family psychoeducation, to tailor a method specific to the couple, addressing issues unique to a spouse with severe and persistent mental illness. Future studies should measure the efficacy of this approach with couples across a wide range of pathologies and aim to measure predictors of successful treatment using this approach.

*Dr. Isenberg-Grzeda is a third-year resident and Dr. Kerner is a second-year resident in the Department of Psychiatry and Behavioral Sciences, Albert Einstein College of Medicine, Montefiore Medical Center, Bronx, N.Y.*

*The authors thank Ms. Madeleine Abrams, L.C.S.W., for her invaluable supervision as well as her guidance and support.*

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## CALL FOR PAPERS

### Have You Ordered a Lab Today?

The Residents' Journal is soliciting manuscripts about the use of laboratory studies in clinical care.

Suggested topics are:

- The measurement of serum antipsychotic levels
- The role of laboratory studies in managing substance use disorders
- Laboratory studies for specific populations (e.g., children, pregnant women)
- The laboratory monitoring of clozapine's systemic effects

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# The Utility of Family Inclusion in the Care of the Psychiatric Patient

Michael Ascher, M.D.

Department of Psychiatry and Behavioral Sciences, Beth Israel Medical Center, New York

In the last two decades, research has increasingly supported the need for mental health practitioners to give more attention to family members of psychiatrically ill patients (1). Family-oriented patient care includes communicating with families, helping them to understand and cope with mental illness, and considering family members as members of the treatment team (2). These interventions can improve patient outcomes and reduce family burden (1). Since family members are often responsible for reminding the patient to adhere to treatment plans, the resident can alert the family to specific signs and symptoms exhibited by their psychiatrically ill relative, which could help in avoiding relapse and hospitalization.

Extensive research has demonstrated that patients can stay out of the hospital longer and function better when their families reduce the level of expressed emotion in the household (3). Expressed emotion refers to high levels of criticism, hostility, and emotional overinvolvement. Psychiatric residents are in a good position to quickly screen and assess the family functioning among a patient's relatives by asking a few basic questions, for example, "Are relatives critical of you," and if so, "How much does that bother you?" (4); "How satisfied are you with your relationship?"; "If you have children, have you talked to them about your condition?" The psychiatrist should also identify the "emotional caretaker," who may not necessarily live with the patient, as well as the needs of the family and the illness beliefs that exist within the family.

When a patient receives a psychiatric diagnosis, this can lead to or exacerbate

conflict within a family. It is helpful for the family to realize that the diagnosis is only one aspect of the patient. Moreover, the caregivers and family members are under tremendous stress and may have diagnosable disorders and symptoms themselves, such as anxiety and depression, which may require treatment (5).

In addition to inquiring about family functioning, the resident should refer the family to useful community resources, such as the National Alliance on Mental Illness, Aware Defeat Depression, the Support and Family Education Program, the Depression and Bipolar Support Alliance, and the National Education Alliance on Borderline Personality Disorder.

However, working with families can present multiple challenges for the resident, who is required to adhere to the Health Insurance Portability and Accountability Act. Patients may not wish to discuss or allow family members to learn certain information. Therefore, the physician must know the patient's preferences and obtain permission to share information accordingly. Other barriers include insurance regulations, which may make it complex to include family support or therapy. In addition, some family members may be reluctant to attend a therapy session, believing that they will be blamed for the patient's condition, or they may be too perturbed by the patient's prior behavior.

The importance of good communication, assessment, support, alliance, and psychoeducation with patients and their families cannot be overemphasized. A wonderful resource for residents is the *Clinical Manual of Couples and Family Therapy* (6),

which outlines practical, evidence-based family therapy skills. In summary, the resident should have a good understanding of how a patient's illness affects the family system as well as how the family affects the patient.

*Dr. Ascher is a third-year resident in the Department of Psychiatry and Behavioral Sciences, Beth Israel Medical Center, New York; he is also a fellow in the Group for the Advancement of Psychiatry Committee on the Family. The author wishes to thank Dr. Ellen Berman for her guidance and contribution to this article.*

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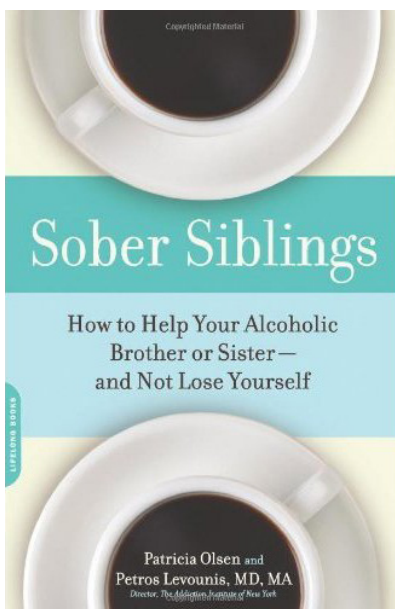
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# Sober Siblings: How to Help Your Alcoholic Brother or Sister—and Not Lose Yourself

Michael Ascher, M.D.  
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Jonathan Avery, M.D.  
Department of Psychiatry, Weill Cornell Medical College, New York

While the physical and psychological effects of alcohol dependence on the individual are well understood, the far-reaching effects of alcohol abuse on family members cannot be overemphasized. Alcohol dependence has been referred to as a “family illness” because the affected individual’s family is subjected to continuous stress and worries (1). Researchers have found that a myriad of emotions, including anger, sadness, shame, guilt, social isolation, and loss, are commonly experienced by the families of alcohol-dependent individuals (2). Treating the individual who suffers from alcohol dependence without including his or her family denies the family opportunity to benefit from family-oriented support and treatment. Recognizing and providing support to families who endure the problems caused by alcohol abuse should be a paramount goal of the psychiatric resident.

*Sober Siblings*, by Patricia Olsen and Petros Levounis, responds to the increasing need for mental health clinicians to help families live and cope with a relative’s alcohol problem. Olsen’s two brothers suffered from alcohol dependence, and Levounis is the director of the Addiction Institute of New York. Using Olsen’s experiences with her two brothers and several other case examples as a backdrop, the book details how siblings of individuals with alcohol dependence can work on their relationships with their family member, set boundaries, and, most importantly, seek help for themselves and their loved one. Levounis offers important information about the nature of alcoholism and the treatments available to affected individuals and their families.



*Sober Siblings: How to Help Your Alcoholic Brother or Sister—and Not Lose Yourself*

by Patricia Olsen and Petros Levounis.  
Boston, Da Capo Press, 2008, 240 pp.,  
\$16.00.

For family members of alcohol-dependent individuals, the book could serve as an introduction to understanding and dealing with alcoholism or could be a useful adjunct to family resources, such as Al-Anon groups. For psychiatrists (and psychiatry residents), it is a good book to recommend to family members, as it can serve as an impetus for patients to seek more comprehensive care in addressing the physical and emotional disturbances caused or exacerbated by alcoholism.

The section on setting boundaries offers useful advice on how to deal with difficult situations, such as drinking with siblings,

handling family holidays, navigating dangerous and life-threatening situations, and learning when to cut off a sibling. The authors assert that “setting boundaries is a way to maintain a relationship with an alcoholic while shielding ourselves from the damage she can inflict” (p. 135). Moreover, anger, frustration, and sadness are not only common emotions but valid ones. With the goal of minimizing resentment on the part of family members, the authors encourage practitioners to engage with families creatively, building on their strengths.

The personal stories and clinical vignettes make this book both readable and compelling. This accessible, insightful, and affordable text is invaluable reading for both mental health professionals and families who experience the maelstrom that alcohol problems cause.

*Dr. Ascher is a third-year resident in the Department of Psychiatry and Behavioral Sciences, Beth Israel Medical Center, New York. Dr. Avery is a third-year resident in the Department of Psychiatry, Weill Cornell Medical College, New York. Both authors are Ginsburg fellows in the Group for the Advancement of Psychiatry.*

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# The History and Influence of the American Psychiatric Association

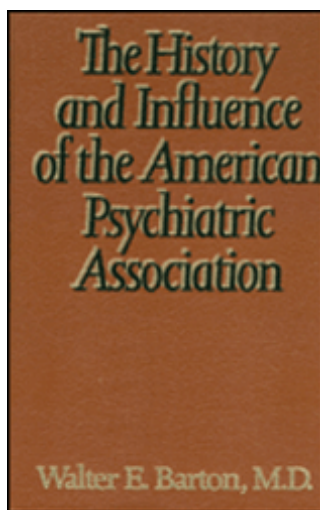
David Hsu, M.D.

Departments of Psychiatry and Internal Medicine, University of California, Davis, Health System, Sacramento, Calif

Twenty-five years ago, past APA president Walter Barton published this classic work on the history of the APA, the oldest national medical organization in the United States. This year marks the 168th anniversary of both APA and the *American Journal of Psychiatry*. It will also mark the 60th anniversary of DSM-I and the 66th anniversary of the National Institute of Mental Health. This year's APA annual meeting will be held in Philadelphia, the city where the organization was founded.

Dr. Barton (1906–1999), who was also past president of the Group for the Advancement of Psychiatry as well as a World War II veteran, weaves together a riveting narrative. He encompasses not only the history of psychiatry but also the history of medicine in general, given his focus on medical advances that have moved the psychiatric profession forward. Examples include his discussions of the first times that lithium and ECT were used as treatments as well as the development of antibiotics and chemotherapy.

Beginning with the pre-colonial era, seven of the book's chapters are devoted to distinct chronological periods as they relate to mental health in America. A significant portion of the book is devoted to the work of Dr. Benjamin Rush and his teachings on the "diseases of the mind." Barton describes in detail that day (October 16, 1844, at 10:00 a.m.) in Philadelphia, where the 13 founding fathers



*The History and Influence of the American Psychiatric Association*

by Walter E. Barton, M.D. Washington, DC, American Psychiatric Publishing, 1987, 416 pp., \$60.00.

of APA convened for the first time. They included four surgeons and nine general physicians, all of whom were interested in mental health, although they were not psychiatrists. The founders were pivotal in organizing psychiatric hospitals, and Charles Dickens wrote favorably of the one that was established in Boston.

Barton's friendship with General William Menninger during the World War II era personalizes this narrative. Menninger founded the Group for the Advancement of Psychiatry and also served as an

APA president. Both men had strong interests in administrative psychiatry, and Barton describes in detail how the subspecialty began. Over the course of the 20th century, administrative psychiatry would flourish into the community mental health movement, with the help of American presidents and the federal government. Menninger specifically recognized that psychiatry needed to be integrated into general medicine, a theme that will be featured again at the 2012 annual meeting.

In the preface, Barton states that this book was written specifically for residents of psychiatry. Although he spent more than 20 years researching for and writing the book, he acknowledges that his participation in APA spanned more than 50 years. Barton is one of an important group of psychiatrists in the 20th century, and this detailed, historical account reveals his passion for American psychiatry. Incorporation of historical studies into educational curricula can often be challenging, but this book has stood the test of time and is still relevant today. Resident psychiatrists should especially read it as they embark on their future careers and continue their participation in APA.

*Dr. Hsu is a fourth-year resident in the departments of psychiatry and internal medicine, University of California, Davis, Health System, Sacramento, Calif.*

# TEST YOUR KNOWLEDGE

In preparation for the PRITE and ABPN Board examinations, test your knowledge with the following questions. (answers will appear in the next issue)

In preparation for the PRITE and ABPN Board examinations, test your knowledge with the following questions (answers will appear in the next issue).

This month's questions are courtesy of Ruxandra Carp, M.D. Dr. Carp is a second-year child and adolescent fellow at Cambridge Health Alliance/Harvard Medical School, Cambridge Mass. Please see the accompanying treatment in psychiatry article in this issue accompanying this month's questions.

## Question #1

A family therapist was asked to assess and treat a nuclear family in which the parents had longstanding difficulties with disciplining their rebellious son. The parents always set high expectations and expressed criticism when their son did not comply with their requests. Usually, they disregarded his emotional needs and the motives for his difficult behavior. This is an example of which of the following parenting styles:

- A. Unpredictable
- B. Authoritative
- C. Authoritarian
- D. Permissive
- E. Combination authoritative and permissive

## Question #2

What is the best initial intervention in the aforementioned case:

- A. Individual therapy for the child
- B. Family therapy with the whole family
- C. Working with the parents to build authoritative parenting skills
- D. Couples therapy for the parents
- E. Psychoeducation

## ANSWERS TO MARCH QUESTIONS

### Question #1

Answer: B

The patient's presentation is most consistent with obsessive-compulsive disorder, since she demonstrates repetitive behaviors (hand washing) that she feels driven to perform in a rigid way in order to prevent distress. In line with criteria (1), the patient's rituals consume more than 1 hour per day and interfere with her occupational functioning. This presentation is not consistent with delusional disorder because there is no delusion present. Patients with a specific phobia demonstrate marked and persistent fear that is excessive or unreasonable, cued by the presence or anticipation of a specific object or situation, which is not characterized in this patient. Finally, this patient does not meet criteria for major depressive disorder.

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### Question #2

Answer: C

The aforementioned patient has a diagnosis of obsessive-compulsive disorder (OCD). Medications with Food and Drug Administration (FDA) approval for the treatment of OCD include clomipramine, fluoxetine, fluvoxamine, paroxetine, and sertraline. Despite clomipramine's FDA approval, selective serotonin reuptake inhibitors (SSRIs), such as sertraline, are preferred for initial trials given their superior tolerability (1). Few studies support the use of antipsychotic medications for OCD monotherapy, although antipsychotic medications might be used to augment SSRI treatment in cases of no response or partial response. Evidence for the use of benzodiazepines is presently limited to case reports.

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We are currently seeking residents who are interested in submitting Board-style questions to appear in the Test Your Knowledge feature. Selected residents will receive acknowledgment in the issue in which their questions are featured.

Submissions should include the following:

1. Two to three Board review-style questions with four to five answer choices.
2. Answers should be complete and include detailed explanations with references from pertinent peer-reviewed journals, textbooks, or reference manuals.

\*Please direct all inquiries and submissions to Dr. Seawell; mseawell@med.wayne.edu.

# Author Information for *The Residents' Journal* Submissions

*The Residents' Journal* accepts manuscripts authored by medical students, resident physicians, and fellows; manuscripts authored by members of faculty cannot be accepted.

- 1. Commentary:** Generally includes descriptions of recent events, opinion pieces, or narratives. Limited to 500 words and five references.
- 2. Treatment in Psychiatry:** This article type begins with a brief, common clinical vignette and involves a description of the evaluation and management of a clinical scenario that house officers frequently encounter. This article type should also include 2-4 multiple choice questions based on the article's content. Limited to 1,500 words, 15 references, and one figure.
- 3. Clinical Case Conference:** A presentation and discussion of an unusual clinical event. Limited to 1,250 words, 10 references, and one figure.
- 4. Original Research:** Reports of novel observations and research. Limited to 1,250 words, 10 references, and two figures.
- 5. Review Article:** A clinically relevant review focused on educating the resident physician. Limited to 1,500 words, 20 references, and one figure.
- 6. Letters to the Editor:** Limited to 250 words (including 3 references) and three authors. Comments on articles published in *The Residents' Journal* will be considered for publication if received within 1 month of publication of the original article.
- 7. Book Review:** Limited to 500 words and 3 references.

Abstracts: Articles should not include an abstract.

## Upcoming Issue Themes

*Please note that we will consider articles outside of the theme.*

### May 2012

Section Theme: Sexual Disorders  
Guest Section Editors: Almari Ginory, D.O., Laura Mayol-Sabatier, M.D., and Nicole Edmond, M.D.  
ginory@ufl.edu

### June 2012

Section Theme: Advocacy in Psychiatry  
Guest Section Editor: John Lusins, M.D.  
drjlusins@gmail.com

### July 2012

Section Theme: ADHD  
Guest Section Editor: Justine Wittenauer, M.D.  
jwittenauer@emory.edu

### August 2012

Section Theme: International Health  
Guest Section Editor: Nicole Zuber, M.D.  
nicajean@gmail.com