ARTICLE

Understanding Families as Essential in Psychiatric Practice

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Family work is a critical component of psychiatric practice. It is important for psychiatrists to be able to understand the role of family relationships and family systems in individual development across the lifespan. Assessing family factors is an important part of developing a biopsychosocial formulation. Understanding family relationships provides a context for an individual's values and beliefs, which are important components of assessing the patient's mental health challenges. Dysfunctional family relationships can be precipitating or perpetuating factors for mental illness. On the other hand, positive family relationships can offer support, be protective, alleviate emotional and behavioral problems, and lead to improved outcomes. It is important for psychiatrists to be able to work effectively with families by providing support, understanding families' needs, assessing families' strengths and limitations, identifying issues requiring family-based intervention, and facilitating referral to a family therapist when necessary. By engaging families as resources and essential partners in treatment planning, the psychiatrist is able to enhance the quality and success of patient care. This article discusses the role of the psychiatrist in assessing family factors implicated in psychiatric illness; offers general context for understanding the response required by families for improving various emotional and behavioral challenges; and provides an overview of family-based interventions, including family psychoeducation and support, parent management training, and family therapy.

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In child psychiatry, engagement with families is critical to success in managing child and adolescent mental illness. Emotional and behavioral issues among children and adolescents exist within the context of family relationships, which affect child development. Dysfunctional family relationships and interactions can be the source of distress or may exacerbate distress. Conversely, family relationships and response to the child can be protective and supportive, contribute to positive child development, ameliorate behavioral and emotional problems, and improve outcomes. In adult psychiatry, understanding the role of family factors contributing to the patient's presenting problem is an important part of assessing the individual patient and is a key part of developing a thorough biopsychosocial formulation. In assessing an individual patient, it is important to understand not only the biologic basis for psychiatric illness, but also that psychiatric illness is affected both positively and negatively by family relationships. In addition, the illness itself can be a stressor that may contribute to dysfunction within the family system, thus perpetuating distress and illness. For adult patients, an understanding of family relationships and their impact on development provides an important context for the beliefs, values, and relationship patterns that perpetuate mental illness. Attention to family factors can also identify family strengths, which can be used to support treatment and recovery.

FAMILY FACTORS IN PSYCHIATRIC AND GENERAL MEDICAL CARE

Patients are affected both positively and negatively by family relationships and functioning. The impact of family factors is relevant in both psychiatric care and general medical care. Within medicine and pediatrics, family involvement in care has been demonstrated to be important for optimal treatment outcomes. For example, good marital quality and dependable social support have been associated with improved outcomes and survival among individuals with cardiac disease as well as breast carcinoma (1). Conversely, family stress, such as caregiving for a spouse with a disability or illness, has been associated with increased risk for cardiovascular illness (1). A family-focused intervention (2) that emphasized family teamwork in the management of adolescents with diabetes, for example, was found to decrease illness complications. Other studies of pediatric populations have described improved patient outcomes with family involvement in care. Such studies have described improved treatment outcomes resulting from parental involvement in

children's postsurgical pain assessment and management and improved behavioral symptoms with implementation of a preventative educational-behavioral intervention program among families of children requiring intensive medical care (1). Additionally, family factors have been identified as protective factors or risk factors that affect outcomes in chronic general medical illness (1).

The impact of family factors in general medical treatment is relevant for psychiatric practice. Psychological functioning and illness outcomes often are affected by comorbid general medical conditions, and family engagement is important in improving general medical outcomes as well as emotional and behavioral functioning. In addition, psychiatric illness has been understood as having a biologic basis, balanced with the impact of contributing psychological and social factors. Psychiatric illness and psychological function are shaped by the family and social environment, and family factors are implicated in the development and maintenance of major psychiatric illness (3). Although biologic factors contribute to vulnerability to psychiatric illness, family factors and functioning contribute to illness expression (3). It is critical for psychiatrists to understand the family system and the role of family work in various mental health–related issues. An understanding of the family enhances the psychiatrist's understanding of the patient's health and illness. Additionally, successful engagement with the patient's family and support network contributes to a strength-based approach for treatment planning which leads to optimal management of illness and progress toward recovery.

Family interventions in psychiatric practice have been found to be beneficial for various conditions, such as depression, anxiety, eating disorders, substance use disorders, attention-deficit hyperactivity disorder (ADHD), conduct disorder, and obsessive-compulsive disorder (OCD) (4), as well as for schizophrenia, bipolar disorders, and borderline personality disorder (1). Family psychoeducation has been shown to have positive effects for adults with psychotic disorders and bipolar disorders (5). Family-based interventions have been shown to optimize treatment, with reduced rates of relapse, improved recovery, and improved family well-being (1). Treatment that focuses attention on the family context enhances treatment, is typically used within child and adolescent psychiatry, and is also relevant for general psychiatric practice.

Psychiatrists work with multiple patient populations for which it is especially important to attune to family systems. Family systems theory conceptualizes the family as a system that attempts to maintain balance, with family relationships and responses maintaining this balance. Clinical problems are understood as an expression of systemic dysfunction within the family as a whole, rather than as solely the result of individual factors (6). Psychiatric practice often is oriented toward a focus on individual and biologic factors for illness, but including attention to family factors is also relevant, particularly for populations seen by general psychiatrists, including adolescents, transition-age youths (ages 18–25 years), young adults, adult patients who are parents or caretakers, geriatric patients, and patients with developmental disabilities. Although exposure to family therapy may be limited within the scope of general psychiatry training, there is a basic family intervention skill set which is broadly useful in general practice. It is important for psychiatrists to be able to ally with and support patients' families and to identify the needs of families and caregivers of patients with severe mental illness. Psychiatrists also should have knowledge of how to assess families, recognize problems related to family systems issues, and determine when a referral for family therapy is necessary for successful treatment (3). This article discusses identification and assessment of problems or concerns that require family-based intervention and presents an overview of family-based interventions.

ASSESSMENT OF FAMILY FACTORS

Development of a clear and balanced case formulation is the foundation of psychiatric treatment planning. Psychosocial factors (e.g., family problems or dysfunction) that contribute to the presenting concern inform the need for family engagement, either in the context of treatment with the psychiatrist or by referral to a child and adolescent psychiatrist or family therapist. During patient assessment, it is important to identify patterns within family relationships that may serve as precipitating or perpetuating factors for psychiatric challenges and ways that stressors related to the illness may be having an impact on family responses to the patient. This assessment contributes to the understanding of how biologic factors for illness interact with psychosocial factors. For example, marital conflict or abuse can precipitate psychiatric problems among family members or can perpetuate existing psychiatric problems, and authoritarian parenting that leads to family dysfunction may be a response to a child's psychopathology (e.g., attention deficits) (4). Multiple family factors have been associated with depression, including parental depression, marital conflict, ineffective parenting practices, loss, negative parent-child interaction, and insecure attachment (4). Childhood anxiety disorders are associated with family factors, including overly controlling and overprotective parenting, as well as parental reinforcement of anxious or avoidant behaviors (4). Disordered eating has been associated with family risk factors, such as insecure child attachment, parental criticism, parental intrusiveness and overcontrol, low family cohesion, and physical or sexual abuse. It has been suggested that some of these risk factors may be a result of the negative eating behaviors, rather than a cause (4). Parental psychopathology and marital conflicts also are associated with childhood disruptive disorders and substance use. In families with children diagnosed as having ADHD, families may have increased stress and conflict, marital distress, poor parenting practice, and less authoritative parenting. Family environment also seems to play a role in management and outcome

of ADHD. Family factors in ADHD may be most influential when comorbid conditions are present, such as disruptive behaviors, school failure, or other psychosocial problems (4).

Additionally, it is important to assess social contexts that may exacerbate family conflicts, such as racial or ethnic discrimination, poverty, or community violence (4). Such topics should be explored in a sensitive manner, with the goals of maintaining the therapeutic alliance and collaborating with the patient in developing an understanding of the psychiatric issues and a shared vision of how to approach such challenges. As part of ongoing assessment, the psychiatrist can develop an impression of how family factors are impacting the difficulties related to the patient's health and functioning. The psychiatrist and patient can discuss whether it would be relevant and helpful to interview family members, with a goal of engaging family in collaborating and identifying goals for positive change, to facilitate successful treatment. Seeking to include family members in treatment is always relevant for children and adolescents. Family interventions also may be relevant for adult patients, when the presenting problems are clearly perpetuated by difficulties related to family relationships or for whom family support would be beneficial in improving recovery and maintenance. When interviewing the patient and family, a strength-based approach is important in assessing and identifying biopsychosocial stressors and for understanding the family's strengths and limitations in supporting the patient. A strength-based approach includes engaging family members' competencies and motivations in an effort to lead to optimal collaboration. This approach can promote the patient's well-being and contribute to positive outcomes (7).

CONSIDERATIONS FOR FAMILY INVOLVEMENT

The initial assessment of adult patients often does not include the presence of family members. In such cases where family involvement is indicated, the psychiatrist should have a discussion with the patient about treatment goals and obtain the patient's consent to involve family. Involvement may include the need to gather family or marital history, to obtain collateral information about behavioral concerns, to observe family dynamics and assess the need for intervention such as family therapy, or to engage family in psychoeducation and support for the patient. The discussion should also include plans for requesting family presence during sessions or for communicating with family outside of sessions (such as via telephone or in separate sessions). It is important to consider potential barriers to family involvement, such as mental health stigma, lack of trust in the medical or mental health system, or family conflict that may render family members unwilling to participate. Other potential barriers may be related to scheduling or transportation. In such cases, it is an important first step to identify and discuss any such cultural, relational, or practical barriers with the patient. The psychiatrist can then partner with the patient to brainstorm ways to address such barriers. One consideration for addressing barriers would be to involve a natural or community support, such as a trusted friend or religious leader, to talk with the patient and family in order to build buy-in for treatment. Consultation with medical interpreters on cultural issues may help facilitate a more effective connection with family members. For more practical barriers, such as lack of transportation, one can consult with social workers for resources. It is important to provide psychoeducation to patients and families about the goals and importance of family involvement for successful treatment.

Although family involvement is ideal and indicated in many cases, situations may arise where patients would prefer not to include their family members in treatment. In such cases, protecting patient confidentiality is fundamental, unless the patient is at risk for harm to self or others. It is advisable to have an open conversation with the patient regarding the reasons for declining family involvement. This discussion will allow for identification of any barriers to family work and may elicit further insight about problematic family dynamics. The psychiatrist should also outline the reasons for recommending family involvement and discuss the proposed structure for family work to empower the patient to make an informed decision. For example, the need to involve family members may simply be for gathering family history or obtaining collateral information. Other reasons for family involvement may be to recommend family psychoeducation or family therapy. If information sharing is a concern, having the family present during sessions will allow for the patient to be aware of all the discussions held. If the concern is that family member presence during a session may cause conflict that will impede progress, the psychiatrist may choose to communicate with family only outside of sessions, if the patient consents. For adult patients, it is important to obtain written consent to communicate with family members. For patients younger than age 18, the involvement of parents or legal guardians is expected and an observation of the child's interaction with the caretaker is an essential component of family assessment (6). However, for psychiatrists working with adolescents, it remains important to maintain an alliance with the patient and to respect the patient's wishes for confidentiality, if there are no safety concerns. If a young patient or transition-age youth does not consent to family involvement, then the psychiatrist can encourage and prepare the youth to directly communicate issues with the family when the patient feels ready. With an ongoing therapeutic alliance, issues involving family dynamics can continue to be explored with the individual patient, potentially allowing for future consent for family involvement.

Family work is contraindicated in some cases. Such situations are ones in which family involvement in treatment would be harmful to the patient. Family sessions should not be held with a family member who is violent, actively using substances, or is unable to participate because of a psychotic disorder or other incapacitating condition. It is important to remember that in cases of abuse or neglect of

children, adolescents, or elderly patients, psychiatrists are mandated reporters and must report to the appropriate state agency for child or elder protection. In cases of domestic violence, community resources can be provided for shelter and legal assistance. The decision for the patient to leave the domestic violence situation is at the timing and discretion of the patient, who should be supported in assessing his or her safety and be provided with resources for assistance.

OVERVIEW OF FAMILY-BASED INTERVENTIONS

There is an evidence base for the efficacy of family-based interventions (1, 4, 8, 9). Examples of evidence-based family interventions include family therapy, parent management training, and family psychoeducation and support. There is evidence for different types of interventions for specific disorders. For general psychiatric practice, it is useful to be able to recognize problems related to family systems issues to determine when a referral for family therapy is necessary for successful treatment. An overview of various family interventions is provided below, which may be helpful in guiding the decision of whether to continue with individual treatment for the adult patient or to refer for further evaluation with a child and adolescent psychiatrist or family therapist.

Various studies have demonstrated improved outcomes of family interventions for adult patients. For patients with schizophrenia, family psychoeducation has consistently been shown to decrease rates of relapse (1). Family psychoeducation supports families in the care of their family member by providing emotional support, illness education, crisis resources, and problem-solving skills. In addition, this treatment is directed at reducing expressed emotion and criticism toward the patient. Successful psychoeducation for families includes coordinating shared goals with the family, understanding the family's strengths and limitations in supporting the patient, understanding family members' expectations for treatment, engaging families as equal partners in treatment planning and delivery, and addressing family's feelings of loss (1). For major depression, family therapy has been shown to lead to greater improvement and decreased suicidality compared with treatment without family therapy (1). Couples therapy for alcohol use disorder has been shown to reduce alcohol use and family violence (1).

An understanding of family interventions for children and adolescents is important for the general psychiatrist, who can identify concerns and facilitate referral for treatment. Family work is relevant for the treatment of adult patients who are parents experiencing distress related to children's behavioral challenges and for treatment of adolescents whose emotional and behavioral health is affected by family interpersonal relationships. Appropriate intervention for emotional and behavioral problems during childhood promotes an improved developmental trajectory, which ultimately benefits the family as a whole.

Depression

Various family interventions can be effective in the treatment of depression among adolescents. Patients who are parents experiencing difficulties or stress related to the depression of their adolescent may benefit from discussion about the role of family intervention. Interpersonal relationships can precipitate, maintain, or exacerbate depression. Families with low tolerance for conflict are threatened by expressions of negative feelings, which reinforces a negative sense of self within the adolescent and diminishes the adolescent's expression of autonomy (4). For adolescent depression to improve, the specific response required by parents and caretakers is parental attachment and availability (8). Family psychoeducation has been shown to result in improved social functioning of the adolescent, improved quality of relationships with parents and peers, and a decrease in depressive symptoms acutely and after 3 months. Family psychoeducation includes topics such as the medical model of understanding depression, patient education, stress vulnerability, and coping models (8).

Attachment-based family therapy is another treatment modality for adolescent depression. This treatment addresses family factors, such as weak attachment, high hostility, parental psychopathology, and poor parenting, which are associated with depression among adolescents. A negative family environment hinders development of the coping skills that would allow an adolescent to buffer social stressors, and the absence of coping skills puts adolescents at risk for developing or exacerbating depressive symptoms. The goal of attachment-based family therapy is to repair attachment between the parent(s) and adolescent and to promote individuation. The treatment focus is on helping families to identify and resolve conflicts that prevent adolescents from viewing parents as a source of emotional support and trust (4). Attachment-based family therapy has been effective in decreasing the severity of depressive and anxious symptoms, as well as hopelessness and suicidal ideation (8).

Individual cognitive-behavioral therapy (CBT) is effective for more rapidly improving depressive symptoms and achieving remission compared with supportive therapy or structural-behavioral family treatment, although Diamond and Josephson (4) found no long-term differences in outcomes between any of the treatments at 2-year follow-up. Chronicity, recurrence of depression, and lack of recovery were found to be predicted by parent-child conflict and low affective involvement at baseline or follow-up (4). Given the impact of interpersonal relationships on depression course, it is important to augment cognitive-behavioral training for children and adolescents with parental involvement, either through parent psychoeducation or family therapy.

Anxiety and OCD

Family factors are associated with childhood anxiety disorders, including overly controlling or overprotective parenting and parental modeling or reinforcement of anxious-avoidant behaviors (4). Improvement of anxiety among children and

adolescents requires the response of parental confidence and security (8). Family behavioral intervention provided in conjunction with CBT is more effective than individual CBT alone. Family intervention for anxiety involves behavioral change that facilitates more adaptive coping strategies both for the child and parents including teaching parents to reward coping behavior, to extinguish anxious behavior, to manage their own anxiety, and to develop family communication and problem-solving skills (4). In addition to providing CBT treatment with techniques focused on managing anxiety for their adult patients, general psychiatrists may discuss family relationships and decide with their patients on the need for referral for additional consultation with a child psychiatrist (for any child) or by a family therapist. For OCD of children and adolescents, family involvement is critical for successful treatment. Treatment with CBT that includes exposure and response prevention requires family involvement to encourage and reinforce behavioral change. Family involvement is also relevant for adult patients with OCD. Family involvement in treatment for OCD is supported by studies in which cognitive-behavioral family therapy has been found to be superior to control groups at baseline and 6-month follow-up (4).

Disruptive Disorders

Disruptive disorders, such as oppositional defiant disorder and conduct disorder, are associated with family factors, such as parental depression, parental antisocial behavior, parental substance use, marital conflict, negative parenting practices, and insecure or disorganized attachment (4). Parenting style is a risk factor for development and maintenance of disruptive disorders, and the response required for improvement of disruptive disorders is parental authority, supervision, and consistency (8).

Parent management training has been found to be effective for disruptive disorders among children. Parent management training is a parent-focused psychoeducational approach that teaches parents skills, including appropriate and constructive play, praise, rewards and discipline, and problem-solving skills. These skills promote prosocial child behaviors and enhance positive parent-child interactions (4, 8). Behavioral family therapy is another modality that targets family, parent, and child factors that may lead to disruptive disorders, such as parental stress, child temperament, and parental beliefs about the child (4). Parent-child interaction therapy is a parent training behavioral management program that can be useful for oppositional defiant disorder among young children (typically ages 3–7). Parent-child interaction therapy focuses on promoting parental skills in nurturing and then improving discipline practices (4).

Multisystemic family therapy is an intensive home- and community-based approach for children and adolescents who have behavioral problems and delinquent behavior. It has been successful in reducing youth delinquent behavior, drug use, incarceration, and hospitalization (4). Functional family therapy is another treatment modality for child and adolescent delinquent behavior. In this therapy, dysfunctional family relationships are viewed as a cause of behavioral and psychiatric problems. Functional family therapy works to establish new patterns of family interaction in three phases. Phase 1 focuses on engagement and motivation, phase 2 on establishing more adaptive family interactions, and phase 3 on generalizing the learned patterns and skills to the broader community (8, 10).

ADHD

ADHD often has a behavioral component, and negative feedback from parents and authority figures can result in progression to oppositional behaviors (8). ADHD among parents can also affect adult patients' experiences and feelings of competence in parenting and is therefore important to manage. Symptoms of ADHD are associated with both deficits and strengths in parenting. Strengths of parents with ADHD include enthusiasm, energy, and playfulness. Difficulties may include problems maintaining attention in supervising their children, such as with feeding an infant, doing homework with a child, keeping track of schedules, or following through with a treatment program. Asking about the impact of ADHD on parenting style can help identify where areas of intervention are needed to optimize family functioning (11).

Eating Disorders

Family risk factors in eating disorders are related to parental modeling and reinforcement and family discord. Specifically, risk factors include parental criticism, intrusiveness and overcontrol, low family cohesion, physical or sexual abuse, and insecure child attachment. These factors may manifest in response to the negative eating behaviors (4). Effective treatment of eating disorders requires a response of parental collaboration and consistency (8). It is important for family treatment to help parents take an active role with adolescents (1). The Maudsley family therapy model has been shown to be effective in treating anorexia nervosa. This treatment focuses on parents taking charge of the patient's eating behavior with the goal of stabilizing health and weight, and then returning autonomy with eating to the adolescent and then to other areas of his or her life (4). Concerns about an eating disorder in an adolescent or adult should be further evaluated medically and psychiatrically, with prompt referral for treatment in collaboration with relevant treatment providers, such as the primary care physician and individual and family therapists.

Trauma

Family involvement is also important in the treatment of trauma in children and adolescents and general psychiatrists can guide patients to treatment resources that can be helpful. Trauma-related problems among children require parents to respond by providing safety and seeing the problem through the eyes of the child or adolescent (8). Trauma-focused CBT is an effective, manualized treatment that consists of several phases, including stabilization, processing of the trauma narrative, and consolidation. This treatment helps the child

and parent(s) to process and contextualize traumatic experiences and teaches coping skills (12).

TRANSITION-AGE YOUTHS

In considering mental health treatment for transition-age youths, it is important to keep in mind that the success of the transition from adolescence to adulthood is influenced by family involvement in the process (13). These youths may consult with an adult psychiatrist for psychiatric concerns. Although work may focus on the individual patient, transition-age youths represent a unique population, in which recognition of family dynamics has critical influence on development to adulthood. Youths transition to more independence and responsibility in the context of significant changes in relationships and identity. Demands during this period may overwhelm a youth's ability to cope. Family factors are important to consider when assessing the needs of a young adult who is in the process of transition. Such factors include parental expectations and support; family functioning or conflict if the youth resides with parents; financial support and resources; parenting styles and relationship dynamics; and parental separation anxiety and its impact on a youth's sense of competence and confidence. Psychiatrists should discuss youths' preferences for involving family in their treatment, as well as who they identify as family. Clinical assessment of family functioning and discussion of including family in care is appropriate for establishing trust, open communication, and engaging patients and their families in treatment planning. Clinical assessment of family functioning includes joining with family members, identifying strengths and limitations, identifying obstacles to family involvement as well as family support, identifying roles of each individual family member in treatment participation, and obtaining medical and psychiatric family history. Psychiatrists should also identify youth and family strengths and limitations, youth and family fears and perceptions, and prior efforts to achieve developmental milestones. It is important to recognize the youth's ability to understand and advocate support for his or her psychiatric issues and support the transition of the parental role in taking responsibility for children's health conditions in order to allow the youth to have more independence in this area. Psychiatric issues may interfere with a youth's ability to progress toward autonomy and responsibility in adulthood, and these are important aspects to explore. Patient confidentiality is important to maintain when working with transition-age youths. If the youth agrees to family participation in treatment, periodic family meetings can be conducted and, if indicated, may evolve into family therapy (13).

CONCLUSIONS

Attention to family factors is critical in general psychiatric practice, because patients' family relationships and social context contribute to development across the lifespan. Family factors are associated with risks for various mental conditions, but positive family relationships can be protective and contribute to improved outcomes and optimal development. It is important for psychiatrists to be able to assess families and to identify areas where family intervention can lead to improved individual and family resilience. Family intervention can be provided in the form of family assessment and periodic engagement in sessions, family psychoeducation, parent guidance, or family therapy. Psychiatrists also should pay attention to the needs of patients' families and, when necessary, facilitate support for respite or identify sources of natural support. Psychiatrists also can facilitate referrals to child and adolescent psychiatrists; family therapists; or community-, school-, or state-based support. Successful treatment of illness is enhanced by engaging family members as essential partners whose competencies and skills can be developed to address emotional and behavioral problems.

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