Chapter 9
Medical Family Therapy in Psychiatry

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The term "Psychiatry," named first in 1808 by physician Johann Christian Reil, is derived from two Greek words: psyche (soul) and *iatros* (healer) (Marneros, 2008). Over the years, psychiatry has remained a specialty of medicine focused on the complexities of the human mind. While understanding the etiologic and remediating factors of mental illness has been a mainstay of psychiatric practice, clinical methods have varied over time. Psychiatry has seen shifts from Freudian psychoanalysis to more structured, manualized therapeutic approaches. Emerging science has taken the profession further away from its therapeutic roots, in favor of psychopharmacologic and neurologic discovery. Nevertheless, psychiatry continues to be a practice defined by interdisciplinary collaboration as well as conceptualization sensitive to familial and cultural factors. This is demonstrated through the American Psychiatric Association's (American Psychiatric Association, 2016a) values of "prevention, access, care and sensitivity for patients and compassion for their families; respect for diverse views and pluralism within the field; and respect for other health professionals" (para 3).

Psychiatry's interaction with family therapy is not new, as the foundational voices of family therapy can be traced to analytically oriented psychiatrists (e.g., Nathan Ackerman, Murray Bowen, Gregory Bateson; Beels, 2002). Early on, interest in how communication may influence an array of psychiatric disorders,

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particularly schizophrenia, spawned debate and inquisition among these originators of knowledge. Though decades have passed, the need for ongoing dialogue between clinicians representing varied lenses persists. The Group for the Advancement of Psychiatry's *Committee on the Family* made recommendations to residency programs to provide educational experiences that emphasize systems theory, life cycle development, and how families can contribute to psychiatric presentations or serve to remediate symptomatology (Berman et al., 2006). Various systemically oriented themes are also represented in the academic milestones for residents and fellows. Reciprocally, many family therapy programs underscore the need for students to obtain diagnostic competency and some degree of pharmacologic familiarity. Ideally, as psychiatrists and medical family therapists (MedFTs) collaborate with each other in integrated settings, this fundamental knowledge acquired in educational programs can grow through an exchange of expertise that arises from clinical partnership. In these circumstances, the integrated care setting serves as a crucible for furtherance of erudition alongside cohesive patient and family care. All names in this vignette are changed to maintain confidentiality.

Clinical Vignette

[Note: This vignette is a compilation of cases that represent treatment in psychiatry. All patients' names and/or identifying information have been changed to maintain confidentiality.]

I (KP), an outpatient MedFT that consults in the inpatient psychiatric unit, received a call from the inpatient social worker about Mr. Brandon Anderson, a 24-year-old male with recent five-day admission following a suicide attempt via *overdose. To hear more about Mr. Anderson's care and current difficulties, I attended the multidisciplinary team meeting the following morning. Upon arriving at the hospital, Dr. Diaz, Brandon's treating inpatient psychiatrist, pulled me aside to share that they called on me to continue treatment on an outpatient basis due to the longstanding nature of Mr. Anderson's obsessive-compulsive disorder (OCD) paired with recent relational difficulties. Dr. Diaz revealed that Mr. Anderson had an onset of OCD at 18 years old during his transition to college. His primary symptoms fell into the contamination/cleaning and forbidden/taboo thought clusters. He obtained some prior supportive counseling at the college mental health clinic but never engaged in cognitive behavioral treatment for his symptoms. Over the last few years, Mr. Anderson's distress with intrusive thoughts, compulsive cleaning/washing, and repetitive mental rituals resulted in a more isolative existence. His withdrawal from social relationships also impacted his marriage to Mrs. Ashley Anderson. The couple were married for two years and dated since late college. Ashley felt frustrated with Brandon's insistence with how things must be kept in their household and bothered at his reluctance to engage in treatment. Additionally, she felt fearful of recently revealed obsessional thoughts concerning physical*

and sexual aggression. Prior to hospitalization, Brandon revealed that he had thoughts of harming her that were deeply disturbing for both members of the couple. The inpatient team confirmed the ego-dystonic nature of these thoughts. When Brandon shared his thoughts with Ashley, she insisted he obtain help and went to her parents' home to stay for the night, stating she "was not sure I can continue on like this in the marriage." At that point Brandon became increasingly down and hopeless, feeling like a burden. He took several old prescriptions but then called 911 due to feeling regretful about his behavior.

During the treatment team meeting, it was noted that Brandon's planned discharge was at the end of the week. He participated in dialectical behavior-oriented skills groups while on the unit. He interacted with others and demonstrated improvement in his overall mood symptoms. He currently denied any suicidal or homicidal ideations. He continued to have intrusive obsessional thoughts, but he had been trying to engage in fewer mental rituals since psycho-education had been provided by Dr. Diaz regarding the problematic outcome of thought suppression. He was adherent and willing to continue fluvoxamine with an outpatient psychiatrist. During the treatment team meeting, current responses of staff members to Brandon's request for reassurance were processed. The team also discussed possible exposures that could be conducted during Brandon's remaining time on the unit. Particular attention was paid to one team member's experience with their own adolescent living with OCD. The team formulated the plan of inpatient social work, inpatient psychiatrist, and MedFT to meet with Brandon and his wife later that day.

During the relational consultation, rapport building occurred with the couple and further education provided on the diagnosis and treatment of OCD/depression. Dr. Diaz discussed the efficacy of medication in these conditions and importance of exposure and response prevention (E/RP). I normalized some relational difficulties for couples' coping with OCD, using externalizing language. Additionally, the treatment team formulated an outpatient plan of enhanced E/RP using a couple-based approach, recently published in the literature. At the conclusion of the meeting, the couple received a written biopsychosocial plan of care. They were agreeable to continue in the hospital's outpatient clinic for medication management and psychotherapy the following week.

At the follow-up visit, a more detailed clinical interview occurred using the Yale-Brown Obsessive Compulsive Scale (YBOCS). Assessment of a variety of relational health constructs (i.e., communication, affective responsiveness, and relational patterns around the illness) also occurred. After obtaining a signed release, collaboration occurred with Brandon's new outpatient psychiatrist, Dr. Smith, so medication could be appropriately titrated. Brandon and Ashley engaged in 16 sessions of E/RP, including disorder-specific couple interventions and partner-assisted exposures. Between each session, Dr. Smith

and I discussed psychological and relational functioning. At period points in treatment, providers shared current diagnoses, medication changes, and treatment plans via *a brief one-page collaborative form to Brandon's primary care doctor. After the initial treatment program, the couple continued on a maintenance schedule of therapy due to the waxing and waning nature of OCD. They currently follow up every three months to review coping skills, identify efficacious self-talk, brainstorm exposures, and discuss life transitions, such as recently reuniting in the same household and the couple's eventual hopes of expanding their family.*

What Is Psychiatry?

Psychiatry is a specialty of medicine, frequently cohabitating with other mental health professions, dedicated to the prevention and treatment of mental disorders. Psychiatrists commonly use subjective reports, collateral data, psychological tests, mental status examinations, and neuroimaging to identify diagnoses. However, even with such extensive information, the assessment of mental illnesses takes time and multiple stakeholders to move from ambiguity to an effective treatment plan. To become an adult psychiatrist, a person completes 4 years of medical school followed by a four-year general psychiatry residency program, which includes varied foci (e.g., inpatient, outpatient, pharmacology, psychotherapy, substance abuse). Following general training, some individuals pursue subspecialty training (e.g., child and adolescent psychiatry, geriatric psychiatry, forensic psychiatry), typically requiring the completion of a fellowship (APA, 2016a, 2016b).

Child and adolescent psychiatrists focus on the treatment of children from birth to young adulthood. These physicians complete an additional 2-year fellowship (1 year often replacing the final year of general psychiatry training). They commonly see youth with neurodevelopmental (e.g., autism spectrum disorders, attention-deficit hyperactivity disorder, motor disorders), anxiety (e.g., phobias, separation anxiety, social anxiety disorder), disruptive behavior (e.g., oppositional defiant disorder, conduct disorder), and emerging substance-related conditions. At the other end of the developmental spectrum, geriatric psychiatrists, who receive one additional year of fellowship training, often see individuals and families coping with neurocognitive disorders related to Alzheimer's disease or another medical condition.

The prevalence of a diagnosis within a particular context will depend greatly upon the demographic and phenomenological features of those who make up that context. For instance, a psychiatrist practicing in a Veterans Affairs (VA) hospital system may see more trauma- and stressor-related disorders, a consult-liaison, or psychosomatically trained psychiatrist will see more somatic symptoms disorders or delirium, and an emergency room psychiatrist may see more acute presentations

of psychosis, suicidality, or substance abuse and/or withdrawal. Additionally, a forensic expert may practice in a prison setting where antisocial personality disorder is a common diagnosis maintained by inmates. They frequently see defendants opting for a "not guilty by reason of insanity plea" or the chronically mentally ill who inappropriately landed in a judicial system instead of community mental health. Regardless of the setting, identification of the correct diagnosis, alongside case conceptualization, serves to guide selection of therapeutic intervention and/or pharmacologic agent. The indicated treatment protocol ultimately determines which members of the interdisciplinary team may be involved for a given patient. General psychiatry and its subspecialties are a perfect example of science meeting art in clinical decision-making. These physicians and the MedFT are also reliant on other professionals to mobilize the patient and family into change.

Treatment Teams in Psychiatry

Given the complexities of treating psychiatric maladies, collaboration between individuals with a host of trainings and areas of expertise is likely to result in a more comprehensive, effective, and efficient treatment (Bustillo, Lauriello, Horan, & Keith, 2001). Because a family requires support in their care for the mentally ill patient throughout their journey, a team of providers is essential for preparing the family with the necessary resources to navigate physical, mental, emotional, and social challenges accompanying psychiatric illness (Heru, 2004). Despite the expectation that practitioners of psychiatry should integrate family factors into a biopsychosocial formulation and treatment plan (as previously mentioned), many psychiatry residencies do not spend significant time emphasizing practical family and relationship maintenance skills (Heru & Drury, 2006).

Therefore, as part of the psychiatric treatment team, MedFTs potentially fill vital gaps in treatment; they do this by facilitating effective communication between providers and health-care workers and in strengthening patients' family and social supports (Berman & Heru, 2005). Inpatient psychiatric patients have reported that MedFTs are critical members of their treatment team who helped them deal with complex family dynamics (e.g., maintaining an intimate connection with a partner throughout treatment, discussing the hospitalization in an age appropriate manner with children; Anderson, Huff, & Hodgson, 2008). Collaboration among various members of a psychiatric treatment team (e.g., psychiatrists, MedFTs, social workers, recreational therapists) may prove vital, given that when psychiatrists made use of family-based and social interventions (in addition to traditional psychiatric treatment), practitioners see reduced relapse rates and medical costs (Bustillo et al., 2001; Law & Crane, 2000). Consequently, stronger incentives are provided to third-party payment providers for the inclusion of family-based psychiatric treatment (Anderson et al., 2008). Therefore, providers who allow a biopsychosocial-spiritual (BPSS) framework to shape psychiatric treatment benefit from a more comprehensive vista of patient functioning, as well as offering more wide-ranging treatment

(Engel, 1977, 1980; Wright, Watson, & Bell, 1996). The following is a non-exhaustive list of important members of a typical psychiatric treatment team with whom MedFTs may encounter when working in psychiatric settings:

Psychiatrists. These providers are licensed medical physicians who specialize in the diagnosis and treatment of mental illness. They may prescribe medication for the treatment of a wide variety of mental illnesses. A psychiatrist is typically the primary/lead member of the treatment team and directs team meetings in collaboration with psychologists, nurses, MedFTs, social workers, etc. Taking into consideration input from all members of the treatment team, a psychiatrist ultimately decides when a patient is sufficiently stable to be released. He or she may refer a complex case to a psychologist for additional psychological testing, which aids in diagnosis and treatment. Psychiatrists may involve MedFTs if complex family dynamics are worsening a patient's mental functioning or, conversely, if family support may be a remediating factor in recovery.

Psychologists. These providers are trained to administer and interpret a number of screenings and assessments that can help diagnose a condition or reveal more about the way a patient thinks, feels, and behaves. Such tests may evaluate intellectual skills, cognitive strengths and deficits, vocational aptitude, personality characteristics, and neuropsychological functioning.

Psychiatric-mental health nurse practitioners. A psychiatric-mental health nurse practitioner (PMHNP) is a registered nurse who often performs similar roles to that of the psychiatrist, including ordering and interpreting tests, diagnosing mental illness, and prescribing medication (prescribing and ordering a commitment privileges may vary according to a PMHNPs state of practice). He or she may also provide psychoeducation and psychotherapy to the patient and family about how to best react in certain challenging situations (e.g., hallucinations, delusions).

Psychiatric care coordinators. Care coordinators may come from a variety of disciplinary backgrounds (e.g., social worker, licensed professional counselor). They collaborate with the psychiatrist and social workers to provide appropriate psychotherapeutic care to patients, offering input to the psychiatrist regarding each patient's progress toward greater mental stability (e.g., decrease in suicidal ideation). Care coordinators often lead process groups with multiple patients and may provide family members with psychoeducation during family visiting hours. They also complete initial screening measures and discharge planning.

Social workers. These providers advocate for the overall welfare of patients and their families. Social workers assist with monitoring behavioral progress of psychiatric patients, set up appointments for therapy and psychiatric visits, and schedule traditional medical visits. They may additionally assist patients with finding housing prior to discharge from an inpatient facility (e.g., for patients in need of assisted living or rehabilitation centers). Some social workers assist with finding community supports for patients, including social and recreational outlets, and offer psychotherapy.

Nurses or medical assistants (MA). These providers educate patients regarding illnesses, provide medication, and assess for treatment progression. In addition to

collaborating with other providers regarding psychotherapy, they monitor sleep, diet, and basic vital indicators (e.g., blood pressure). Nurses or MAs are generally the first responders to assist a patient in crisis (e.g., via non-violent crisis intervention to prevent the patients from hurting themselves or someone else).

Mental health technicians. Mental health technicians collaborate extensively with nurses and MAs, as these providers are especially important for ensuring patient safety. They often sit in patients' rooms in cases of suicidal or homicidal ideation. They regularly perform room checks on the psychiatric unit to verify that every patient is present and safe. While employers may hire and train high school graduates to be mental health technicians/psychiatric aides, most hold a certificate or associate's degree in mental health technology.

Occupational therapists. These providers assist with patient activities of daily living (e.g., basic hygiene, grooming, dressing, and cleaning one's living space). Occupational therapists also perform safety evaluations to verify that patients are safe to return home after inpatient care and/or in accord with subsequent recommendations made by the psychiatrist.

Recreational therapists. Recreational therapists collaborate with the care coordinator and social workers to offer support to psychiatric patients through stress management and recreational activities. Such interventions may include meditation training, group outings, exercise classes, animal assisted therapy, aquatic activities, and biofeedback measurements and techniques.

Pharmacists. Most psychiatric units have a pharmacist on-call who collaborates extensively with the psychiatrist by providing expertise regarding prescriptions and possible emotional/behavioral side effects. These professionals also offer consultation concerning potential interactions between medications.

Fundamentals of Care in Psychiatry

When considering the ease of including a MedFT in collaborative psychiatric contexts, there are both strengths and cautions. The overlapping fundamentals between members of the treatment team, such as diagnostic language, may ease the tensions sometimes felt on interdisciplinary teams. However, the professionals' shared skill set (e.g., making a diagnosis, delivery of screening measures, treatment planning regarding therapeutic indications) can raise "turf wars," duplicate services, and questions regarding scope of practice. In the best of scenarios, the members of the treatment team collaborate in a way to bring forth the powerful influence of their complimentary skill sets. In this sense, the shared knowledge can serve to advance care by professionals speaking the same language. Undoubtedly, the value of a MedFT is to monitor the emotional climate of the treatment team, ensuring that the systemic process at play is collaborative and focused on the patient or family's best interest rather than letting competitive incidents take over. To effectively function

on this team, MedFTs should be aware of fundamentals concerning the diagnosis and treatment of mental illness, especially information that may be lacking in some advanced training programs.

Diagnosis

One of the major differences in the diagnosis of psychiatric illnesses compared to other illnesses is that diagnoses are made without the benefit of definitive testing. Instead, psychiatric illnesses are diagnosed based on a pattern of symptoms that occur over time. It is not unusual for a patient to have a change in diagnosis as new information comes to light. Substance use and medical illness can act as etiological factors for various psychiatric symptoms, making the exact diagnosis more difficult. This can be frustrating for patients and their families, so clear explanations about how diagnoses are made are an important part of delivering care. Patients and families frequently "google their symptoms," so it is worth providing good written information or websites as soon as possible, especially since much misinformation exists within the online community.

The concept of psychiatric illness can be confusing for patients and family members as many psychological symptoms are part of normal life experience. For example, sudden changes in mood, transient anxiety symptoms, and panic when faced with a life-threatening situation can all occur as part of the normal human experience. It is the persistence of these symptoms, their association with other symptoms, and their interference with normal functioning that allows them to reach the threshold for diagnosis of a psychiatric illness. The Diagnostic and Statistical Manual of Mental Disorders—Fifth Edition (DSM-5; APA, 2013)—is frequently referred to as the "Bible of Psychiatry," but psychiatrists often disagree about the validity of some diagnoses. For example, many clusters of symptoms once considered pathological, such as homosexuality, have been removed and new diagnoses (e.g., premenstrual dysphoric disorder and hoarding) have been added. Conditions warranting more clinical research and experience, (e.g., internet gaming disorder), are listed in DSM-5, Sect. 3. It should also be noted that there is inherent human bias in making a diagnosis. Some diagnoses are made more commonly in women than men (e.g., borderline personality disorder), while others are made more commonly in men than women (e.g., antisocial personality disorder). This may be the result of study selection bias and that women voluntarily seek treatment more frequently than men (Bjorkland, 2006). Conversely, more men may be mandated for treatment secondary to violent behaviors comparable to women, resulting in an antisocial diagnosis in some cases. Epidemiological data and diagnostic descriptors must thereby be considered.

Treatment Setting

MedFTs will encounter patients with psychiatric illnesses in many settings, such as primary care, community mental health centers, specialty clinics, and inpatient medical or psychiatric hospitals. In primary care, patients usually have mild to moderate anxiety and depression, but some patients with more severe symptomatology may be reluctant to transition care to a psychiatric clinic. Within these outpatient mental health clinics, psychiatrists typically see patients with moderate to severe mood disorders and anxiety disorders and/or those with high complexity. Patients with complex mental disorders tend to have either treatment-resistant illnesses (e.g., mood or psychotic illnesses that persists through initial treatments), comorbid substance use disorders, or personality disorders. Additionally, many of these patients have had failed pharmacotherapy or psychotherapy trials, necessitating the involvement of a specialist. In the inpatient psychiatric setting, patients are admitted mostly for concern of safety toward self or others or grave disability. Suicidality is most likely in the context of depressive illnesses (e.g., major depression, bipolar disorder depressive phase, or adjustment disorder with depressed mood). Grave disability is usually associated with chronic serious mental illness (e.g., schizophrenia, bipolar disorder, or neurocognitive disorders).

Pharmacology and Associated Treatments

As previously noted, psychiatrists focus on difficult to treat or treatment-resistant illnesses. Treatment-resistant schizophrenia is the persistence of symptoms despite adequate pharmacological treatment and occurs in up to 60% of patients with schizophrenia (Miller, McEvoy, Jeste, et al., 2006). Adequate treatment is defined as two or more treatment trials of antipsychotics—such as olanzapine, risperidone, or haloperidol—at adequate dosages for 4–6 weeks (Silverman et al., 2016). Other strategies are then tried (e.g., clozapine and/or psychosocial treatments). Likewise, treatment-resistant depression (TRD) is defined as depression that is resistant to standard treatments. According to Papakostas and Fava (2010), 45% of patients with depression, when treated by a primary-care physician alone, do not respond. The next step is a reevaluation of the diagnosis and consideration of hitherto unexamined aspects of the case, such as family dysfunction, social location factors (e.g., struggles with gender sexual identity, racial/ethnic disparities, religious/spiritual crises), or other medical diagnosis not yet discovered or treated (e.g., diabetes, hypothyroidism, cancer, Parkinson's disease).

Thankfully, a significant portion of patients present with depressive disorders who are responsive to medication and/or psychotherapeutic intervention. For these patients, the initiation of a selective serotonin reuptake inhibitor (SSRI) or serotonin norepinephrine reuptake inhibitor (SNRI) leads to the resolution of most symptoms within 4–6 weeks (Silverman et al., 2016). Psychotherapeutic approaches to

depression are outlined later in great detail within the research-informed practice subsection. Prescription of serotonergic medications for individuals with depression necessitates careful screening for manic symptoms, as to not cause iatrogenic effects in a bipolar individual. Bipolar disorder requires long-term management with mood stabilizers—such as lithium, valproic acid, and/or carbamazepine—and significant psycho-education of patients and families to ensure compliance and reduce the risk of hospitalization. Patients with anxiety, obsessionality, and compulsivity often benefit from serotonergic agents as well. Though effective treatment of anxiety disorders such as the SSRIs and cognitive-behavioral therapy (CBT) exist, about 40% of patients with anxiety disorders are partially or completely resistant to first-line treatment (Bystritsky, 2006). Advances in psychiatry and genetics have found that patients with a "short" arm of the serotonin transporter gene are significantly less likely to respond to maximally titrated SSRIs than patients with the "long" arm of this gene (Stein, Seedat, & Gelernter, 2006). Regarding Brandon, our patient with OCD, SSRIs, such as fluoxetine, fluvoxamine, or sertraline, are first-line medications. Clomipramine, a member of an older class of tricyclic antidepressants is also effective. Patients often require higher doses of these medications in the treatment of OCD compared to depression, and they may take longer to work: 8–12 weeks (Silverman et al., 2016). If symptoms do not improve with these types of medications, some patients may respond to an antipsychotic medication, such as risperidone. Psychotherapy, such as cognitive behavior therapy (CBT) and other related therapies such as exposure and response prevention (E/RP), is effective in reducing compulsive behaviors in OCD, even in people who do not respond well to medication. Innovative treatments include medication combinations as well as techniques, such as deep brain stimulation (DBS) (Silverman et al., 2016).

Most psychiatric illnesses are chronic and, rather than aiming for complete resolution of symptoms, require management (Keitner & Mansfield, 2012). Management requires adding a psychosocial approach, often with a strong family psychoeducation component and deemphasizing finding the "right drug." Nevertheless, most patients and families want information on medications; the National Institute of Mental Health website (http://www.nimh.nih.gov/health/topics/mental-health-medications/index.shtml) offers a good overview of all psychiatric medications, including those approved by the Food and Drug Administration (FDA) and those used as "off label."

In addition to medication options, neuromodulation programs that provide a range of services are emerging in psychiatry for treatment-resistant illnesses. In general, neuromodulation induces electrical current in peripheral or central nervous tissue, through various techniques such as electroconvulsive therapy (ECT), vagus nerve stimulation (VNS), transcranial magnetic stimulation (TMS), and deep brain stimulation (DBS). ECT has been used for many decades in psychiatry, and the evidence for its efficacy for specific indications (e.g., psychotic depression) is higher than the other modalities (e.g., VNS, TMS, DBS) (Silverman et al., 2016).

When engaging in treatment planning, it is important to remember that patients live in their own families and cultures, bringing specific and sometimes deeply personal beliefs about health and illness. It is not uncommon for patients and their families to consult with traditional and nontraditional healers in addition to Western

Stigma

Other factors likely influencing care-seeking behaviors, diagnosis, and treatment planning are the judgments often extended to people with mental illness. Stigma and discrimination have been described as sometimes having worse consequences than the conditions themselves (Thornicroft et al., 2016). Self-stigma occurs when patients accept negative stereotypes held against them (Corrigan & Watson, 2006). Stigma by association occurs with families who feel ostracized because their loved one has been diagnosed with a mental illness (Angermeyer, Schulze, & Dietrich, 2003). Patients with psychiatric illness are also subjected to unequal treatment in comparison to those with physical illnesses (Thornicroft et al., 2016), resulting in higher morbidity and mortality. Differences exist among ethnic groups regarding perceptions of stigma affecting access to support services (Smith et al., 2014). MedFTs, with their inherent strengths-based approach and attunement to subjugation, can assist families in building agency and communion in their health-care contexts rather than feeling victimized by the judgments of self or others. As these factors are addressed directly, they can enhance the experience of care and impact patients and their families' willingness to engage in treatment.

Psychiatry Across the MedFT Healthcare Continuum

Application of the MedFT Healthcare Continuum (Hodgson, Lamson, Mendenhall, & Tyndall, 2014) in a psychiatry context involves careful consideration of the role that the MedFT plays within the system. While some contexts afford the clinician a choice in how he or she integrates, others have a solid work flow and strict reimbursement system that challenges integration at more advanced levels. This section aims to highlight, using the case example at the beginning of this chapter, the various ways that MedFTs may be assimilated into psychiatric care settings. It builds off of Tables 9.1 and 9.2 wherein MedFT knowledge and skills across the continuum in this setting are provided.

Levels 1 and *2* of the continuum feature the skills one would expect to see from a clinician, researcher, and/or policy advocate or professional with some training in MedFT who executes components of a relational and BPSS framework (Engel, 1977, 1980; Wright et al., 1996) during assessment, diagnosis, and treatment phases. At these levels, the MedFT may or may not have the fluency, training, or "green light" within the outpatient or inpatient psychiatry system for moving to a more advanced level on the continuum. MedFTs in psychiatry settings are more commonly in roles where they provide both integrated behavioral health-care (IBHC) services and traditional psychotherapy services, alongside teaching and research. Their expertise is in working relationally and applying the BPSS framework, but at these levels this expertise is often sought after for "special cases" or "special situations" rather than as a routine service. For example, the MedFT in this

Table 9.1 MedFTs in Psychiatric Care: Basic Knowledge and Skills

MedFT Healthcare Continuum Level	Level 1	Level 2	Level 3
Knowledge	Basic knowledge about BPSS approaches to psychiatric services; sensitive to how mental health and biological conditions are mutually influential; advanced understanding of the diagnoses included in the most up to date version of the DSM.	Can differentiate between DSM diagnoses and other comorbid health conditions; familiar with basic causes and symptoms of serious and persistent mental illnesses; can identify some disease-related complications.	Working knowledge of specific team members (e.g., psychiatrist, psychiatric nurses, recreational therapists, chaplains) and medical terminology with regard to side effects of medications (e.g., dyskinesia, akathisia, tics) and common comorbid medical conditions to psychiatric illnesses (e.g., diabetes, hypertension, TBI).
	Familiar with psychiatry as a medical specialty; limited understanding of organic causes for psychiatric and comorbid health conditions that exacerbate psychiatric illnesses.	Familiar with benefits of couple and family engagement in health-related adjustments and/ or lifestyle maintenance.	Broad range of knowledge about research-informed family therapy and BPSS interventions; able to conduct couple and family therapy and incorporate BPSS health factors into treatment with minimal need to refer out due to limited expertise.
	Uncertain how and when to engage professional members, patients, and support system members, their unique and overlapping skills/roles, and the team's overall structure.	Knowledgeable about how to use the electronic health record system or other forms of secured communication to collaboration with various team members.	When work permits, is knowledgeable and consistency committed to conducting research and constructing policy/ advocacy work that identifies and intervenes on behalf of individuals, couples, families, and health-care teams toward the advancement of BPSS health and well-being.
	Basic understanding regarding strategies for a healthy lifestyle when living with a psychiatric illness.	Is an occasional contributor to discussions about research design and policy/advocacy work that include relational and/or BPSS aspects of health and well-being.	
	If conducting research and/or policy/advocacy work is able to do it in collaboration with other disciplines related to psychiatry and include relational and/or BPSS aspects of health and well-being.		

Table 9.1 (continued)

MedFT Healthcare Continuum Level	Level 1	Level 2	Level 3
Skills	Able to recognize the BPSS dimensions of health and apply a BPSS lens to practice, research, and/or policy/advocacy work. Can discuss (and psycho-educate) basic relationships between biological processes, personal well-being, and interpersonal functioning. Demonstrates minimal collaborative skills with psychiatry and other related health-care providers; prefers to work in an individual practitioner model but is able to contact/refer to other providers about services when needed.	Applies systemic interventions in practice usually; assesses patients and support system members present for background issues such as family history and related risk factors. Demonstrates adequate collaborative skills through (a) written and verbal communication mediums that are understandable to all team members and (b) coordination of referrals to specialty mental health providers and communication with the patient's primary care provider. Conducts separate treatment plan from other providers involved in the patient's care; goals and interventions can overlap with—or be informed by—a psychiatry team but not consistently.	Able to integrate respective team members' expertise and counsel into treatment planning. Implements successfully a systemic assessment of a patient and family with competencies in assessing for BPSS aspects of psychiatric illness and/or comorbid disease and resources within the family. Engages other professionals usually who are actively involved in the patient's care. Skilled with standardized measures to track patients' individual and relational strengths and challenges (e.g., PHQ9, GAD7, Relationship Dynamics Scale; Stanley & Markman, 1996). Attends and contributes usually to team meetings to help shape BPSS treatment plans for patients.

providers. This is especially noticeable when working with patients who are living with a psychiatric illness due to the high levels of stigma that many project unto such struggles. Some patients and families will be quite forthcoming with information about alternative medication or health behaviors, whereas others may be more guarded secondary to concerns about the perceptions that Western professionals may have about such practices. It is thereby vital to normalize this part of the clinical assessment and treatment plan.

Table 9.2 MedFTs in Psychiatric Care: Advanced Knowledge and Skills

MedFT Healthcare Continuum Level	Level 4	Level 5
Knowledge	Proficient understanding of DSM psychiatric illness and common comorbid conditions and their associated treatments, medications, and terminologies.	Understands treatment and care sequences for unique and/or challenging topics in psychiatric practice (e.g., delirium, medication interaction effects, comorbidities); can consult effectively with professionals about medical topics from other fields.
	Conversant in nearly all terms, measures, and facets of psychiatric care (e.g., medications, injections, normal lab values, electroconvulsive treatment, biofeedback).	Conversant with evidence-based treatments regarding most mental health disorders and their role(s) in the family; has background to provide psychoeducation to patients and families about a variety of symptoms, medications, and behavioral health management.
	Understands how to implement and collaborate with other disciplines to implement evidence-based BPSS and family therapy protocols in traditional and integrated behavioral health-care contexts.	Knowledgeable in clinical topics, research design and execution, policy, and administrative areas of psychiatric care; proficient in developing a curriculum on integrated behavioral healthcare, BPSS applications, MedFT, etc., to mental health and other health professionals.
	Identifies self as a MedFT.	
	Understands and can help design policies that govern BPSS-oriented inpatient and outpatient psychiatric care services.	Understands leadership strategies for building integrated behavioral health-care teams in outpatient and inpatient psychiatric settings.
	Aware of advocacy needs for patients and families in psychiatric settings.	Supervises other MedFTs and health professionals who are integrating behavioral health services into psychiatric inpatient and outpatient settings.

Table 9.2 (continued)

MedFT Healthcare Continuum Level	Level 4	Level 5
Skills	Able to deliver seminars and workshops about the BPSS complexities of a variety of DSM diagnoses to a variety of professional types (e.g., mental health, biomedical). Can apply several BPSS interventions in care (including most types of brief interventions); can administer mood- and disease-specific assessment tools proficiently. Consistently collaborates with key psychiatry team members (e.g., psychiatrist, psychiatric nurse, social worker, psychologist, rehabilitation counselor, substance abuse counselor, pharmacist, chaplain); initiates team visits with multiple providers when working with patients and families. Able to integrate effectively into inpatient and/or outpatient psychiatric contexts and adapt to the clinical, operational, and financial needs of the system. Can independently and collaboratively construct research and program evaluation studies that study the impact of BPSS interventions with a variety of diagnoses and patient/family units of care.	Able to synthesize and conduct research and clinical work; engages in community-oriented projects outside of tertiary clinic. Goes beyond interventions routine for this population; can integrate specific models of care into routine practice (e.g., family therapy, PCBH, Chronic Care Model). Routinely engages as an administrator/leader and supervisor in a team-based approach to inpatient and/or outpatient psychiatric care, with consistent communication through electronic health records, patient introductions, curb-side consultations, and team meetings/huddles/visits. Works proficiently as a MedFT and collaborates with other providers from a variety of disciples. Creates and executes curriculum related to DSM diagnoses and common comorbidities, MedFT, BPSS framework, and integrated behavioral healthcare to a variety of professional types (e.g., mental health, biomedical).

chapter was engaged by the inpatient social worker at a *Level 2*, via a referral, after she recognized that the patient was experiencing a relational crisis with his marriage. KP, the therapist, functioned at a *Level 2* when he incorporated the wife into the treatment during the "relational consultation." However, KP moved beyond *Level 2* when he incorporated the wife into the treatment plan versus maintaining her in a consulting role.

While MedFTs at *Levels 1* and *2* have a complementary skill set to other members of the team, they should also have a working knowledge of the pharmaceuticals more commonly being prescribed by the team and a familiarity with non-psychiatric diagnoses that may exacerbate or be a consequence of treatments for psychiatric

conditions (e.g., medications for depression that cause weight gain or medications for hepatitis C that result in depression symptomatology). These skills should be executed more frequently and advance across the entire continuum as the MedFT becomes more fully integrated. As she/he becomes more integrated, she/he then moves beyond a siloed "mental health" or discipline-specific role into one where she/he is a member of the team wherein expertise among all members, including the patient and his support system member, is shared and respected collectively. Additionally, with regard to research and policy/advocacy, MedFTs operating at *Levels 1* or *2* may rarely to occasionally be asked or inspired to add to a study or policy addendum that taps into BPSS interactional dynamics. They may also advocate or be consulted with regarding relational and BPSS factors that influence the psychiatric setting's clinical, operational, financial, training/education policies and protocols. One example of this would be the modification of a policy on when and where support system members can visit with patients who are receiving treatment and who may participate in the patient's treatment per se.

At *Level 3* the MedFT is applying his use of MedFT knowledge and skills and is demonstrating how he can integrate effectively into the inpatient and outpatient psychiatric settings. He or she is known by the social worker as possessing skills in family therapy, which appears in our vignette to be the impetus for her referral to him for consultation. While not all MedFTs will have relational and BPSS research or policy/advocacy opportunities in psychiatric settings, this level of MedFT has the skills and experience necessary for participating in opportunities related to each and is able to contribute them effectively. In relation to the chapter's case example, something appears to be embedded in the procedures of the system wherein providers of different disciplines know about and refer to one another. At a *Level 3*, collaboration usually continues past the referral point and how frequently it occurs may depend upon the complexity of the case and how much the providers value it. The fact that KP collaborated with providers internal and external to his clinic and, not just in response to a crisis, demonstrated a *Level 3* application of MedFT clinical and collaborative knowledge and skills. He also worked to engage the spouse in treatment, acknowledging that she is important to the success of the patient's decrease in symptomatology, as well as caring about her own BPSS health.

MedFT at *Levels 4* and *5* highlights consistent and then proficient applications of MedFT knowledge and skills. At these levels the clinician, like KP, will identify as a MedFT professionally. He will be seen as part of the health-care team versus exclusively as a specialty care provider. Examples of this advanced level of skill would be when he offered guidance to team members about how to respond to Brandon, the patient, when he sought reassurance. Informing team members to label his reassurance seeking (e.g., "Do you think I might go to hell for having these thoughts or trying to take my life?" and "Do you know if these walls might have asbestos in them?") as his OCD talking was a means to begin some E/RP in the inpatient setting. It also ensured that all team members were responding similarly to his requests for comfort.

Additionally, KP was very attentive to one team member's personal narrative about what happened with her son, as well as beneficial ideas for "sitting with suf-

fering" when Brandon was overwhelmed when reassurance did not occur. MedFTs, as systems thinkers, believe that caring for the team and acknowledging their personal and/or professional experiences with similar issues, is a part of good caring (Hodgson et al., 2014). *Level 5* skills were also evident with this case when KP led the team in developing a treatment plan that would be best for the couple, not just the patient. Both Brandon and Ashley were given a voice in this family consultation. Team members had access to each other's notes and everyone shared responsibility for encouraging the team's overall goals with the patient and his wife versus only the goals aligned with their individual treatment plans.

Research-Informed Practices

Frequently in psychiatric care, a multimodal treatment plan is utilized where medication management and individual and family therapy approaches coexist. While most therapeutic approaches to psychiatric care focus on psychosocial stressors, interpersonal functioning, emotional processing, cognitive patterns, and physiological soothing to some degree, where the provider places his or her primary focus, likely determine the type of therapy that is utilized. Clinicians often align with a certain school of therapy; however, it is recommended that MedFTs use a science-practitioner model. Using this mode, clinicians draw on techniques and strategies that have been shown to remediate suffering associated with the psychiatric illness and/or co-occurring relational distress (i.e., evidence-based modalities). Regardless of therapeutic approach employed, attunement to the patient-family provider dynamic is crucial for ongoing treatment engagement and progress.

Individual Approaches

Individual therapies in the twenty-first century are typically brief in nature, often lasting between 10 and 20 sessions (Steenbarger, Greenberg, & Dewan, 2012). This is dissimilar to some early psychotherapies, such as psychoanalysis, which were much more lengthy. As in family therapy, the developers of some individual psychotherapies started as psychoanalysts but decided to take a different, present-oriented approach to problems. Behavioral therapy was one of the first departures from psychoanalytic theory. Patients were asked to approach the feared stimuli using principles of systemic desensitization, taking graded steps toward ultimate exposure to avoided scenario. These behavioral principles have been applied to an array of psychopathology, including exposure and response prevention (E/RP) for obsessive-compulsive disorder or prolonged exposure therapy (PE) for post-traumatic stress disorder (Gillihan, Hembree, & Foa, 2012). Other more recent evidence-based approaches include exposure techniques for social or specific phobias and habit reversal approaches to body-focused repetitive disorders or tic disorders

(Comprehensive Behavioral Intervention for Tics; Woods et al., 2008). These behavioral treatments are commonly used in conjunction with selective serotonin reuptake inhibitors. Benzodiazepines are often not utilized as their use can perpetuate a patient's external locus of control and need to rid themselves of anxiety, which runs counter to the habituation necessary for treatment efficacy.

One of the most widely known therapeutic approaches commonly utilized alongside behavior therapy, called cognitive therapy, was developed by Aaron Beck in the mid-1960s. The cognitive model states that an individual's automatic thoughts influence and are influenced by his or her emotional, behavioral, and physiological experiences (Beck, 1964, 1995). Cognitive therapists develop a comprehensive conceptualization of the patient that guides intervention. Techniques include psychoeducation, cognitive restructuring (i.e., analyzing the validity and utility of thoughts), problem-solving, activity scheduling, and behavioral experimentation (Beck, Bieling, & Grant, 2012). When this therapy is combined with behavior therapy, it is called cognitive behavioral therapy, or CBT.

A recent comprehensive survey of 106 meta-analyses examining the efficacy of CBT demonstrated that this approach has the strongest support for anxiety disorders, somatic symptoms, bulimia, anger control, and overall stress management (Hofmann, Asnaani, Vonk, Sawyer, & Fang, 2012). In this review, CBT showed higher response rates than the comparison condition in the overwhelming majority of DSM diagnoses studied. Existing practice parameters by the American Academy of Child and Adolescent Psychiatry (AACAP, 2016) typically recommend the initiation of pharmacologic agents alongside cognitive behavioral therapy for severe mental disorders, whereas youth with mild to moderate distress should first obtain cognitive and/or behavioral intervention.

An outgrowth of CBT is dialectical-behavioral therapy (DBT), which was developed by Marsha Linehan. Due to the difficulty of applying existing therapeutic paradigms to borderline personality disorder, Linehan chose to merge traditional cognitive techniques with Eastern principles of mental wellness. This led to the structured and highly evidence-based approach. Patients involved in DBT programs attend individual outpatient psychotherapy, skills training, supportive process group therapy, and telephone consultations for approximately 1 year (Linehan, 1993, 2015). Content of this efficacious treatment involves four primary modules: mindfulness, distress tolerance, emotional regulation, and interpersonal effectiveness (Linehan, 1993, 2015). While brief cognitive therapy and the lengthier DBT are typically delivered in an outpatient context, the inpatient MedFT should still be familiar with their utility and efficacy as they are increasingly used during inpatient process groups and intensive outpatient programs (IOPs).

Another individual approach commonly used to ameliorate mental symptoms includes motivational interviewing (MI). This approach is utilized in many areas of medicine to change behavior (Miller & Rose, 2009). Beyond its efficacy with a number of mental disorders (particularly substance abuse), MI has been helpful in enhancing patient outcomes in other evidence-based treatments, such as cognitive therapy, when delivered early in care (Fischer & Moyers, 2012). Moreover, MI is

useful to increase engagement in behavioral treatments that seem quite paradoxical (e.g., approach what makes you fearful).

Two other individual approaches are commonly used in outpatient psychiatric contexts: interpersonal psychotherapy and time-limited psychodynamic psychotherapy. Interpersonal psychotherapy (IPT) is a short-term psychotherapy wherein relationships and mood are the primary treatment foci. The therapist centers his or her assessment on three things—grief and loss, interpersonal disputes, and role transitions—using interpersonal inventories, communication analysis, and role plays to create change (Stuart, 2012). IPT is compatible with many other psychotherapies and shown to be effective for a number of depressive disorders (e.g., adolescent depression, geriatric depression, persistent depressive disorder, depressive phase of bipolar disorder, and perinatal depression; Cuijpers, van Straten, Andersson, & van Oppen, 2008; O'Hara, Stuart, Gorman, & Wenzel, 2000; Stuart, 2012). Time-limited dynamic psychotherapy shares IPT's focus on interpersonal relatedness and attachment theory but tends to focus more on early life experiences, repetitive maladaptive patterns, and transference/counter-transference (Levenson, 2012). Meta-analyses of short-term and long-term dynamic therapies have demonstrated large effect sizes for a number of mood, eating, and personality disorders (Leichsenring, Rabung, & Leibing, 2004; Leichsenring & Rabung, 2008). In an era of eclecticism in psychiatry, all of the abovementioned individual therapy techniques can be integrated with evidence-based family therapies.

Family Approaches

The role of the family has gone through a significant transformation in the field of psychiatry and among the broader therapeutic community. Early on, families were seen as an etiological and contributing factor in mental disorders, e.g., double binds (Weakland, 1960), communication deviance (Singer & Wynne, 1963), and the schizophrenogenic mother (Fromm-Reichman, 1948). However, over time families have been seen as an avenue of rehabilitation and support from the patient with mental illness (Falloon, 2003). Alongside this perspective shift, the concept of expressed emotion (EE), criticism, and overinvolvement emerged in the 1950s, 1960s, and 1970s (Brown, Carstairs, & Topping, 1958; Vaughn & Leff, 1976). Subsequent research on high EE families where one member has schizophrenia or bipolar disorder demonstrated a relapse rate ranging from 3 to 5 times higher than that of low EE families (Parker & Hadzi-Pavlovic, 1990; Yan, Hammen, Cohen, Daley, & Henry, 2004). This knowledge led to the advent of psycho-educational family groups, among other services offered through the National Alliance on Mental Illness (NAMI).

The effectiveness of family therapy and systemic intervention for psychiatric disorders has been carefully overviewed by Baucom, Shoham, Mueser, Daiuto, and Stickle (1998), Carr, (2009a, 2009b), Diamond and Josephson (2005), and Falloon (2003). A synopsis of these reviews is that behavioral family therapy (e.g., parent-

child interaction therapy, Positive Parenting Program (Triple P), parent management training, Barkley model), functional family therapy, multidimensional therapy, and multisystemic therapy show utility in treating behavioral concerns of childhood and adolescence. While attention-deficit-hyperactivity disorder is most commonly treated with stimulant medication, behavioral approaches can be useful in addressing common co-occurring behavioral disturbances.

Recent investigators also encouraged integration partners and family members into cognitive and behavioral treatments to enhance efficacy (Baucom et al., 1998; Carr, 2009a, 2009b; Diamond & Josephson, 2005). Indeed, authors in a recent meta-analysis highlighted the interplay of family accommodation and OCD symptom severity (Strauss, Hale, & Stobie, 2015). Reflecting on Mr. Anderson from our case, literature is becoming rich with emerging couple-based approaches to anxiety difficulties, such as enhanced E/RP for OCD (Abramowitz et al., 2012). Pertaining to younger patients needing E/RP, CBT family treatment for childhood OCD, including a strong systemic component, was effective 7 years posttreatment (O'Leary, Barrett, & Fjermestad, O'Leary, Barrett, & Fjermestad, 2009). The benefits of relationally focused CBT extend beyond OCD, too. Empirical support for cognitive behavioral couple therapies (CBCT) was recently reviewed by Fischer, Baucom, and Cohen (Fischer, Baucom, & Cohen, 2016); findings showed evidentiary support in the treatment of mood disorders, substance use disorders, anxiety disorders, and post-traumatic stress disorder.

Another empirically supported couples treatment modality that incorporates behavioral, humanistic, and systemic principles is emotionally focused couples therapy (EFT; Johnson, 2004). Since the development of EFT in the 1980s, it has been found to meet or exceed the guidelines at the highest level (Sexton et al., 2011) as an evidence-based couple therapy approach with both efficacy and effectiveness studies to back it up. EFT is rooted in attachment theory and has been studied with several mental health issues such as general relational distress (as reviewed in Wiebe & Johnson, 2016), depressive disorders (Denton, Wittenborn, & Golden, 2012; Dessaulles, Johnson, & Denton, 2003), and post-traumatic stress disorder (Dalton, Greenman, Classen, & Johnson, 2013; MacIntosh & Johnson, 2008; Weissmann et al., 2017). It also has been found effective with high-risk couples caring for a chronically ill child (Cloutier, Manion, Walker, & Johnson, 2002; Walker, Manion, Cloutier, & Johnson, 1992), reducing pain and lowering neurological threats (Johnson et al., 2013), increasing partner's empathic caregiving (McLean, Walton, Rodin, Esplen, & Jones, 2013), and improving relationship satisfaction and quality of life for couples undergoing cancer treatment (Naaman, 2008).

Lastly, integrative behavioral couple therapy (IBCT), developed Jacobson and Christensen (1998), is a couple-based treatment modality for use in mental health settings. IBCT was developed out of behavioral acceptance-based therapies and has a research base rooted primarily in examining its impact on relationship distress and satisfaction (Roddy, Nowlan, Doss, & Christensen, 2016) with a few studies demonstrating positive impact on individual mental health symptoms (e.g., Christensen et al., 2004; Christensen, Atkins, Yi, Baucom, & George, 2006). While both IBCT and EFT therapists work with couples toward increasing emotional intimacy, IBCT approaches it more from a behavioral lens versus strengthening of the attachment

bonds as in EFT. Also, while both IBCT and CBCT look at the intersection of cognitive and emotional changes to help reduce relational distress. IBCT focuses primarily on change through a new pattern of couple interaction, whereas CBCT works with couples to identify and correct cognitive errors in their thinking. Recently, Veteran Affairs Medical Centers endorsed integrative behavioral couple therapy (IBCT) for nationwide training and dissemination to all its centers (Roddy et al., 2016); however, more research is needed for its effectiveness and efficacy.

Another established approach that has received attention in the literature is a family-based approach (called the Maudsley method) for adolescents with anorexia nervosa; it has demonstrated superior effects when compared to individual treatment (Lock, Le Grange, Agras, & Dare, 2001). This approach pulls from structural family therapy, strategic family therapy, Milan systems therapy, and feminist theory. A final area of family intervention is attachment-based approaches, such as attachment-based family therapy (ABFT) and emotionally focused couple therapy (EFT). ABFT demonstrated considerable remission for adolescents with depression, alongside reductions in family conflict, anxiety, and hopelessness (Diamond, Reis, Diamond, Siqueland, & Isaacs, 2002; Diamond, Russon, & Levy, 2016). More recent inquiry shows reductions in depressive symptoms and suicidal ideation for high-risk youth (Diamond et al., 2010, 2016; Israel & Diamond, 2012).

Community Approaches

Since the de-institutionalization of psychiatric hospitals, patients who would have been in an inpatient setting have instead been in the least restrictive setting, residing in their communities. Given the volume of individuals with chronic and persistent mental illness paired with the hope to decrease repeated hospitalizations, many systems employ an Assertive Community Treatment (ACT) team. ACT is an individualized way of delivering care where patients with chronic and persistent mental illness, such as schizophrenia or schizoaffective disorder, receive psychopharmacologic treatment, individual supportive therapy, mobile crisis intervention, rehabilitation, and support services for family (NAMI, 2016).

Other resources for patients and families coping with mental health concerns include nonprofit organizations and foundations. These organizations are based at both the state and national levels, providing psychoeducational classes and support groups to families navigating an array of psychiatric difficulties. NAMI, the Depression-Bipolar Support Alliance, and the American Foundation for Suicide Prevention are examples of organizations offering guidance at a national level. Locally, organizations often have family-to-family support. In this model, families who have been coping with a mental illness for a considerable time are paired with families newer to the illness journey. The mentoring family offers an empathetic ear and education on prognosis or treatment options from a patient's perspective. Through this guiding role, the giving family receives altruistic benefits of sharing their knowledge and experience. Other groups, such as Alcoholics Anonymous and 12 step

groups (e.g., Emotions Anonymous, Narcotics Anonymous, Overeaters Anonymous, Sex Addicts Anonymous), provide avenues for communion for those experiencing substance use disorders or impulse control difficulties in most geographic areas.

Conclusion

Psychiatry helped to give rise to the field of family therapy, recognizing that mental illness impacts and is impacted by the family system. While we have not been able to cure illnesses such as schizophrenia and bipolar disorder, we have figured out ways that family and support system members can facilitate gains in treatment. MedFTs are strong contributors to inpatient and outpatient settings helping the psychiatric team to design treatment plans that are patient and family centered. While colleagues bring a set of diagnostic and intervention skills that are more intra-individual, the MedFT encourages the team to think about how interventions will impact and be impacted by the patient's natural context(s).

Reflection Questions
1. As a MedFT working in a psychiatric setting, how will you define and make known your scope of practice when many other professionals (e.g., psychiatrist, psychiatric nurse, psychologist, social worker) may have similar skills sets?
2. How might a person or family's personal preferences, intergenerational patterns, or cultural beliefs impact their expression of mental health concerns, engagement in care, and willingness to participate in certain treatment approaches?
3. After reviewing the therapeutic approaches to mental illness outlined in this chapter, how do treatment providers go about determining the most efficacious treatment plan? For instance, should a person with major depressive disorder and alcoholism in a tumultuous marriage receive CBT, EFT, CBCT, AA, pharmacology, another treatment approach, or some combination of approaches? How might these decisions be made in light of the literature and practice restraints?

Glossary of Important Terms for Care in Psychiatry

Atypical antipsychotic Group of psychiatric drugs, also known as second-generation antipsychotics that block receptors in the brain's dopamine pathways; they are commonly used to treat psychosis, autism, and mood disorders.

Benzodiazepine Group of psychiatric drugs, also called "benzos" that lead to sedative and anxiolytic effects; they are commonly used to treat acute anxiety while other antidepressant drugs are taking effect.

Countertransference Emotional reactions of a therapist to a patient.

Ego-dystonic Thoughts (e.g., violent, sexual, religious, impulses) that are in conflict with the person's self-image, often seen in those with OCD.

Electroconvulsive therapy (ECT) Procedure where small electrical currents pass through the brain to trigger small seizure activity en route to relief from severe mental illnesses.

Emotional regulation Inhibiting and modulating one's emotional experience.

Enabling When family or friends, in an attempt to help resolve a specific problem (e.g., distress from cravings), perpetuate or exacerbate the problem (e.g., substance abuse) due to accommodation made for harmful behaviors (e.g., providing substances or money).

Expressed emotion Interactions in the family environment that are critical, hostile, or emotionally over-involved; these are known to exacerbate psychiatric illnesses.

Family accommodation Family members take part in compulsive rituals, avoidance patterns, or modifications of routines in an attempt to assist a patient with OCD.

Forensic interviewing Structured evaluation (not treatment) used to determine facts of a case related to child maltreatment, as well as the role of an individual's mental illness in criminal or civil litigation.

Intensive Outpatient Treatment (IOP) Part-time or full-time day treatment program used for those who do not meet criteria for hospitalization but need a higher level of care than traditional outpatient care.

Involuntary commitment Legal process where an individual who is determined to have symptoms of severe psychiatric illness (e.g., pose harm to self or others, lack self-care abilities) is court-ordered to treatment in an inpatient psychiatric hospital or outpatient community treatment program.

Mood stabilizer Group of psychiatric drugs used to treat mood disorders, such as bipolar disorders and schizoaffective disorder.

Psychological testing Evaluation of psychological symptoms by objective and standardized measures, commonly used in the diagnosis of neurocognitive and neurodevelopmental disorders.

Selective serotonin reuptake inhibitor (SSRI) Group of psychiatric drugs often used as a first-line pharmacologic treatment for depressive and anxiety disorders; they work by blocking the reuptake of serotonin in the brain.

Serotonin norepinephrine reuptake inhibitor (SNRI) Group of psychiatric drugs often used as a pharmacologic treatment for depressive disorders (occasionally anxiety and nerve pain as well) that block the reuptake of serotonin and norepinephrine.

Transference Unconscious redirection of feelings and desires from one person (often from one's family of origin) to another (often one's treatment provider).

Tricyclic antidepressant Group of early antidepressant medications that work by blocking the reabsorption of neurochemicals (e.g., norepinephrine, serotonin)] in the brain; this class of medications is rarely used nowadays due to high frequencies of associated side effects.

Typical antipsychotic Group of early antipsychotic medications often replaced by newer atypical antipsychotics due to side effects that are used in the treatment of psychosis and acute mania.

Urine toxicology screen (UTOX) Test that checks for drugs or other chemicals that could contribute to the presentation of psychiatric illness.

Additional Resources

Literature

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Keiter, G. I., Heru, A. M., & Glick, I. D. (2010). *Clinical manual of couples and family therapy.* Arlington, VA: American Psychiatric Publishing, Inc.

Linehan, M. M. (2015). *DBT skills training manual.* New York, NY: Guilford Press.

Measures/Instruments

Beck Scales. https://www.beckinstitute.org/get-informed/tools-and-resources/professionals/patient-assessment-tools/

Child/Adolescent Psychiatry Screen (CAPS). http://www2.massgeneral.org/school-psychiatry/childadolescentpscychiatryscreencaps.pdf

Generalized Anxiety Disorder 7-item scale (GAD-7). http://www.integration.samhsa.gov/clinical-practice/GAD708.19.08Cartwright.pdfMulti-Health Systems, Inc., http://www.mhs.com

Patient Health Questionnaire (PHQ-9). http://www.cqaimh.org/pdf/tool_phq9.pdf

Screen for Child Anxiety Related Disorders (SCARED). http://psychiatry.pitt.edu/sites/default/files/Documents/assessments/SCARED%20Child.pdf

Yale-Brown Obsessive Compulsive Scale Symptom Checklist. http://healthnet.umassmed.edu/mhealth/YBOCSymptomChecklist.pdf

Organizations/Associations

American Academy of Child and Adolescent Psychiatry. http://www.aacap.org
Association for Behavioral and Cognitive Therapies. http://www.abct.org/Home/
Association of Family Psychiatrists. http://familypsychiatrists.org
American Psychiatric Association. https://www.psychiatry.org
Beck Institute. https://www.beckinstitute.org
National Alliance on Mental Illness. https://www.nami.org

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