

Family-Based Integrated

Care:

A framework for formulation and tools for
therapy

PROGRAMS

BRADLEY HOSPITAL INTENSIVE

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Disclosures

Planners : Michele Gessman LICSW and Michelle Rickerby MD have no relevant financial interest in, or any affiliation with any commercial interest to disclose

Speaker: Michelle Rickerby MD has no relevant financial interest in, or any affiliation with any commercial interest to disclose

“DISCLOSURE OF RELEVANT FINANCIAL CONFLICTS OF INTEREST WITHIN THE LAST 12 MONTHS MUST BE MADE AND REOLVED PRIOR TO THE CME ACTIVITY. OUR IINTENT IS TO ASSIST LEARNERS IN ASSESSING THE POTENTIAL FOR BIAS IN INFORMATION THAT IS PRESENTED DURNG THIS CME ACTIVITY”

Objectives

1

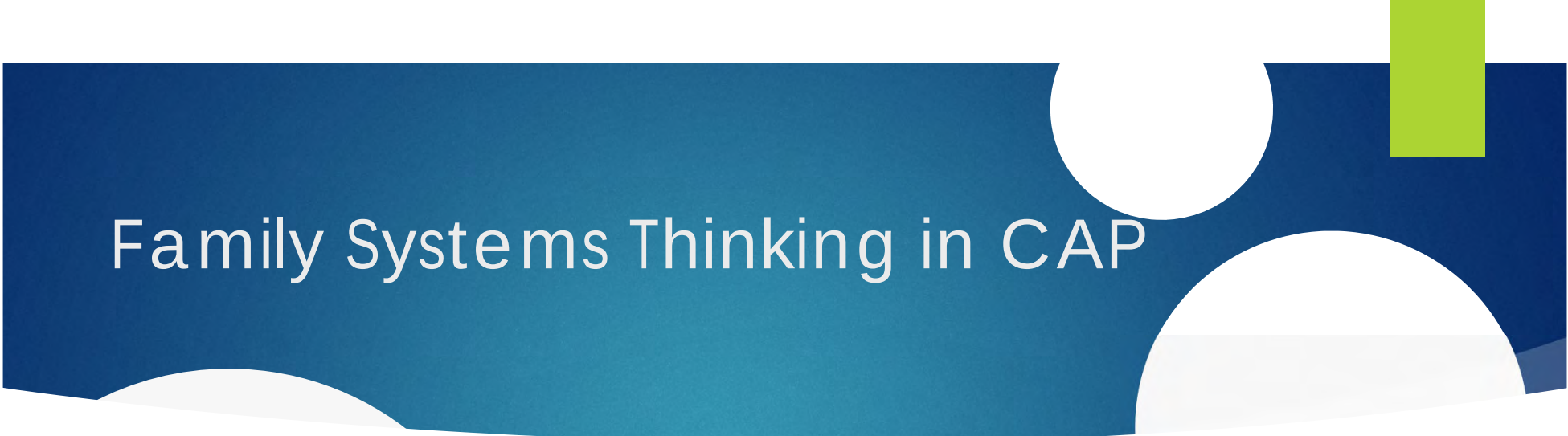
Participants will be able to employ the framework of family-based integrated care in the formulation of patients and families that they see in practice.

2

Participants will be comfortable defining the concepts of joining, reframing, bridging, and circular questions as related to their practice of psychotherapy.

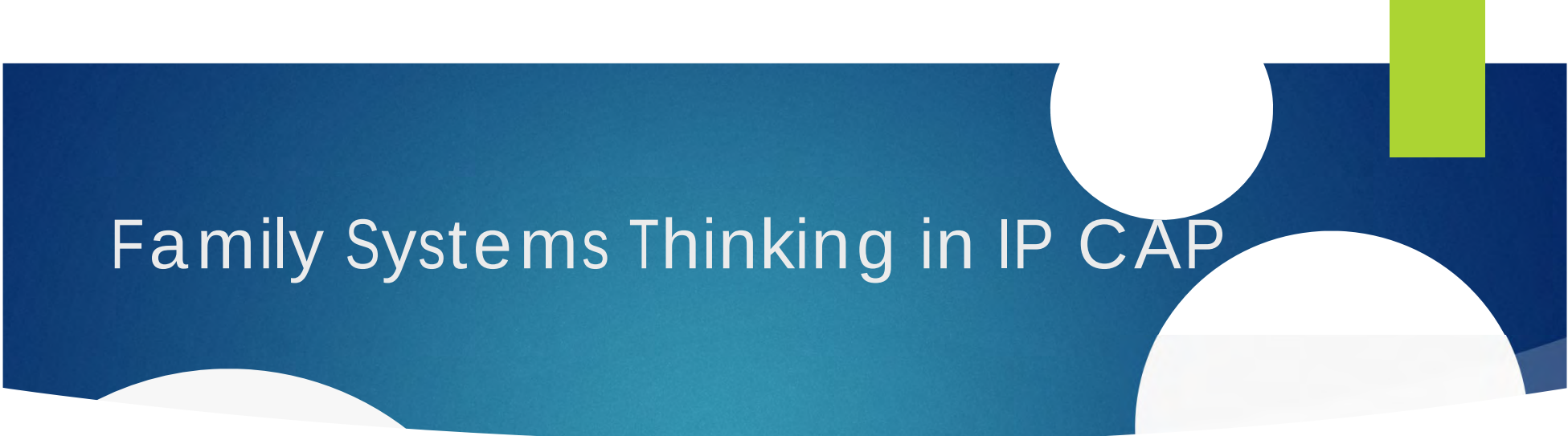
3

Participants will have tools to use in their own practice to support families in breaking non-productive patterns including: blame, destructive affect, parental splits and avoidance.



Family Systems Thinking in CAP

- Sometimes children and teens are dysregulated and distressed primarily due to neuropsychiatric illness and sometimes due to a context of unhealthy relationships and often both (we need to know the difference)
- Psychiatric illness put immense pressure on family functioning and relationships (collateral damage)
 - Often more than one family member has psychiatric illness which conveys more pressure on system
- Regardless of modality of therapy (individual or family) a family systems understanding of the patient maximizes benefit
- Intervention starts during “assessment” and assessment continues over the course of “intervention”



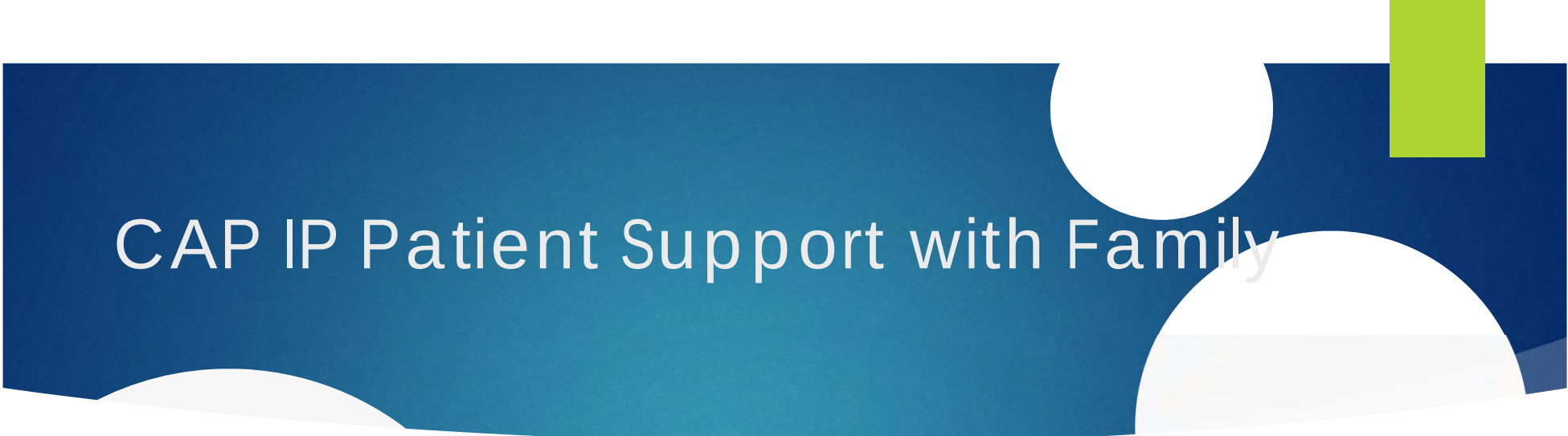
Family Systems Thinking in IP CAP

- Positives- safety, possibility for intensive intervention, removes pressure from family system in some ways
- Negatives- can feel traumatic, disrupts life of patient and family, makes it harder to understand systemic challenges around child
- Stays are not generally long enough to have significant shifts in symptoms, patient insight, or “improved coping” of patient
- The most important “shift point” of an Inpatient stay is shifts in beliefs of family system around the patient (and how this translates into interactions in relationships)
- The amount of possible “movement” of a family system is more dependent on “where they are” functionally (beliefs and relationships) than the level of care--- regardless of level of care this is what guides “next steps”



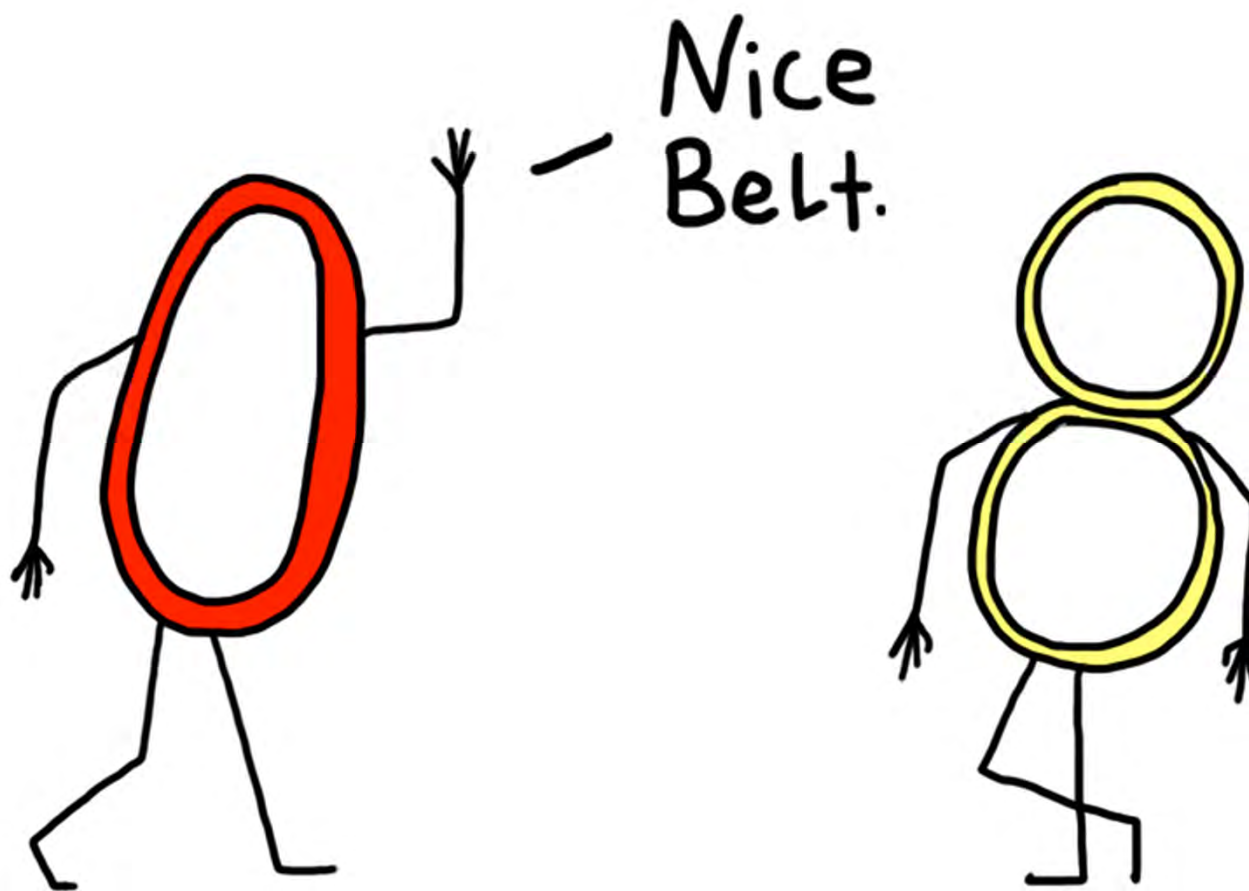
Family Involvement in IP CAP Care

- Admission
- Telephone contact
- Visits
- Family Meetings (Education, Tx decisions, D/C planning)
- Family Therapy (focused effort to improve interactions between patient and family)
- Family Groups
- Medication discussions



CAP IP Patient Support with Family

- Unit team awareness of basic family status for understanding what supports may be needed before/during/after phone contact/visit
- “Bridging” discussions in therapy in prep for family meetings
- Careful decisions about who is in the room when for family sessions (support before and/or after)
- Consideration of need for parent’s referrals for their own treatment



PSYCHOTHERAPY ASSUMPTIONS

PATIENTS DON'T SHARE THEIR REALITY UNLESS THEY FEEL SAFE

- AT HOME AND IN TREATMENT

EVERYONE HAS MIXED FEELINGS ABOUT EVERYTHING

- THERE IS ALWAYS AT LEAST TWO (OFTEN MORE) SIDES TO EVERYTHING

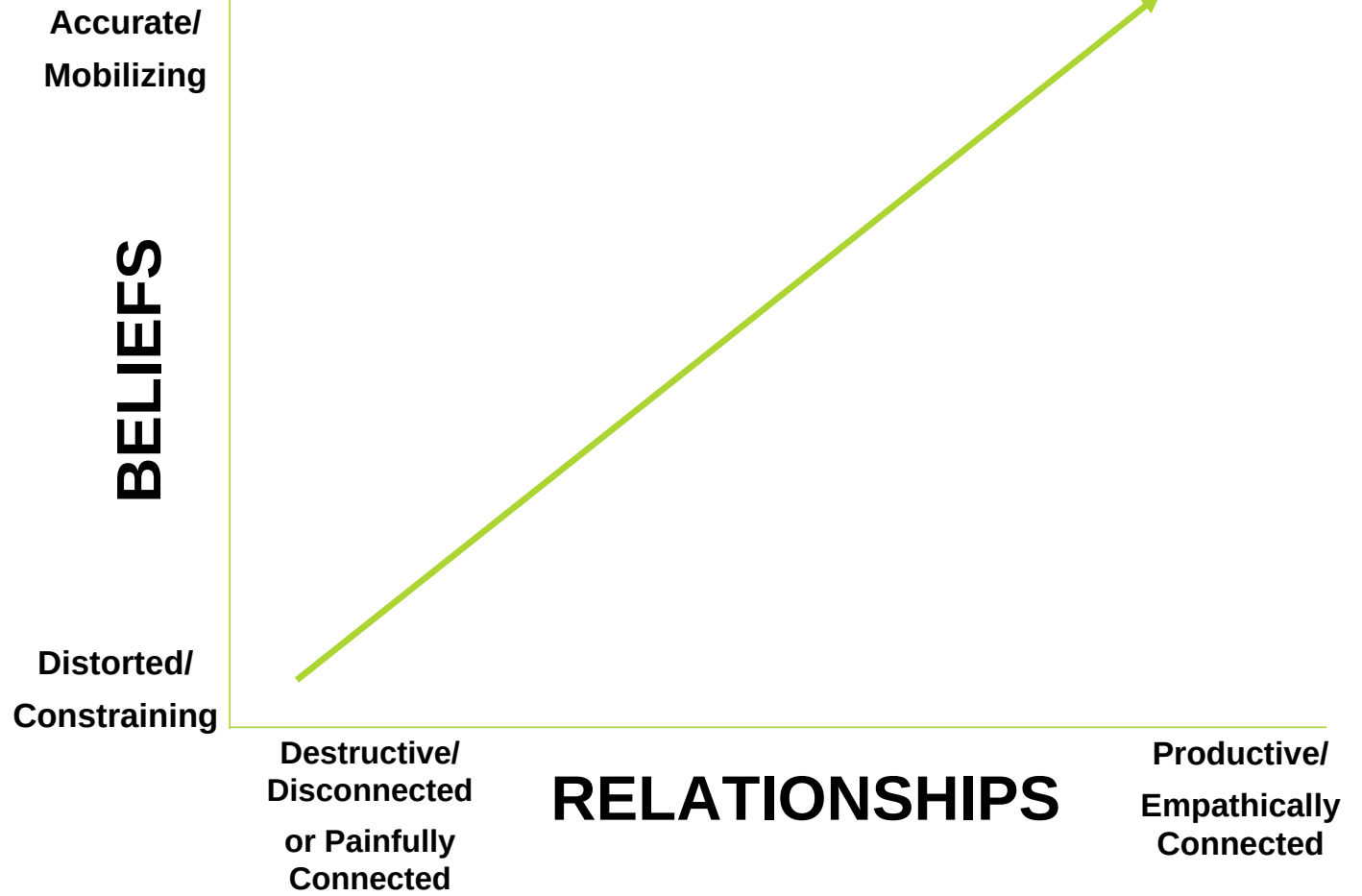
IF PAIN AND DISTRESS IS SHARED AND THE RESPONSE IS SUPPORTIVE AND EMPATHIC IT LEADS TO DECREASED PAIN AND DISTRESS

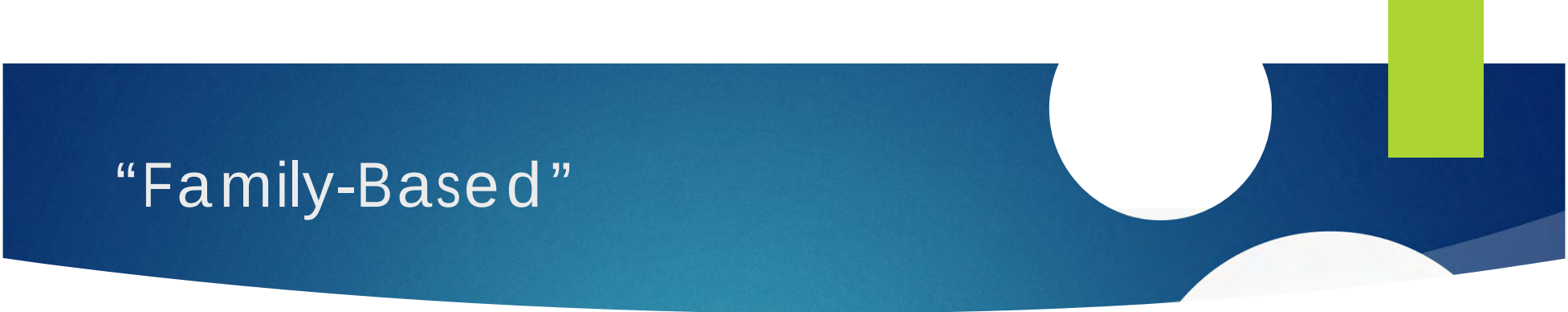
- THE GOAL OF TALKING ABOUT PAINFUL THINGS IS FOR IT TO BE PRODUCTIVE RATHER THAN DESTRUCTIVE

ALL CASES ARE "FAMILY" CASES

FBIC - The Big Picture

- ▶ What is family-based integrated care?
 - ▶ An empowering perspective about symptoms and illness focusing on supporting accurate beliefs and healthy family relationships in the context of illness crises
- ▶ Relationships
 - ▶ Destructive, disconnected, or painfully connected → productive and empathically connected
- ▶ Beliefs
 - ▶ Distorted/ Constraining > Accurate/Mobilizing
- ▶ Team Model
 - ▶ Message Magnification



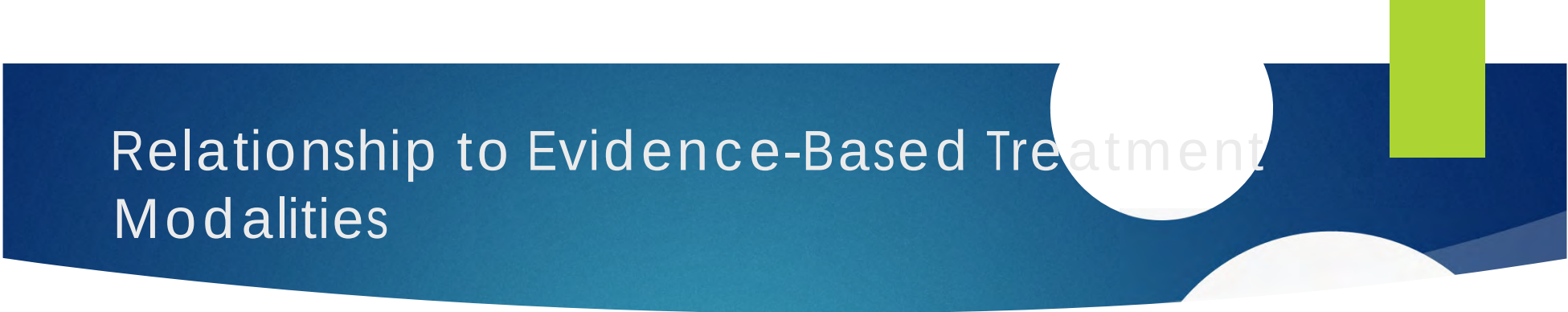


“Family-Based”

- ▶ Not simply “involving” or “updating” the family
- ▶ Not just using family therapy as a treatment modality
- ▶ Making every decision from the perspective that family illness beliefs and family relationships together constitute the two most powerful forces in illness management/recovery

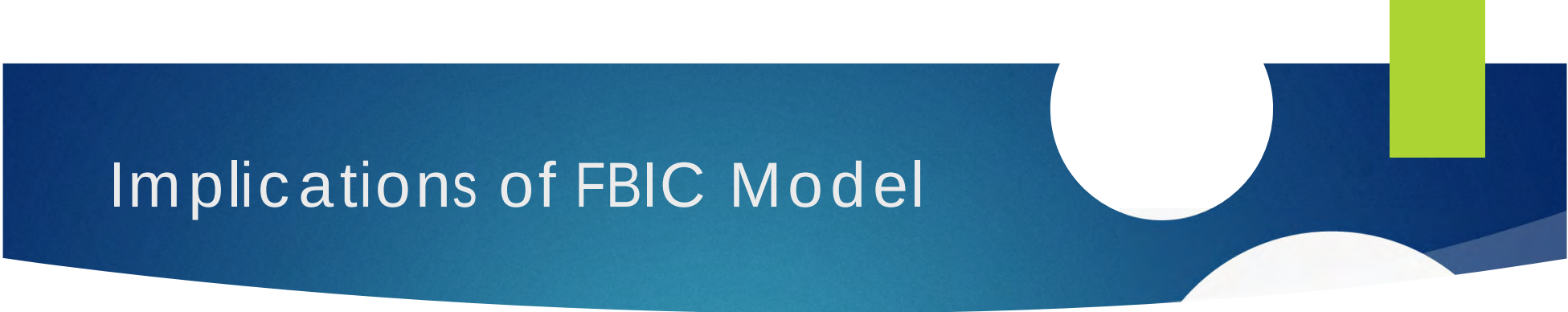
“Integrated”

- ▶ Not simply communication between medical and psychiatric providers
- ▶ Not simply the concept of integrating physical and psychological issues in treatment
- ▶ The integration of modalities (pediatric care, psychotherapy, case management, ancillary service care, psychopharmacology) through consistent provider communication and the **provision of coordinated messages to families**



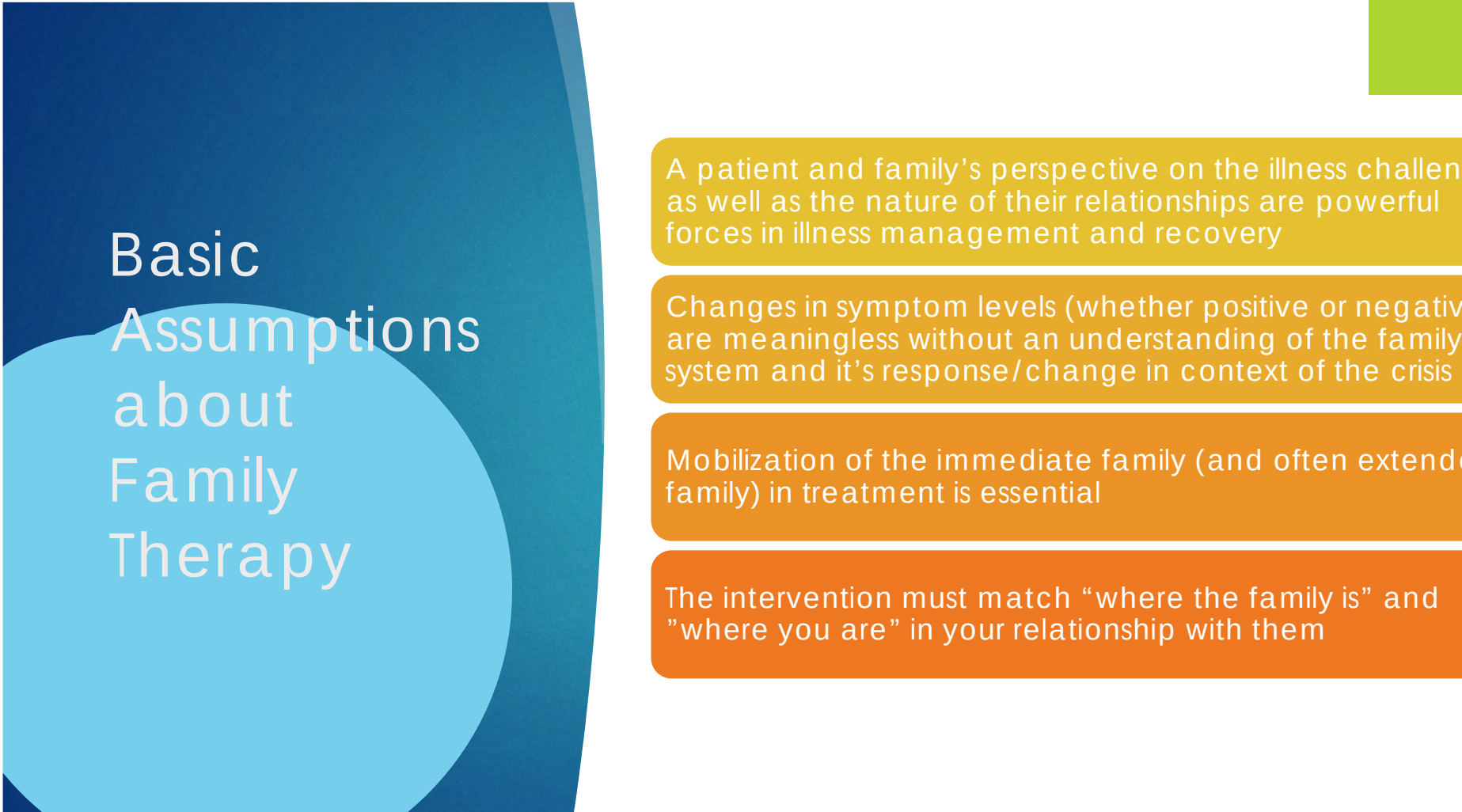
Relationship to Evidence-Based Treatment Modalities

- ▶ FBIC acknowledges contextual factors unique to each individual patient and family
- ▶ FBIC provides a frame to allow for intervention in challenging family patterns that can interfere with a range of standard treatments
- ▶ Evidence-Based Treatments can “map on” to FBIC framework



Implications of FBIC Model

- ▶ Provides an illness-independent vision that can be shared across levels of care
- ▶ Applicable to all functionally impairing diagnoses and conditions
- ▶ Allows for optimal team communication across disciplines
- ▶ Improves likelihood of the level of care and the treatment components matching family needs
 - ▶ Families tell us and show us “where they are”
- ▶ Less conflict/dissatisfaction with providers even at the most difficult junctures based on open communication



Basic Assumptions about Family Therapy

A patient and family's perspective on the illness challenge as well as the nature of their relationships are powerful forces in illness management and recovery

Changes in symptom levels (whether positive or negative) are meaningless without an understanding of the family system and its response/change in context of the crisis

Mobilization of the immediate family (and often extended family) in treatment is essential

The intervention must match "where the family is" and "where you are" in your relationship with them

The “Language” of Family-Based Treatment

A systems understanding of change necessitates use of language in treatment that incorporates this belief

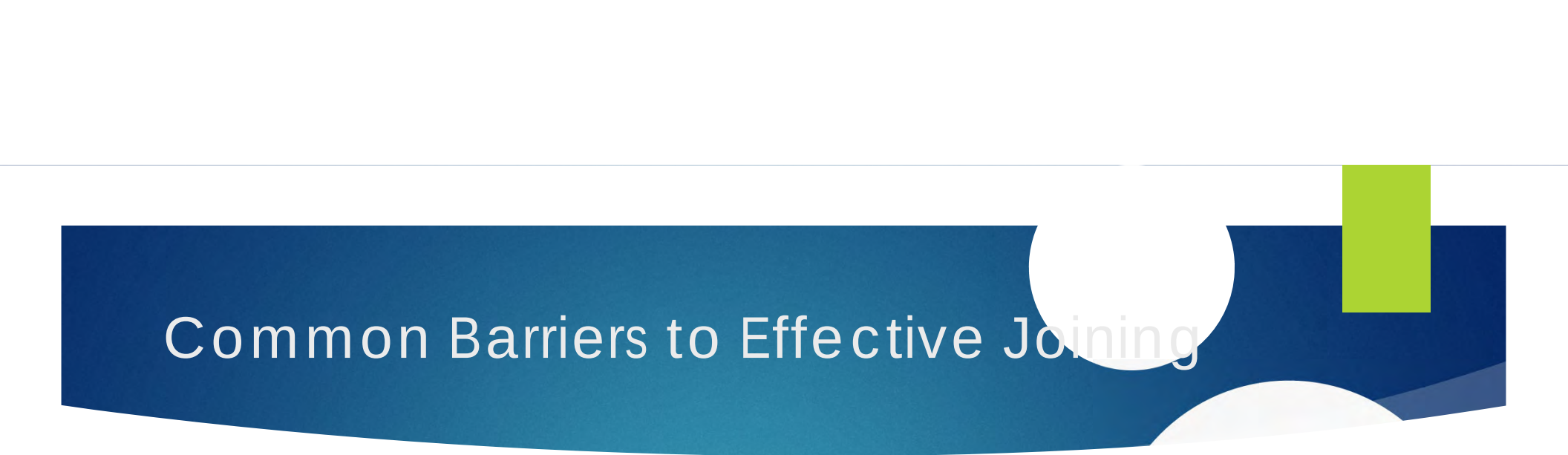
- Circular versus linear assumptions
- “Interventive Interviewing”

Messages matter

- Family messages
- Provider messages
- If more time is needed to offer a coordinated message, take more time

Family Therapy Techniques: Joining

- ▶ Joining: Creating a genuine and productive connection with each individual and the family as a whole
- ▶ Joining is an ongoing process
- ▶ Establishing a clear understanding of each person's belief about the identified problem as well as about the family as an entity
- ▶ Reinforcing the framework of therapist as partner with the patient and family- "We're in this together"



Common Barriers to Effective Joining

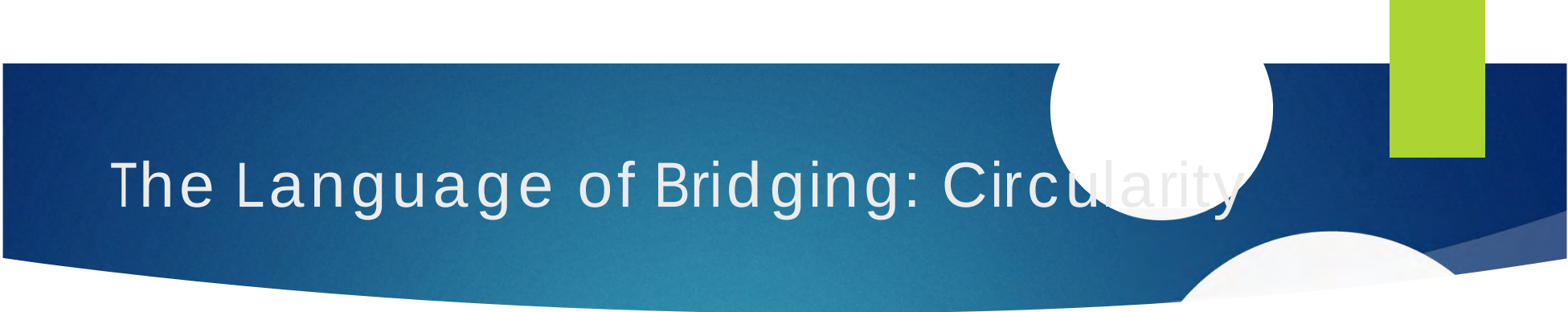
- ▶ The power of the illness and symptoms
 - ▶ Behaviorally
 - ▶ Cognitively
 - ▶ Emotionally
- ▶ The Family Protection Fallacy
- ▶ Blame dynamics
- ▶ Destructive expression of affect

Family Therapy Techniques: Reframing

- ▶ Reframing: Creating space for consideration of other perspectives
- ▶ Telling people what to do doesn't work
- ▶ Examples:
 - ▶ Externalization of the Illness
 - ▶ Normalizing the level of pressure the illness puts on relationships
 - ▶ Flipping affect (the other side of mixed feelings)
 - ▶ Supporting mentalization
 - ▶ Raising awareness of messages being sent

Family Therapy Techniques: Bridging

- ▶ Bridging: Supporting productive communication between family members
- ▶ Opening doors between people
- ▶ Therapist as buffer
- ▶ Role of combined treatment: preparation in individual or collateral conversations for joint discussions
- ▶ Stages of Systems Change
 - ▶ “Can’t be in the same room”
 - ▶ Needs intensive support in session
 - ▶ Needs less support in session
 - ▶ Productive conversations happen at home



The Language of Bridging: Circularity

- ▶ Questions embedded in a relationship
- ▶ Systemic focus and language throughout
- ▶ Use in individual as well as conjoint sessions

Blame and Destructive Affect: Joining

- ▶ “You feel strongly because you care”
- ▶ The power of underlying shame, guilt, loss
- ▶ Example of intervention: “What do you think _____ may most misunderstand about what it’s like for you to _____ ?”

Blame and Destructive Affect: Reframing

- ▶ Goal of increasing awareness of the negative impact on the patient
- ▶ "Blame" construct shifting to "everyone taking responsibility for their part"
- ▶ The power of affect shifting
 - ▶ "As enraged as you are at the decisions your ex is making about your son/daughter right now, what about the situation do you feel most sad about?"
- ▶ Shifting from focus on blaming others to what the person faults themselves for
 - ▶ "As much as you blame your ex for the crisis your child is in right now, what part are you most faulting yourself for?"

Blame and Destructive Affect: Bridging

- ▶ Circular/Interventive Questions

- ▶ “As angry as your daughter is about _____, what is the saddest part for her when she thinks about it?”
- ▶ “As much as _____ blames you for this crisis what is the part he faults himself most for?”

Parental Split: Joining

- ▶ Joining point is love for children
- ▶ Use the word RESPECT often
- ▶ Normalize conflict/differences in parenting styles/perspectives
 - ▶ Introduce the possibility of balance

Parental Split: Reframing

- ▶ Two sides (pros and cons) of style/belief differences
 - ▶ “What is the best/worst for your son/daughter about your _____ style?”
- ▶ Raise awareness of the impact of mixed messages
 - ▶ “Would your son/daughter say you two mostly agree or disagree about _____?”
- ▶ Highlight the concept of team work/ co-parenting

Parental Split :Bridging

- ▶ Examples of circular/interventive questions:
 - ▶ “As much as your ex-wife is angry at you about the crisis that your daughter is in, what is she most faulting herself about?”
 - ▶ “If I asked your children would they say that the two of you get along better, worse, or the same as before you got divorced?”
 - ▶ “If I asked your son would he say that the two of you mostly agree or mostly disagree when it comes to making decisions about him?”

Family Protection Fallacy: Joining

- ▶ Normalize the pain of seeing children distressed
- ▶ Normalize how out of control the situation feels
- ▶ Normalize how hard honesty is
- ▶ Remember that some people have never experienced support in response to being open about vulnerability

Family Protection Fallacy: Reframing

- ▶ Pain can be gain
 - ▶ “Have you been able to talk about painful things without it feeling destructive or hurtful?”
 - ▶ “My goal is to help you be able to talk about painful things in a productive way.”
- ▶ The family culture of emotional expression matters
 - ▶ “Would your son/daughter say that you believe it’s okay to share painful things or that it’s better to keep them inside?”
- ▶ Normalize that each family member may have a different rate and shape to their process
 - ▶ “Who in the family is farthest along with accepting_____ and who has the farthest to go?”

Family Protection Fallacy: Bridging

- ▶ Examples of circular/interventive questions:

- ▶ "Does Mom/Dad understand how hard it is for you to talk about _____?"
- ▶ "Is your son/daughter/father/son holding their feelings/pain in because : they don't think it makes a difference to share it; they are worried you will be angry at them; or they are trying to protect you, or some of each?"
- ▶ "As painful as it is for your mom/dad/child to hear you share about _____ are they relieved in knowing that you are now not alone in this pain?"

TAKE HOME LESSONS:

The “Good News” Regarding High Intensity Illness Challenges

- ▶ Illness beliefs and interpersonal relationships within families can, in fact, be modified, and targeting these areas does improve outcomes.
- ▶ If we “know where we are” with family relationships and illness beliefs, we know what to do.
- ▶ Consistent messages matter and are powerful.
- ▶ Excellent provider collaboration is a strong force in supporting patient/family success.
- ▶ Any painful challenge/symptom/illness is improved with an empowered set of beliefs about illness and empathic relationships, which is most effectively accomplished via family-based treatment in the context of integrated messages from providers.

Applications to your practice

- ▶ Consider using the FBIC “graph” to orient you about the “big picture” of the case
 - ▶ Focus treatment goals in a realistic way
 - ▶ Increased ease/empathy joining with families who may be “in the lower corner of the graph”
- ▶ Be aware of the power of messages to patients and families
 - ▶ Keep it simple
 - ▶ Externalizing the illness
 - ▶ Pain doesn’t have to be destructive
 - ▶ Comment on the larger picture even if you are responsible for a small part of care
- ▶ Consider how your practice group team can improve both internal communication as well as that with other providers across the system of care

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References

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