Family Systems Care in Public Sector Settings

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Introduction

Patients in public sector settings present with complex mental health and social needs, such as homelessness, substance abuse, immigration, poverty, and minority status. For these patients, a family-centered approach incorporating family psychoeducation provides a framework for understanding and including the individuals involved in their system of care. A family-centered approach may appear daunting because of the difficulty in bringing in family members or the clinician's lack of experience in dealing with family members, but family inclusion can begin by simply inviting the family into the conversation. This chapter uses case material to outline the current status of family-centered care and point to future directions. We weave in the knowledge base needed for family inclusion and evidence-based family interventions, focusing on family psychoeducation because of its evidence base, cultural adaptations, and efficiency.

Family-centered care encompasses multiple systems: the social support systems providing emotional, spiritual, and community life; the public system providing financial support (e.g., Medicaid, Medicare); and the healthcare system (Bamm and Rosenbaum 2008). In fact, patients and their families are supported by multiple individuals in these systems. A family-centered approach begins with collaborating with these individuals. All agencies can benefit from a comprehensive treatment plan which also includes information about advocacy organizations, such as the National Alliance on Mental Illness (NAMI), Mental Health America (MHA), and Depression and Bipolar Support Alliance (DBSA), as well as self-help organizations for alcoholism and substance abuse, such as Alcoholics Anonymous (AA), Narcotics Anonymous (NA), and Al-Anon (Alcoholics Anonymous support group for loved ones of alcoholics). Most important is our need to partner directly with families. We owe it to families to include them at all levels of care, especially decision-making and treatment planning and in ongoing treatment.

Many patients in the public sector setting have limited contact with their families. Despite this, family-centered approaches can still be utilized to provide stability and support. Staff members in different systems can become a patient's "family."

The case examples adopt the McMaster Approach to Family Assessment (Epstein et al. 1983). This model uses six dimensions of family functioning to guide assessment and treatment

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and has a comprehensive, time-efficient way to evaluate strengths and weaknesses in family functioning.

1. Problem-Solving: ability to resolve problems at a level that maintains effective family functioning.
2. Communication: exchange of information among family members.
3. Roles: established patterns of behavior for handling family functions, including provision of resources, support, and personal development.
4. Affective Responsiveness: extent to which individual family members experience appropriate affect and emotions.
5. Affective Involvement: extent to which family members are interested in and place value on each other's activities and concerns. A healthy family has an intermediate level of involvement, neither too little nor too much.
6. Behavioral Control: how a family expresses and maintains standards for the behavior of its members. Examples include patterns of control (flexible, rigid, chaotic, etc.).

Case Example #1

Ms. Smith is a 23-year-old single female who presents to establish care. Her past medical history includes chronic Lyme disease, fibromyalgia, irritable bowel disease, chronic pain previously on high-dose opioids, and a psychiatric history of hospitalizations for suicide attempts, depression with chronic suicidal ideation, anxiety, anorexia nervosa, and opioid and benzodiazepine dependence in full sustained remission. Her mother completed suicide by overdose 2 years ago, and her father has been absent from her life since her mother's death due to his inability to cope with his feelings of loss. Ms. Smith is an only child. She has remained sober from substances for 2 years after completing 9 months of residential treatment and ongoing connection with Alcoholics Anonymous (AA). Since attaining sobriety, her chronic suicidal ideation persisted, but she has had no suicide attempts. Her treatment team consists of her primary care doctor (eating disorders specialist), psychiatrist, DBT therapist, eating disorders program therapist, dietician, and support network including AA and her AA sponsor. Each clinician focuses on a single problem: her PCP, dietician, and eating disorders therapist focusing on her eating disorder; her DBT therapist and psychiatrist focusing on her chronic suicidal ideation and feelings of abandonment; and her AA sponsor on maintaining sobriety.

Family Assessment with Ms. Smith and Her Psychiatrist, Primary Care Doctor (PCP), DBT Therapist, Eating Disorders Program Therapist, Dietician, and AA Sponsor

Her psychiatrist scheduled a 1-hour meeting to develop a treatment plan. The first step is to clarify each person's understanding of the presenting problems.

Problem-Solving

Because of the instability in her family and housing, her treatment team and support network become her "family" and provide stability.

Communication

After the meeting, each clinician has a comprehensive understanding of how each of her symptoms is perpetuated and worsened by other symptoms. The plan is for all communication to go through her primary care physician.

Roles

The treatment team meeting allows each clinician to understand their role in Ms. Smith's care and agree that her symptoms need to be addressed as a whole.

Affective Responsiveness

Ms. Smith is angry that her mother died and her father left her. She used to spend time with her mother and misses her a great deal. These feelings trigger her urges to act impulsively. Her AA sponsor is scared when Ms. Smith is impulsive. Her psychiatrist and PCP feel overwhelmed because she is in constant crisis.

Affective Involvement

Each member of her treatment team is invested in her well-being and the need for consistent boundaries.

Behavior Control

Adequate when Ms. Smith is in control of her feelings.

Case Formulation

Ms. Smith's emotional balance (family stability) was disrupted by the loss of her parents and move to another state (family transitions). Early collaboration of care provided increased stability and understanding of all of Ms. Smith's needs from multiple perspectives. Everyone agreed that monthly check-in calls together as a cohesive treatment team allowed for the identification of triggers and earlier interventions to maintain remission and prevention of relapse. As she experiences feelings of abandonment and loss, the stability and consistency of her team helped her avoid acting on her suicidal ideation. The cohesiveness of her treatment team formed a "family" system that helped her navigate crises.

Learning Points

When patients do not have family, treatment team members and social and community support networks can become a "family." However, like any family system, ensuring consistent boundaries and limit-setting within the family, and, in this case, the treatment team, is crucial.

Family Inclusion

Involving families in assessment and treatment reduces risk for the patient and the provider. Good rapport with family members and good documentation provide a protective function against adverse provider outcomes such as lawsuits (Recupero 2007). By simply inviting and including family as part of the assessment, questions about family functioning (including adaptation to illness, the family narrative, caregiving concerns, family interactions) facilitate a solid working diagnosis (Heru 2015). Families provide information that increases the likelihood of an accurate diagnosis or early detection of harmful behaviors. Involving the family in decision-making about treatment and disposition is key to patient compliance and leads to more successful outcomes (Baird and Doherty 1990; Lang et al. 2002; McDaniel et al. 1990). Understanding family characteristics provides an understanding of how the psychosocial context influences the presenting symptoms. Listening to the family, taking their fears and concerns seriously, and teaching them how to help keep their loved one safe are steps in providing family-oriented patient care. A primary biomedical intervention may be sufficient to treat some presenting acute illnesses; most psychiatric problems require an understanding of the relational context for successful treatment.

This example demonstrates how inviting the family into the conversation allows for a broader understanding of the patient.

Case Example #2

Mrs. Nguyen is a 64-year-old, married, Vietnamese-speaking woman with obstructive sleep apnea, bilateral cataracts, recurrent urinary tract infections, and vaginal prolapse. She presents to the outpatient psychiatry clinic with severe anxiety and depression. She was previously a successful business owner, but in the past 2 years, she has progressively declined and become bed-ridden, isolative, and unable to work. She lives with her husband, and her family constellation includes a son and two adult daughters who live nearby and are involved in her care. She has had two prior extended inpatient hospitalizations of 2–3 months each, due to difficulty with discharge planning. When depressed, she is unable to care for herself independently and becomes extremely aggressive, prompting family to bring her to the emergency room for admission. This has been a repeated cycle every 6 months over the past 2 years. She has had many medication trials of antidepressants, benzodiazepines, antipsychotics, and mood stabilizers and biological trials of transcranial magnetic stimulation, electroconvulsive therapy, and ketamine infusions.

Inviting the family into the conversation Since she is accompanied by one of her daughters, the psychiatrist invites her to join the second half of the evaluation. The daughter is grateful to be included. The patient's husband joins by phone using a video conference interpreter service. The family provides information about an extensive trauma history: witnessing extensive violence and the patient herself is a victim of sexual abuse. Her daughter notes her strengths of being a good mother, raising three successful children, and maintaining a business for many years. It is revealed that in the last 2 years, her two daughters moved out of the home, married, and had children.

Shared decision-making between the professional, patient, and family Follow-up visits focus on collaborating with the family and validating the patient's trauma history. Consistent calls to both the husband and daughter, as well as connecting the patient with a Vietnamese-speaking therapist, allow the patient to become more engaged. The family members become aware of the patient's triggers and begin to understand how to manage her physical outbursts. They learn how to de-escalate the patient at home, rather than bringing her to the hospital. The patient's medication list is reduced, with emphasis on issues of adherence. Trauma-focused psychotherapy addresses years of repressed memories and feelings that were triggered by her two adult daughters leaving the home.

Case formulation The psychiatrist's discussion with Mrs. Nguyen's family helped place her symptoms in a larger relational context. The family's emotional balance (family stability) had been disrupted by the numerous changes such as her inability to work, her daughters leaving the home (family transitions), as well as a longstanding trauma history that was never previously discussed or addressed. The psychiatrist acknowledged the family's strengths and caring for one another and invited the family to explore how the family's functioning and involvement might play a part in Mrs. Nguyen's symptom presentation, her level of engagement, and ultimately her symptom alleviation (family as a system).

Learning points Including the family as members of the treatment team allowed both the psychiatrist and the family to identify the family's strengths as well as barriers to treatment: Mrs. Nguyen's unaddressed trauma and language and cultural barriers. Use of language interpreters helped Mrs. Nguyen feel more comfortable communicating with her entire treatment team and allowed for ongoing psychoeducation and collaboration throughout her hospitalization.

With family inclusion, the family is simply invited into the clinical setting (Heru 2015). Families are physicians' natural allies in caring for patients with chronic illness and can also uncover aspects of the patient that were not otherwise considered. Families can help with adhering to medication and watching for side effects, keeping appointments, promoting a healthy lifestyle, and providing positive emotional support. Patients need to know when they should be doing for themselves and when they can rely on family members. Families frequently need permission and guidance to carry out these functions. Clinicians should embrace the view that families are team members.

Barriers to Collaborating with Family Members and Incorporating Families into Their Work with Patients

Clinicians encounter multiple and interacting systemic barriers to routinely including family members of the people they treat even when their clients grant consent for them to do so. Other barriers include lack of confidence or expertise in collaborating with family members. In the past several decades, psychiatrists primarily focused on medication management in order to contain costs. Family and social systems work are often relegated to non-psychiatrists such as social workers or family advocacy groups, such as NAMI, which exist separately from behavioral health agencies (Mannion et al. 2012). Additional challenges include a lack of family-friendly policies and procedures and, in some instances, family members who are negative, critical, or hostile (Heru and Drury 2005). Lastly, even if family members want to be involved, coordinating a meeting time can be challenging.

For most clinicians, learning family-centered care skills requires additional training. Similarly, training in family skills in psychiatric residency programs has been challenging due to these conflicting theoretical paradigms. Currently, there is a lack of faculty and supervisors who can teach family-focused care, or supervisors who can demonstrate family interventions on a clinical rotation, providing a positive experience in involving family members in treatment (Mannion et al. 2012). Some ways to address these challenges in training include arranging community-based clinical services and consultation opportunities for trainees, engaging family support organizations for increased collaboration, including family members as faculty in trainee education, and increasing awareness and advocacy for family-centered care in training programs.

Family Assessment

Family assessment begins with the first visit and is a continuous process. Like the medical assessment, clinicians can assess the “anatomy,” development, and functioning of a family over time. The family anatomy is understood by identifying the members of the nuclear family and who is part of the larger family system. Attending to family development means understanding the developmental stages of all family members. Family functioning is assessed by taking a history of the family, observing their interactions, and understanding the relational context of presenting symptoms. Table 1 outlines examples of

Table 1 Questions to help with family assessment

Family as a system
Who are the members of your family?
When it comes to daily support, who do you consider supportive?
Family stability
With all of the changes, how do you maintain a good family balance so everyone feels cared for?
If the illness progresses too quickly, what do you think might happen to your family?
Family transition
How have things changed now that your mother-in-law has moved in with you?
How are you, as a family, adjusting to your daughter starting high school?
Family world view (culture)
Do your parents generally feel that you are able to help each other out in crises?
How has it been when you’ve had to “fill in” for one another before?
How do family members let one another know when they need help?
Relational context of the symptom
How does a family member’s symptoms influence everyone else in the family?
Have you noticed if there are things that you, as parents, do that make your son take more or less responsibility for his medications?

questions to ask both patients and available family to assess functioning.

Case Example #3

Mr. Cadie is a single, formerly incarcerated, homeless 50-year-old man living in a halfway house. He has diagnoses of bipolar disorder and alcohol dependence. Neighbors called police because he is outside yelling at midnight. He is admitted to a medical floor with uncontrolled diabetes, alcohol dependence, and metabolic syndrome. He is transferred to a psychiatric inpatient unit where he voices angry feelings toward his mother for betraying the memory of his father who died 4 years ago. A case manager and his 75-year-old mother, Mrs. Zabir, are his only social contacts. His mother is well, works part time, and recently remarried. She sees her son periodically but expresses fear about his impulsivity and anger since he recently threw his phone at her. The outpatient psychiatrist arranges to meet with Mrs. Zabir and the case manager to develop a treatment plan.

Family Assessment with Mr. Cadie and His Mother and Stepfather, Case Manager, and Psychiatrist

The meeting is scheduled for 1 hour and begins with the stated goal of developing a treatment plan for Mr. Cadie. Each family member is asked to identify problems. Mr. Cadie says that he does not want any contact with his mother. Mrs. Zabir says that she wants her son to have good medical care. Mr. Zabir says that he wants to be able to help Mr. Cadie in any way that he can. The case manager asks about medical problems and expresses concern about treatment compliance especially with his diabetic medication.

Problem-Solving

When sober, Mr. Cadie has good and adequate problem-solving, takes his medication reliably, and stays in the halfway house where he feels comfortable.

Communication

When sober, all agree that he communicates adequately.

Roles

His mother manages all his finances and all are happy with that role. In terms of other roles such as social contact, friendships, and relationships, all agree that Mr. Cadie has become isolated and socially less competent and now frequently abuses alcohol.

Affective Responsiveness

The patient is angry with his mother and sad about the loss of his father. Mr. Cadie used to spend time with his father and misses him a great deal. His mother is afraid of him; her new husband is unsure of the situation.

Affective Involvement

The patient is more isolated since his father died and his mother is more involved with her new husband.

Behavior Control

Adequate when Mr. Cadie is sober.

Case Formulation

All agreed with the assessment and the following problem list was generated.

Mr. Cadie has significant challenges getting his healthcare needs met.

Alcohol abuse is a result of his social isolation.

Mr. Cadie needs new social contacts.

Mrs. Zabir has a new life and wants to have less involvement with her son. She is afraid of him when he has been drinking.

Mr. Zabir is unsure how much he wants to be involved with Mr. Cadie.

The psychiatrist facilitates a family discussion about problem resolution and psychoeducation. The family decides that a good intervention is to have Mr. Zabir drive Mr. Cadie to AA meetings three times a week. Mrs. Zabir will wait to hear from her son when he next wants to talk with her. She will not visit him at his home. If her son wants to talk to her, they will meet in a neutral place such as Joe's Diner. (This place was chosen by Mr. Cadie as he had fond memories there as a child with his parents.) The case manager suggests that Mr. Cadie call his brother who is out of state to talk on the phone once a week. (The case manager has in mind a possible transfer of medical power of attorney to Mr. Cadie's brother.) A follow-up meeting is arranged for 1 month.

Learning Points

The family relationships have to change after Mr. Cadie threw a phone at his mother. A family approach allows the family members to renegotiate their own relationships with the guidance of professionals. This family assessment and intervention is proactive with the goal of preventing future deterioration of the patient, encouraging sobriety, and reducing isolation and allowing, if necessary, for a transition of power of attorney to another family member.

Homeless individuals and families are a diverse population. In addition to pragmatic issues created by poverty, homeless individuals exhibit a wide spectrum of serious psychiatric conditions including addiction, psychotic symptoms, anxiety, depression, personality disorders, and trauma symptoms. Relational symptoms such as domestic violence, separation and divorce, and alienation from family can be present.

Cultural Considerations to Family Assessment

In community settings, clinicians encounter patients from established ethnocultural communities and immigrants and refugees. Language barriers and cultural complexity may prevent adequate diagnosis and treatment for a significant number of patients, so it is essential to consider the cultural meaning of symptoms and explore the social context of distress. Various models have been developed to meet this clinical challenge, such as ethnospecific mental health services, mental health translators and culture brokers, and the training of clinicians in generic approaches to cultural competence (Kirmayer et al. 2003). Additionally, immigrants may report higher rates of mental disorders and lower levels of use of mental health service (Giammusso et al. 2018). The use of professional interpreters improves clinical care and raises the quality of care for limited English proficiency patients, approaching or equaling the outcome in patients without language barriers (Karliner et al. 2007). In the case example of Mrs. Nguyen, inviting the family into the conversation both provided a larger cultural context contributing to her illness and bridged the language barrier that was impeding her comprehension of care and collaboration with her family. Although these resources may not be as available in public sector settings, it is important to rely on family to help patients feel more at ease, secure, comfortable, and willing to communicate and share with the treatment team.

Healthcare redesign can incorporate family. Don Berwick, the Former Administrator for the Centers for Medicare & Medicaid Services, described Alaska's Southcentral Foundation Nuka System of Care as the "leading example of healthcare redesign in the nation, maybe the world" (https://scfnuka.com). The NUKA healthcare system incorporates family and cultural practices, creating a welcoming environment for patients and their families. The NUKA Native

Community emphasizes developing services that are built on relationships. One program, called the Family Wellness Warriors Initiative Program, addresses domestic violence, abuse, and neglect in the Alaska Native community.

Family-centered care does exist in mental health centers. A family-oriented recovery program for children called "wraparound" provides mental health and community services individualized to each child and family (Hinden and Wilder 2008). The wraparound process builds on family strengths with families and children setting their own goals. Frequently, there is a paid family support specialist from a similar cultural background as the family, which helps engage the family. Informal community supports include extended family, friends, the faith-based community, boys' and girls' clubs, teachers, and neighbors.

Despite these efforts, many people will not attend mental health clinics citing stigma and pathologizing labels. Such was the case with Bosnian and Kosovar refugees who ultimately benefited from a community-based family resilience approach. Families readily participated because it was held in a storefront in their neighborhood and tapped into cultural values. The 9-week treatment affirmed strengths, resources, and kinship networks and recognized the families' determination to rise above tragedy and forge a new life. Facilitators from the community were trained to co-lead the groups, thus fostering collaboration and the development of local resources (Walsh 2007). A family resilience perspective focuses on strengths and coping skills rather than deficits and psychopathology.

Afro-Caribbeans are sometimes labelled "hard-to-reach" by mainstream mental health services and are under-represented in research. However, a study using a "culturally adapted family interventions in schizophrenia model" demonstrated that Afro-Caribbeans were highly motivated to engage with providers and researchers (Edge and Grey 2018). Using an evidence-based model of family intervention with four focus groups, the English Afro-Caribbean participants recommended adding topics such as racism and discrimination and different models of mental health and illness to improve cultural appropriateness. Additionally, emphasis was placed on developing a new ethos of delivery, which participants called "shared learning." This approach explicitly acknowledges the power imbalances where delivery of interventions involves White therapists and Black patients. The therapists' cultural competence was considered fundamental for successful engagement.

While it is unfair to draw generalizations across cultures because this does not consider the within-group variation, some studies do suggest norms in specific cultural/ethnic settings. Historically, having high levels of expressed emotion (EE) within the family environment has generally been associated with poorer patient outcomes. However, high EE (high criticalness) in African-American families with a patient with schizophrenia was associated with better patient outcomes (Gurak and Weisman de Mamani 2017). On qualitative analysis, patients perceived high-EE family comments as "direct and expressive," supportive, and an expression of concern, whereas low-EE family comments were perceived as passive and uncertain.

Family Psychoeducation

Psychoeducation explores the meaning of the illness for each family member and helps develop a repertoire of coping skills. Psychoeducation can be delivered to individuals or to families either in single family sessions or in multifamily groups (MFPG) and is considered an evidence-based practice (McFarlane 2016). The skills needed to run a psychoeducational program can be taught in about 6 hours. This is done with didactic teaching about basic group principles and by becoming an observer/participant in a psychoeducational program. Training includes being able to handle family emotional reactions, such as feelings of anger, sadness, or frustration. Helping a family with these feelings facilitates the adjustment of the family to the presence of illness. McFarlane's online training workbook can be accessed here:

https://training.mccmh.net/Portals/0/training/MFG,FamPsychoEd_Workbook.pdf.

Family psychoeducation as a treatment for schizophrenia was developed over 40 years ago, and over 100 studies show the reduction in patient relapse rates by 50–60%, compared to treatment as usual (McFarlane 2016). Explicitly disavowing the assumptions that family pathology caused relapse and deterioration, family psychoeducation engages family members as partners in care, teaches them about the illness, and supports their struggles as a family. New iterations of MFPG are being applied to first episode and prodromal psychosis, internationally and nationally (McFarlane 2016). A qualitative study of an ethnoculturally specific MFPG allowed Chinese and Tamil participants to share experiences and support each other in their own language during and after sessions (Chow et al. 2010). The study found decreased hostility and conflict and better understanding among family members and patients. Communication skills training improved the family members' ability to handle disagreements. Increased knowledge about mental illness impacted positively on participants' beliefs about health maintenance, medication, and side effects. Family members learned to observe for signs and symptoms of relapse and seek help. Both patients and family members developed great trust toward staff, facilitating treatment.

In Mexican American families with a patient with schizophrenia ($n = 174$), Kopelowicz and colleagues successfully adapted MFPG, with the goal of supporting medication adherence (Kopelowicz et al. 2015). Before the intervention, a systematic assessment of each family enabled the clinical researchers to capture the cultural elements considered important for the adaptation. Family warmth and moderate family emotional over-involvement emerged as good prognostic factors.

Most MFPG research has focused on schizophrenia, but MFPG is also used for other psychiatric and medical illnesses. A group-based program that includes MFPG showed feasibility for patients with non-epileptic seizures and their families (Libbon et al. 2019). A program for Native Americans with substance use includes multifamily psychoeducational groups in which adolescents and their families learn together and celebrate the healing process in a Weekly Circle (Novins et al. 2012). A Weekly Circle (multifamily group) promotes sobriety and builds a community of healing. The Department of Veterans Affairs healthcare system's leadership has endorsed family involvement in veterans' mental healthcare as an important component of treatment. Evidence suggests that family interventions for PTSD improve veteran and family outcomes (Sherman et al. 2012).

Despite the consistent evidence demonstrating the effectiveness of family psychoeducation, it has been the least implemented of all of the evidence-based practices. According to the 2009 Community Mental Health Services Uniform Reporting System Output Tables, only 1.1% of providers nationally offer family psychoeducation, with only 19 states reporting any provision of this service (Mannion et al. 2012).

In contrast, NAMI's Family-to-Family (FTF) program has been widely implemented as an educational tool for family, significant others, and friends of people with mental health conditions. NAMI's FTF is a peer-led, self-help program. It includes a structured, 12-week curriculum, with participants attending weekly, for 2- or 3-hour sessions. The focus is on giving and receiving emotional support and to develop insight into their feelings about mental illness. This approach helps relatives who have unmet needs associated with their loved one's mental health concerns and care. Because of its time-limited approach and its inclusiveness of all family members, the program has had wider accessibility and utilization compared to family psychoeducation. A randomized controlled trial of FTF ($n = 138$) was conducted to assess the effectiveness of the program across a demographically diverse state in the USA. Compared to the 3-month wait-list control group, participants in FTF experienced improved coping, problem-solving, empowerment, and reduced anxiety and depression (Schiffman et al. 2015).

Other Family Considerations

In the next section, several non-traditional family roles are discussed.

Parenting as a Patient with Serious Mental Illness

Most parents who have mental illness do a great job of parenting their children; however, societal attitudes are stacked against mothers with mental illness. To support parents with mental illness, we can provide practical and emotional support, provide parenting classes, and discuss issues such as what to do if you become ill, who you trust to care for your child, and the implications of mental illness on questions of custody. The development of a care plan can be key in this regard. The care plan contains information for the care of a baby/child if the patient is unable to care for him/her due to illness or hospitalization. It can contain as much information as the parent wants, but usually contains the names of surrogate caregivers, medication information, vaccinations, feeding, and regular activities (http://www.copmi.net.au/parents/helping-my-child-and-family/care-plans).

The role of others in child-rearing must be considered, particularly for those women who are involved in multiple partner fertility unions. In these situations, the concept of "othermothering" is distinct from step-mothering and involves sharing parenting responsibilities with the children's biological parents. This can involve co-parenting children who are their romantic partners' children from previous or current relationships (Burton and Hardaway 2012). A study of 256 low-income mostly unmarried mothers (Latino, African American, and White) found that 78% of the mothers had been, or were involved, in multiple partner fertility relationships (Burton and Hardaway 2012). This study was carried out over a period of 6 years in economically disadvantaged neighborhoods in Boston, Chicago, and San Antonio to monitor the consequences of welfare reform for the well-being of families and children. "Othermothers" can be invited into the care of young adult patients who present in the clinic. The case that follows expands on the role of "othermothers."

Case Example #4

Ms. Talia is a 37-year-old, Hispanic woman with morbid obesity, obstructive sleep apnea, and asthma. She presents with anxiety and panic attacks. She has a past history of substance abuse and has been in prison for drug-related crimes. She is receiving disability. Her family constellation consists of four teenage sons in her mother's custody. Her sons live between her house and her mother's house. A young girl baby, who is the child of her niece, is living with the patient. The niece, who is actively using substances, sometimes stays with the patient and sometimes disappears for weeks. A boyfriend also sometimes stays with her. Ms. Talia wants custody of the baby girl and presents in the clinic asking for help with her psychiatric symptoms so that she can be well enough to go to court to get custody.

Family Assessment with Ms. Talia and Her Mother

The psychiatrist met with the patient and the mother and completed the family assessment over several routine visits. Medication management occurred in the treatment sessions.

Problem-Solving

Ms. Talia relies on her mother to help with all problems. She states that she would like to be more independent but does not know how. The mother supports her goal.

Communication

The mother and the daughter do everything together. Ms. Talia shares all her thoughts and feelings with her mother. The mother does not share her thoughts with the patient and says that she "just wants to help." The mother is not critical and says, "It is my duty as a mother to help."

Roles

The mother and the daughter spend most of their time caring for children, theirs and children of the extended family. The mother, although on a fixed income, provides as much financial support as possible for her daughter. Her daughter is also on a fixed income but gives away food and money to other family members and her boyfriend.

Affective Responsiveness

The patient is anxious most of the time. She experiences pleasure with her baby girl in the house, dressing her and changing her outfits many times a day. The mother thinks she is obsessed with the baby and she treats the baby like a doll. The patient cries and feels overwhelmed a lot and feels guilty because she depends on her mother for money and emotional support. The mother experiences a normal and full range of emotions.

Affective Involvement

There is over-involvement between the patient and her mother, with guilt on the part of the patient for depending on her mother. The mother accompanies her to all appointments, grocery shopping, etc. The mother acknowledges her over-involvement but says, "It is my duty to help."

Behavioral Control

There are no house rules. It is unclear from appointment to appointment who is living in Ms. Talia's house. She is thinking about setting rules about substance abuse and throwing her niece out of her house but is not able to because "there is nowhere for her to go."

Case Formulation

Ms. Talia has generalized anxiety disorder, panic disorder, personality disorder with dependent and histrionic traits, and a significant past history of substance abuse. Her family assessment reveals an over-involved relationship with her mother and a chaotic living situation. Family strengths are caring of others and their self-identification as strong good mothers. Ms. Talia and her mother agree with the formulation. The mother and the patient agree that Ms. Talia needs to set limits with the niece and her boyfriend and tell them they cannot stay there if they are "high" or "crashing." She agrees to tell family members that she can no longer give them money, when she herself does not have enough for groceries. She says that although she agrees and knows she needs to do this, she "feels bad for other people." The mother, supported by the psychiatrist, takes the stance that while this is an admirable and valued family trait, she will not get better and thus will not be able to get custody of the baby girl unless she sets limits and controls her home environment. Ms. Talia asks for medications to help her. The psychiatrist agrees that medications are part of the plan but that the patient needs to do her part and set up house rules. The mother and the patient agree.

At each meeting, the plan is reviewed. Eventually, Ms. Talia puts out the freeloaders and sets family rules for those who remain in her house. Ms. Talia reports that her level of anxiety and panic has not changed but she is feeling better now that she has some control over her life. Monthly visits with the patient and her mother set goals such as the patient taking her citalopram 20 mg and keeping her medical appointments. She sets general health goals such as healthier eating and more exercise.

Learning Points

There are many potential interventions for Ms. Talia. The family assessment approach pinpointed family strengths that can be used in treatment: her relationship with her mother, strong mothering qualities, and her desire to care for the girl baby. The patient's relationships have unsettling elements, e.g., dressing up the baby girl and over-involvement with her mother. Medication administration is incorporated into a larger contract with the patient and her mother. Without a family assessment, the strengths and weaknesses of the family system would not have been evident. The recommendations are framed in a family context with an emphasis on family strengths.

Children as Caregivers to Parents with Serious Mental Illness

Children are "invisible" to mental health professionals who provide care to adults, yet they are present in the home and participate in the care of their parents. It is estimated that 13% to 51% of adults attending psychiatric outpatient clinics have children (Maybery and Reupert 2018). In the development of one program, young adults who have lived experience of parents with mental illness and/or substance use problems were consulted to help with interventions (Reupert et al. 2019). The resulting intervention called mi.spot is an online intervention for groups of up to 20 young adults (aged 18–25), who have a parent with a mental illness and/or substance use problem. Mi.spot offers six, 1-hour, professionally facilitated psychoeducational modules using a private, online diary (called mi.thoughts.spot) for participants. There are opportunities for participants to chat informally with each other on threads initiated by a participant or facilitator. A lot of child care programs have been developed in the UK and Australia and could be implemented in the USA. In a book called *Building Children's Resilience in the Face of Parental Mental Illness* (Cooklin and Gorell Barnes 2020), Cooklin includes advice that young caregivers want to give to psychiatrists:

1. *Introduce yourself. Tell us who you are and what your job is.*
2. *Give us as much information as you can.*
3. *Tell us what is wrong with our parents.*
4. *Tell us what is going to happen next.*
5. *Talk to us and listen to us. Remember, it is not hard to speak to us; we are not aliens.*
6. *Ask us what we know and what we think. We live with our parents; we know how they have been behaving.*
7. *Tell us it is not our fault. We can feel really guilty if our mum or dad is ill. We need to know we are not to blame.*
8. *Please don't ignore us. Remember we are part of the family and we live there too.*
9. *Keep on talking to us and keep us informed. We need to know what is happening.*
10. *Tell us if there is anyone we can talk to. MAYBE IT COULD BE YOU.*

Lesbian, Gay, Bisexual, Transgender, Queer (LGBTQ) Families

Over the past few decades, lesbian, gay, bisexual, transgender, queer, questioning, and other sexual and gender minorities (LGBTQ) have become visible. LGBTQ youth may experience strained relationships with families due to the stigma related to their sexual orientation and/or gender identity (Newcomb et al. 2019). Family rejection is strongly associated with mental health problems, substance use, increased sexual risk, and higher prevalence of homeless youth (Bouris et al. 2010; Institute for Gender Health and Sexual Minority 2017; Simons et al. 2013). Additionally, LGBTQ youth are disproportionally represented in the foster care population and often face discrimination within the system (Fish et al. 2019).

For LGBTQ youth, having a strong, stable, supportive relationship with an adult, such as a parent, is one of the strongest predictors of long-term adjustment in the general adolescent population (Roe 2017). A study looking at the role of protective factors in suicidality of LGBTQ youth ($n = 2255$) found that family connectedness accounted for more variance than sexual orientation or the other protective factors. Despite the limited research and lack of randomized control trials on family-based interventions for LGBTQ youth, these findings suggest that improving relationships between LGBTQ youth and their parents is vital (Eisenberg and Resnick 2006). A study examining strategies for building stronger relationships between LGBTQ youth and their foster caregivers found that acceptance, support, and ensuring safety were important elements to include in programming aiming to improve placement stability and well-being (Salazar et al. 2018). The approach to LGBTQ families should start with rapport building to establish a sense of safety, support, and trust before exploring various factors that may contribute to feelings of rejection, isolation, and stigma. Assessment of families should include understanding these influences to better address the mental health needs of LGBTQ individuals.

Case Example # 5

Ms. Sharon presents with anxiety symptoms and requests benzodiazepines. She is new to the clinic and states that she has been treated in the past for PTSD and has had several hospitalizations. She lives with Ms. Anna whom she describes as her caregiver. You ask her to bring Ms. Anna to the next appointment. At the next few appointments, you find out that Ms. Anna has significant depressive symptoms and is Ms. Sharon’s significant other but is afraid to acknowledge this out of fear of judgement, stigma, and rejection. Ms. Anna was disowned by her religious and conservative family. Both women express suicidal thoughts and want to support each other better.

Family Assessment with Ms. Sharon, Ms. Anna, the Psychiatrist, and the Social Worker

A 1-hour family assessment meeting is scheduled.

Problem-Solving

They each identify problems but do not communicate them to each other, nor do they try to solve them together.

Communication

There is poor communication due to fears of judgment and rejection and guilt of burdening each other.

Roles

They each contribute to the household income for rent and food. They are in an intimate and caring relationship that they both find satisfying. However, both are alienated from their families and only have each other to rely on.

Affective Responsiveness

They have warm caring feelings for each other but do not communicate these feelings. They each have intermittent suicidal ideation.

Affective Involvement

They spend most of their time together and have few friends. They both feel lonely and isolated.

Behavioral Control

They engage in secretive suicidal and self-injurious behaviors from time to time. They would like to change this.

Case Formulation

Both Ms. Anna and Ms. Sharon agree they want to work on improving their relationship. The psychiatrist is most concerned about their suicidal ideation and self-injurious behavior and works on developing a mutual safety plan. In the following appointments, the treatment team works on establishing rapport and fostering a supportive, accepting environment where they feel comfortable sharing with the clinicians and with each other. They work on spending quality time together, accepting that their relationship is strong, and feeling more comfortable with their sexual identities. They work on improving their communication, problem-solving, and sharing more positive feelings.

Learning Point

Although this couple cannot change the circumstances of their lives, they can reduce acting out behavior and improve the quality of their relationship.

Conclusion

A narrow approach to the treatment of psychiatric illness often does not yield optimal results. Although it may seem that one part of the family can exist in isolation from the rest of the family, the case examples demonstrate that family functioning cannot be fully understood by understanding each individual alone. Although there may be an assumption that involving families may increase conflict, the clinician can discuss strengths of the individual and the family and identify areas of agreement.

Starting with a family meeting is key to understanding the patient in their family context. When the patient says that the family cannot come to an appointment, clinicians can gently insist on meeting the family. “Thinking Family” is the first step. When families are difficult to understand or when the assessment process gets bogged down or when the psychiatrist feels unsure of what to do, then seeking supervision or a referral to an experienced family therapist is appropriate. Most families appreciate being involved and will work hard to help you help their family member (Heru 2015). “Thinking Family” means listening to family members when they call with a question, even if the patient has not signed a release. Confidentiality means stating that you cannot discuss patient specifics but that you can listen and provide general information on how to handle emergency situations.

Psychiatry in public sector settings can promote a clinic that is family-friendly, supporting connection and involvement, and include multi-family psychoeducational groups (Heru 2015). Educational literature can be offered in several languages. Resources may include a list of books written for families such as Michelle Sherman’s *I’m Not Alone: A Teen’s Guide to Living with a Parent Who Has a Mental Illness* (Sherman and Sherman 2006). The World Fellowship for Schizophrenia and Allied Disorders website (http://www.world-schizophrenia.org/resources/booklist.html) has a list of recommended books for patients and their families. Families can be given access to additional services such as transportation, parenting classes, learning English as a second language, etc. Psychiatry must recognize the important contribution that family members bring, allowing clinicians to understand the presenting symptoms and the orientation of the family and provide any needed family interventions.

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