Whatever Happened to Couples and Family Therapy in Psychiatry?

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To quote Dr. Seuss, "Oh, the places we've been!" Couples and family therapies were propelled onto the mental health scene, especially during their enthusiastic entrance during the 1970s, with the encouragement and support of the psychiatric establishment. At the time, the field represented a powerful and intriguing critique of the dominant orthodoxies in contemporary psychiatry, an expression of countercultural values, and a new paradigm for thinking about people and their problems. During this significant period of social change in America and abroad, many psychiatrists, psychologists, social workers, and other mental health professionals embraced family therapy with the hope that changing dysfunctional family dynamics would reduce psychiatric distress faster than the current modality at that time—individual psychotherapy. The field was largely championed by a few charismatic psychiatrists who also introduced innovative didactic and training methods, such as video and live supervision, both of which have been gradually absorbed into general psychiatric training (1). Unfortunately, some of the field's practitioners also took the view that psychiatric disorders were primarily rooted in dysfunctional interpersonal processes, thereby diminishing the significant role that genetics, biology, and individual differences played in the development and maintenance of psychopathology.

Subsequently, psychiatry's leadership in couples and family treatment began to wane for three additional reasons. First, psychiatry's embrace of psychopharmacology and neuroscience reduced its strong position in the psychotherapies. Second, influential initiatives in many areas of psychotherapy and mental health practice, which had been traditionally spearheaded by psychiatrists, changed over time as members of other professional disciplines gained influence and equity. Finally, as the field increased its response to the call for evidence-based practice, much of the development of new, empirically validated treatments and outcome research was led by psychologists rather than psychiatrists.

We make the case here for psychiatrists to once again systematically think about and consider some form of couples or family intervention in their clinical practice. Trainees and experienced psychiatrists alike are increasingly confronted with complex clinical problems that can be understood from a range of perspectives. Because family systems thinking provides a powerful framework for looking at multiple levels of systems and their interrelationships, greater emphasis on developing a strong systemic perspective should be considered as a core competency in general psychiatry, as well as child and adolescent psychiatry, training (2). The objective, in the end, is to improve both the experience of the treatment process and treatment outcomes for patients as well as for their family members and significant others.

Changes in Psychiatry and Psychiatric Training

Looking at the field of psychiatry and mental health in 2019, we see few psychiatric residency programs that continue to value and formally teach couples and family therapy, and most residents and fellows receive only minimal exposure to working with larger systems. However, not every patient needs couples and family treatment. There is a clear distinction between offering couples or family therapy and including families as part of family assessment, consultation, or psychoeducation. This latter consultative stance can be described as "thinking family," and it most easily is carried out by "sitting with families."

Along with this trend, the challenges in training psychiatrists have increased as residency programs contend with how to adequately teach psychopharmacology, psychotherapy, and neuroscience to residents in the limited time available. In many residency training programs, the psychotherapies have been deemphasized, and leadership in the teaching of psychotherapies has been taken up by, or yielded to, colleagues in psychology and social work. Furthermore, competency in couples and family therapy currently is not training mandated by the Accreditation Council for Graduate Medical Education (ACGME).

So, what happened to couples and family therapy in psychiatry, and what is to become of couples and family therapy in psychiatric training? Training in couples and family therapy is still the exception rather than the rule in general psychiatry residency and child and adolescent psychiatry fellowship training programs, although these therapies have been found to be effective in treating patients with a broad range of presenting problems, including most axis I psychiatric disorders (2). That this is the case is puzzling for the following reasons.

Family Factors and Psychiatric Illness

First, there is strong evidence that family factors are implicated in the initiation and maintenance of psychiatric illness. For example, research on expressed emotion (which describes families with high levels of criticism, hostility, and overinvolvement) has found that high expressed emotion is a robust predictor of relapse in many psychiatric illnesses, such as schizophrenia, depressive disorders, bipolar disorder, and substance abuse. Caregiver research has identified the high emotional and practical burdens of caring for relatives with psychiatric illnesses. Because family psychoeducation also has been shown to be central to medication adherence, family interventions are the ideal complementary therapy to psychopharmacology. American Psychiatric Association practice guidelines already recommend early couple and family involvement as well as family-based interventions for axis I disorders, including, but not limited to, schizophrenia, bipolar disorder, major depression, panic disorder, and eating disorders (3, 4).

Second, the trend toward family-centered, collaborative models of health care for patients with general medical illness provides further impetus for family training in psychiatry. Heru (5) suggested that "improving the family environment has important health implications equivalent to the reduction of risk factors for chronic illness." As consultants in medical settings, psychiatrists serve an important function in recognizing that chronic illness, disability, terminal illness, and loss represent changes that invariably affect every family member (6).

Third, briefer hospital stays, greater reliance on outpatient care, and the shift toward health care practices that attend to the biomedical and psychosocial challenges of major mental health conditions by necessity should involve family members. Patient-centered and family-centered care together represent a humane, biopsychosocial approach to the planning, delivery, and evaluation of health care that brings together patients, families, and health care practitioners, which can enhance patient and family health outcomes, patient and staff satisfaction, and cost-effectiveness (2).

We now accept that genetic and etiologic factors may result in enduring brain effects, including dysfunctions in brain circuitry. In addition to using systems biology as a model for understanding disorders of the brain, we might also add the same type of systems thinking—in this case, viewing the patient's problem through a family systems lens—to our case formulation. It is not uncommon for a psychiatrist to see a patient with several concurrent psychiatric diagnoses, each of which can lead to pain and distress in close loved ones. Given that psychiatrists frequently encounter distraught families of patients struggling with such trying psychiatric difficulties, exploring how family systems thinking and interventions can be routinely integrated into psychiatric practice is worthwhile.

Integrating Family Systems Interventions Into Psychiatric Practice

First and foremost, simply including the family in the assessment process and in the prescription of medications improves patient adherence in primary care treatment of most serious mental illnesses and can result in better outcomes than would occur without family involvement (4). Second, thoughtfully screening families can better reveal their needs. Psychiatric clinicians can always benefit from recognizing the important role that families play in the lives of their patients. The family is an accessible unit of the biopsychosocial system, and if psychiatrists are to thoroughly and compassionately understand each patient's current and future needs, they will likely find value in hearing family members' stories—what they have been through, their disappointments and fears, and their hopes and wishes for their distressed family member.

If there is a troubled family member, others in the family are likely to be affected and concerned, so including them in the process of treating a family member will most often be helpful, if only to learn more, provide feedback on the patient's progress, and assist them in navigating an increasingly complicated health care system. Families typically want to help, and they often only need to be encouraged and invited to participate in the process. As a central treatment feature, the psychiatrist should be engaging, respectful, and collaborative with the family.

Some couples and families may need brief support, some may benefit from family psychoeducation, and others may require couples or family therapy. In order to refer patients for any type of couples or family intervention, the psychiatrist will be best served by developing a basic knowledge of family systems dynamics. This understanding usually comes through experiential work with couples and families, and, in training, this work has included structural, emotionally focused, cognitive-behavioral, and other family systems treatment approaches.

Training in couples and family therapy requires a commitment to understanding the critical role that interpersonal processes play in the maintenance and the amelioration of psychiatric distress. When given the chance, residents and fellows express a high degree of satisfaction with training in systems thinking as well as in couples and family therapy (7, 8). One residency curriculum also fulfilled ACGME requirements for systems-based practice by teaching the basic concepts of family systems theory to understand the complex patient, provider, and institutional systems that are commonly encountered by resident psychiatrists (9).

Residency programs need to change their curricula to include family therapy courses, clinical experience, and supervision over the 4 years of psychiatric training. In addition, there are other entry points for systems thinking. Cultural psychiatry and community psychiatry are two such options, as is the synergy between family work and individual therapy in

psychotherapy courses. However, introducing family training into residency and fellowship programs, while challenging, is just a first step. Ultimately, keeping the biopsychosocial model's promise in clear view and finding new, engaging ways to develop patient-centered as well as family-centered care for patients with both psychiatric and medical conditions is our biggest challenge and opportunity.

In summary, given the episodic nature and chronicity of illnesses that patients experience over a lifetime, psychiatrists need to know when and how to offer a broad array of somatic and psychotherapeutic interventions to patients and their families. Psychiatrists are not expected to be proficient in the practice of all therapeutic modalities, but sufficient exposure to and a basic working knowledge of couples and family interventions inevitably will improve both treatment recommendations and clinical care. Most important, we believe that for virtually every psychiatric disorder, both "thinking family" and including families in both the assessment and the treatment of the patient should be considered in every case (10). We actively involve families in our clinical practice and, over the long run, have received appreciation from both patients and their families as we have worked together to achieve health and well-being, improve treatment efficacy, decrease family burden, and revitalize hope.

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