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Recommended Curriculum Guidelines for Family Medicine Residents

Human Behavior and Mental Health

This document was endorsed by the American Academy of Family Physicians (AAFP), the American Psychiatric Association (APA), the American Psychological Association (APA), the Association of Departments of Family Medicine (ADFM), the Association of Family Medicine Residency Directors (AFMRD), and the Society of Teachers of Family Medicine (STFM).

Introduction

This Curriculum Guideline defines a recommended training strategy for family medicine residents. Topic competencies, attitudes, knowledge, and skills that are critical to family medicine should be attained through longitudinal experience that promotes educational competencies defined by the Accreditation Council for Graduate Medical Education (ACGME) http://www.acgme.org. The curriculum must include structured experience in several specified areas. Most of the resident's knowledge will be gained by caring for ambulatory patients who visit the family medicine center. Structured didactic lectures, conferences, journal clubs, and workshops must be included in the curriculum with an emphasis on outcomes-oriented, evidence-based studies that delineate common and chronic diseases affecting patients of all ages. Targeted techniques of health promotion and disease prevention are hallmarks of family medicine. Appropriate referral patterns and provision of cost-effective care should also be part of the curriculum.

Program requirements specific to family medicine residencies may be found on the ACGME Web site. Current AAFP Curriculum Guidelines may be found online at http://www.aafp.org/cg. These guidelines are periodically updated and endorsed by the AAFP and, in many instances, other specialty societies as indicated on each guideline.

Each residency program is responsible for its own curriculum. ***This guideline provides a useful strategy to help residency programs form their curricula for educating family physicians.***

Preamble

Family physicians incorporate knowledge of human behavior, mental health and mental disorders into their everyday practice of medicine. This guideline provides suggestions for appropriate curricula in human behavior and mental health for family medicine residents.

It is suggested that the relationship between the patient and the patient's family be considered basic to an understanding of human behavior and mental health throughout the curriculum. The family medicine resident should have sensitivity to, and knowledge of, the emotional aspects of organic illness.

Family physicians must be able to recognize interrelationships among biologic, psychologic, and social factors in all patients. It is important that the ethical dimensions of patient care be considered among these interrelationships. To facilitate learning, attention must be paid to these principles as a continuum throughout the family medicine residency program.

Competencies

At the completion of residency training, a family medicine resident should:

- Understand normal and abnormal psychosocial growth and development across the life cycle and be able to apply this knowledge to the care of the individual patient. (Medical Knowledge, Patient Care)
- Be able to recognize, initiate treatment for, and utilize appropriate referrals for mental health disorders to optimize patient care. (Systems-based Practice, Practice-based Learning and Improvement)
- Demonstrate the ability to effectively interview and evaluate patients for mental health disorders using appropriate techniques and skills to enhance the doctor-patient relationship. (Interpersonal and Communication Skills, Patient Care)
- Have sensitivity to and knowledge of the emotional aspects of organic illness. (Patient Care, Professionalism)
- Be able to intervene effectively and professionally in emergent psychiatric, domestic violence, child abuse, and disaster situations. (Professionalism, Systems-based Practice)
- Understand the impact of mental health disorders on the family unit.

Attitudes

The resident should demonstrate attitudes that encompass:

- Awareness of and willingness to overcome the physician's own attitudes and stereotypes of mental illness and social diversity, as well as a recognition of how attitudes and stereotypes affect patient care.
- Recognition of the complex bidirectional interaction between family and social factors and individual health.
- Acceptance of patient's right to self-determination.
- Respect and compassion for the psychosocial dynamics that influence human behavior and the doctor/patient relationship.
- Recognition of the prevalence of abuse in society and willingness to help patients escape abusive situations.
- Understanding of the importance of a multidisciplinary approach to the enhancement of individualized care.
- Commitment to lifelong learning about the interaction of the biological, social, psychological, and psychiatric interaction of the human life cycle.

Knowledge

In the appropriate setting, the resident should demonstrate the ability to apply knowledge of:

1. Basic behavioral knowledge
    a. Normal, abnormal, and variant psychosocial growth and development across the life cycle
    b. Recognition of interrelationships among biologic, psychologic, and social factors in all patients
    c. Reciprocal effects of acute and chronic illnesses on patients and their families
    d. Factors that influence adherence to a treatment plan
    e. Family functions and common interactional patterns in coping with stress
    f. Awareness of one's own attitudes and values, which influence effectiveness and satisfaction as a physician
    g. Stressors on physicians and approaches to effective coping
    h. Ethical issues in medical practice, including informed consent, patient autonomy, confidentiality, and quality of life

2. Mental health disorders
    a. Disorders principally diagnosed in infancy, childhood, or adolescence
        i. Mental retardation
        ii. Learning disorders
        iii. Motor skills disorders
        iv. Communication disorders
        v. Pervasive developmental disorders
        vi. Attention deficit and disruptive behavior disorders, i.e., Oppositional Defiant Disorder, Conduct Disorder
        vii. Feeding and eating disorders of infancy or early childhood
        viii. Tic disorders
        ix. Elimination disorders
    b. Delirium, dementia, amnestic and other cognitive disorders
    c. Substance-related disorders
        i. Alcohol
        ii. Amphetamines
        iii. Caffeine
        iv. Cannabis
        v. Cocaine
        vi. Hallucinogens
        vii. Inhalants
        viii. Nicotine
        ix. Opioids
        x. Phencyclidine
        xi. Sedative-, hypnotic- or anxiolytic-related disorders
        xii. Polysubstance-related disorder
    d. Psychotic disorders
        i. Schizophrenia
        ii. Paranoid
        iii. Disorganized
        iv. Catatonic
    e. Mood disorders
        i. Major depressive disorder
        ii. Dysthymic disorder
        iii. Bipolar disorders, including hypomanic, manic, mixed and depressed
    f. Anxiety disorders
        i. Panic attack
        ii. Phobias
        iii. Obsessive-compulsive disorder
        iv. Post-traumatic stress disorder
        v. Acute stress disorder
        vi. Generalized anxiety disorder

g. Somatoform disorders
    i. Somatization disorder
    ii. Conversion disorder
    iii. Pain disorder
    iv. Hypochondriasis

h. Factitious disorders

i. Dissociative disorders

j. Sexual and gender identity disorders
    i. Sexual desire disorder
    ii. Sexual aversion disorder
    iii. Orgasmic disorders
    iv. Sexual pain disorders
    v. Sexual dysfunction related to a general medical condition
    vi. Gender identity disorder

k. Eating disorders
    i. Anorexia nervosa
    ii. Bulimia nervosa

l. Sleep disorders
    i. Insomnia
    ii. Hypersomnia
    iii. Narcolepsy
    iv. Breathing-related sleep disorder
    v. Circadian-rhythm sleep disorders
    vi. Parasomnias

m. Impulse control disorders
    i. Pathological Gambling
    ii. Trichotillomania

n. Adjustment disorders
    i. Depressed mood
    ii. Anxiety
    iii. Mixed anxiety and depressed mood
    iv. Disturbance of conduct

o. Personality disorders
    i. Paranoid
    ii. Schizoid
    iii. Schizotypal
    iv. Antisocial
    v. Borderline
    vi. Histrionic
    vii. Narcissistic
    viii. Avoidant
    ix. Dependent
    x. Obsessive-compulsive

p. Problems related to abuse or neglect

q. Additional conditions
   i. Nonadherence / noncompliance
   ii. Malingering
   iii. Borderline intellectual functioning
   iv. Age-related cognitive decline
   v. Bereavement
   vi. Marital discord
   vii. Academic problem
   viii. Occupational problem
   ix. Identity problem
   x. Religious or spiritual problem
   xi. Acculturation problem
   xii. Phase-of-life problem

Skills

In the appropriate setting, the resident should demonstrate the ability to independently perform or appropriately refer:

1. Use of evaluation tools and interviewing skills, which enhance data collection in short periods of time and optimize the doctor/patient relationship.

2. Techniques to elicit the context of the visit [BATHE (background, affect, trouble, handling and empathy) or other techniques].

3. Mental status examination

4. Evaluation of indications for special procedures in psychiatric disorder diagnosis, including psychologic testing, laboratory testing and brain imaging

5. Elicit and recognize the common signs and symptoms of the disorders under Knowledge
   a. Teach patients methods for evaluating and selecting reliable websites for medical information

6. Assessment of depression [PHQ-9, Beck, Zung, Hamilton Scales, SIG-E-CAPS mnemonic (sleep, interest, guilt, energy, concentration, appetite, psychomotor and suicidal ideation)]

7. Evaluation of indications for psychiatric consultation

8. Management of emotional aspects of nonpsychiatric disorders

9. Techniques for enhancing compliance with medical treatment regimens

10. Initial management of psychiatric emergencies: the suicidal patient, the acutely psychotic patient

11. Proper use of psychopharmacologic agents
    a. Diagnostic indications and contraindications
    b. Dosage, length of use, monitoring of response, side effects and compliance
    c. Drug interactions
    d. Associated medical problems

12. Family support therapy

13. Behavioral modification techniques
    a. Stress management
        i. Breathing
        ii. Muscle relaxation
        iii. Imagery
        iv. Cognitive restructuring
    b. Smoking cessation, obesity management and other lifestyle changes
    c. Chronic pain management

14. Utilization of community resources
    a. Community resources
    b. Patient care team of other mental health professionals

15. Crisis-counseling skills

16. Modification of patient environment

17. Variations in treatment based on the patient's personality, lifestyle and family setting

18. Identification of, intervention in and therapy for drug and alcohol dependency and abuse

19. Appropriate care of health disorders listed under psychopathology

20. Appropriate referral procedures to ensure continuity of care, provide optimal information sharing and enhance patient compliance
    a. Indications
    b. Process
    c. Follow-up

Implementation

Training in human behavior and mental health should be accomplished primarily in the outpatient setting through a combination of longitudinal experiences, supervised experiences and didactic teaching. This combination should include experience in diagnostic assessment, psychotherapeutic techniques, and psychopharmacologic management. Learning tools such as Balint Groups, video review, direct observation, and role-playing are useful and recommended. Collaboration with multiple mental health professionals, including psychiatrists, psychologists, and other mental health professionals working as a team, is often useful.

Resources

Disorders Principally Diagnosed in Infancy, Childhood, or Adolescence

Daughton JM, Kratochvil CJ. Review of ADHD pharmacotherapies: advantages, disadvantages, and clinical pearls. *J Am Acad Child Adolesc Psychiatry.* 2009;48(3):240-248.

Hamilton SS, Armando J. Oppositional defiant disorder. *Am Fam Physician.* 2008;78(7):861-866.

Safren SA, Knouse LE. Current status of cognitive behavioral therapy for adult attention-deficit hyperactivity disorder. *Psychiatr Clin North Am.* 2010;33(3):497-509.

Searight HR, Rottnek F, Abby S. Conduct disorder: diagnosis and treatment in primary care. *Am Fam Physician.* 2001;63(8):1579-1589.

Smucker W, Hedayat M. Evaluation and treatment of ADHD. *Am Fam Physician.* 2001;64(5):817-830.

Substance Use

Bayard M, McIntyre J, Hill KR, et al. Alcohol withdrawal syndrome. *Am Fam Physician.* 2004;69(6):1443-1450.

Delirium and Dementia

Adelman AM, Daly MP. Initial evaluation of the patient with suspected dementia. *Am Fam Physician.* 2005;71(9):1745-1750.

Gleason OC. Delirium. *Am Fam Physician* 2003;67(5):1027-1034.

Mood Disorders

Ebell MH. Point-of-care guides: screening instruments for depression. *Am Fam Physician.* 2008;78(2):244-246.

Sharp LK, Lipsky MS. Screening for depression across the lifespan: a review of measures for use in primary care settings. *Am Fam Physician.* 2002;66(6):1001-1009.

Spitzer RL, Kroenke K, Williams JB, PHQ Primary Care Study Group. Validation and utility of a self-report version of PRIME-MD: the PHQ primary care study. *J of Am Med Association.* 1999;282(18):1737-1744.

Anxiety Disorders

Fenske JN, Schwenk TL. Obsessive-compulsive disorder: diagnosis and management. *Am Fam Physician.* 2009;80(3):239-245.

Ham P, Waters DB, Oliver MN. Treatment of panic disorder. *Am Fam Physician.* 2005;71(4):733-739.

Lange JT, Lange CL, Cabaltica RBG. Primary care treatment of post-traumatic stress disorder. *Am Fam Physician.* 2000;62(5):1035-1040.

Schizophrenia

Schultz SH, North SW, Shields CG. Schizophrenia: a review. *Am Fam Physician.* 2007;75(12):1821-1829.

Somatoform Disorders

Oyama O, Paltoo C, Greengold J. Somatoform disorders. *Am Fam Physician.* 2007;76(9); 1333-1338.

Eating Disorders

Williams PM, Goodie J, Motsinger CD. Treating eating disorders in primary care. *Am Fam Physician.* 2008; 77(2):187-195.

Personality Disorders

Ward RK. Assessment and management of personality disorders. *Am Fam Physician.* 2004;70(8):1505-1512.

Additional Resources

American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders: Primary Care Version*. 4th ed. Arlington, Va: American Psychiatric Publishing Inc; 1995.

Gillies RA, Manning JS. Mental health. *Prim Care.* 2007;34(3):445-681.

Goldman LS, Wise TN, Brody DS, eds. *Psychiatry for Primary Care Physicians*. 2d ed. Chicago, Il: American Medical Association; 2003.

Pingitore D, Sansone R. Using DSM-IV primary care version: a guide to psychiatric diagnosis in primary care. *Am Fam Physician.* 1998;58(6):1347-1352.

Stuart MR, Liberman JA III. *The Fifteen Minute Hour: Practical Therapeutic Interventions in Primary Care*. 3rd ed. Philadelphia, Pa: Saunders;2002.

Website Resources

American Psychiatric Association: http://www.psych.org

American Psychological Association: http://www.apa.org

Athealth.com: http://www.athealth.com

The Center for Advancing Health (CFAH): http://www.cfah.org

Collaborative Family Healthcare Association: http://cfha.site-ym.com

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