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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).

Introduction

This Curriculum Guideline defines a recommended training strategy for family medicine residents. Attitudes, behaviors, 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), www.acgme.org. The family medicine curriculum must include structured experience in several specified areas. Much of the resident's knowledge will be gained by caring for ambulatory patients who visit the family medicine center, although additional experience gained in various other settings (e.g., an inpatient setting, a patient's home, a long-term care facility, the emergency department, the community) is critical for well-rounded residency training. The residents should be able to develop a skill set and apply their skills appropriately to all patient care settings.

Structured didactic lectures, conferences, journal clubs, and workshops must be included in the curriculum to supplement experiential learning, with an emphasis on outcomes-oriented, evidence-based studies that delineate common diseases affecting patients of all ages. Patient-centered care, and targeted techniques of health promotion and disease prevention are hallmarks of family medicine and should be integrated in all settings. Appropriate referral patterns, transitions of care, and the 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 website. Current AAFP Curriculum Guidelines may be found online at 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 Curriculum Guideline provides suggestions for appropriate curricula in human behavior and mental health for family medicine residents.

The relationship between the patient and the patient's family is 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 mind-body connection that comes into play in every aspect of wellness, illness, and family and individual stress, as well as how the mind-body connection may influence a patient's presentation at any given time. Additionally, residents should learn to recognize the effect of their medical practice on their own wellness so that they can develop coping and self-care strategies in order to commit not only to their patients' lifelong health and well-being, but also to their own. It is suggested that residencies include a curriculum regarding physician wellness.

Family physicians must be able to recognize interrelationships among biologic, psychologic, social, and environmental 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 training period.

Competencies

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

- Apply knowledge of normal and abnormal psychosocial growth and development across the lifespan to the care of the individual patient (Medical Knowledge, Patient Care)
- Recognize emotional aspects of illness and demonstrate empathy in patient care (Patient Care, Professionalism)

- Recognize the stages and impacts of stress in the family life cycles of diverse family structures (Medical Knowledge, Interpersonal and Communication Skills)
- Describe the impacts of mental health disorders on the family unit (Medical Knowledge, Systems-based Practice)
- Elicit and apply information pertaining to cultural values and beliefs, family systems, social history, and environmental context to develop physician-patient rapport and support patient behavioral changes (Interpersonal and Communication Skills)
- Master a variety of brief counseling techniques, including motivational interviewing, person-centered counseling, BATHE (Background, Affect, Trouble, Handling, Empathy) technique, solution-focused therapy, and cognitive behavioral techniques to enhance the physician-patient relationships and support health promotion through behavior change (Interpersonal and Communication Skills, Practice-based Learning and Improvement)
- Interview and evaluate patients for mental health disorders using evidence-based screening and assessment tools (Patient Care)
- Recognize and manage mental health disorders, including use of appropriate referrals for behavioral therapy, counseling, community resources, and psychiatric specialty care to optimize patient health (Systems-based Practice, Practice-based Learning and Improvement)
- Assess, manage, and coordinate care for patients at risk for, or experiencing, abuse, neglect, and family and community violence (Medical Knowledge, Interpersonal and Communication Skills)
- Screen for prior trauma in a sensitive and effective manner and engage in trauma-informed care to minimize retraumatizing patients (Professionalism, Interpersonal and Communication Skills)
- Identify, manage, and coordinate care for patients experiencing emergent psychiatric health needs, domestic violence, child abuse, and disaster situations (Professionalism, Systems-based Practice)

Attitudes

The resident should demonstrate attitudes that encompass:

- Awareness of, and willingness to, overcome personal biases, attitudes, and stereotypes regarding mental illness and social diversity, as well as recognition of how attitudes and stereotypes affect patient care
- Recognition of the complex bidirectional interaction between family, social, and environmental factors and individual health
- Empathy and acceptance of the patient’s right to self-determination
- Sensitivity and acceptance of differences among people, including differences in gender, race, age, ethnicity, religion, sexuality, culture, and others
- Respect and compassion for the psychosocial dynamics that influence human behavior and the physician-patient relationship

- Recognition of the prevalence of abuse in society and willingness to support patients who are experiencing or have experienced abuse
- Valuing a multidisciplinary approach to the enhancement of individualized care
- Commitment to lifelong learning about the dynamic interaction of the biological, social, spiritual, and psychological aspects of the human life cycle
- Willingness to explore the multitude of diverse factors that play a role in a patient's medical decision making

Knowledge

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

1. Basic human behavior
    a. Normal, abnormal, and variant psychosocial growth and development across the lifespan
    b. Interrelationships among biologic, psychologic, spiritual, environmental, 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 management plan
    e. Family functions and common interactional patterns in coping with stress
    f. Awareness of personal attitudes, biases, and values that influence effectiveness and satisfaction as a physician
    g. Stressors on physicians and approaches to effective coping and wellness
    h. Ethical issues in medical practice, including informed consent, patient autonomy, confidentiality, quality of life, and end-of-life care
    i. Differential diagnoses of common mental health disorders
    j. Content in the current *Diagnostic and Statistical Manual of Mental Disorders*
2. Mental health disorders
    a. Neurodevelopmental disorders
        i. Intellectual disability (intellectual developmental disorder)
        ii. Learning disorders
        iii. Motor disorders
        iv. Communication disorders
        v. Autism spectrum disorder
        vi. Attention deficit/hyperactivity disorder (ADHD)
        vii. Tic disorder
    b. Feeding and eating disorders
        i. Avoidant/restrictive food intake disorder
        ii. Anorexia nervosa
        iii. Bulimia nervosa

    iv. Binge eating disorder

c. Elimination disorders

d. Sleep-wake disorders
    i. Insomnia disorder
    ii. Hypersomnolence disorder
    iii. Narcolepsy
    iv. Breathing-related sleep disorders
    v. Circadian rhythm sleep disorder
    vi. Restless leg syndrome

e. Neurocognitive disorders
    i. Major neurocognitive disorder (NCD) (dementia)
    ii. Mild NCD
    iii. Major or mild NCD due to: Alzheimer disease, frontotemporal lobar degeneration, Lewy body disease, vascular disease, traumatic brain injury, substance/medication use, HIV infection, prion disease, Parkinson disease, and Huntington disease
    iv. Delirium
    v. Cognitive disorder not otherwise specified

f. Substance-related and addictive disorders
    i. Substance use disorder
    ii. Gambling disorder

g. Schizophrenia spectrum and other psychotic disorders
    i. Schizophrenia
    ii. Schizoaffective disorder
    iii. Delusional disorder
    iv. Catatonia
    v. Brief psychotic disorder
    vi. Psychotic disorder due to another medical condition
    vii. Substance-/medication-induced psychotic disorder

h. Bipolar and related disorders
    i. Bipolar disorders (including hypomanic, manic, mixed, and depressed)

i. Depressive disorders
    i. Major depressive disorder
    ii. Persistent depressive disorder
    iii. Disruptive mood dysregulation disorder
    iv. Premenstrual dysphoric disorder

j. Anxiety disorders
    i. Panic attack
    ii. Panic disorder
    iii. Phobias (agoraphobia, specific phobia, and social anxiety disorder [social phobia])
    iv. Generalized anxiety disorder
    v. Separation anxiety disorder
    vi. Selective mutism

k. Somatic symptom and related disorders

i. Conversion disorder (functional neurological symptom disorder)
ii. Illness anxiety disorder
iii. Somatic symptom disorder

l. Sexual dysfunctions
   i. Sexual interest/arousal disorder
   ii. Orgasmic disorders
   iii. Genito-pelvic pain/penetration disorder
   iv. Sexual pain disorders
   v. Sexual dysfunction related to a general medical condition

m. Gender dysphoria

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

o. Trauma- and stressor-related disorders
   i. Acute stress disorder
   ii. Adjustment disorders
   iii. Post-traumatic stress disorder
   iv. Reactive attachment disorder
   v. Disinhibited social engagement disorder

p. Dissociative disorders
   i. Dissociative identity disorder
   ii. Disruptive, impulse-control, and conduct disorders
   iii. Oppositional defiant disorder
   iv. Conduct disorder
   v. Intermittent explosive disorder

q. Additional conditions
   i. Problems related to family upbringing
   ii. Other problems related to primary support group
   iii. Child maltreatment and neglect problems
   iv. Adult maltreatment and neglect problems
   v. Academic or educational problems
   vi. Occupational problems
   vii. Housing problems
   viii. Economic problems
   ix. Circumstances of personal history (other personal history of psychological trauma; personal history of self-harm; personal history of military deployment; other personal risk factors; problem related to lifestyle; adult antisocial behavior; child or adolescent antisocial behavior)

x. Problems related to access to medical and other health care
xi. Nonadherence to medical treatment
xii. Overweight or obesity
xiii. Malingering
xiv. Borderline intellectual functioning
xv. Problems related to crime or interaction with the legal system
xvi. Other health service encounters for counseling and medical advice
xvii. Religious or spiritual problem
xviii. Acculturation problem
xix. Phase-of-life problem
xx. Problems related to other psychosocial, personal, and environmental circumstances (e.g., unwanted pregnancy; victim of terrorism or torture; exposure to disaster, war, or other hostilities)

Skills

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

1. Use evaluation tools and interviewing skills to efficiently collect data and optimize the physician-patient relationship
   a. Obtain permission to discuss sensitive topics, use open-ended questions to gather patient information, apply nonjudgmental approaches to physician-patient communication
   b. Create an environment that encourages honest patient responses
2. Apply the BATHE (Background, Affect, Trouble, Handling, Empathy) technique to gain appropriate context in a physician-patient interaction
3. Perform a mental status examination
4. Use or refer for special procedures in psychiatric disorder diagnosis, including psychological testing, laboratory testing, and brain imaging, where appropriate
5. Elicit and recognize the common signs and symptoms of the disorders listed under “Knowledge”
6. Teach patients methods for evaluating and selecting reliable websites for medical information
7. Describe the advantages and disadvantages of various screening tools, and screen for depression, anxiety, and suicidality:
   Depression: Patient Health Questionnaire (PHQ-2) (PHQ-9), Beck Depression Inventory, Zung Self-Rating Depression Scale, Hamilton Rating Scale for Depression, and SIG-E-CAPS Mnemonic (Sleep, Interest, Guilt, Energy, Concentration, Appetite, Psychomotor, and Suicidal ideation)
   Anxiety: Generalized Anxiety Disorder 7-item Scale (GAD-7)
   Suicide: Columbia-Suicide Severity Rating Scale (C-SSRS)

8. Refer appropriately to cognitive behavioral therapy and psychiatric consultation
    a. Describe the central therapeutic role of the primary care physician
    b. Utilize team-based collaborative care, such as the Improving Mood—Promoting Access to Collaborative Treatment (IMPACT) model of evidence-based depression care
    c. If limited or no local referrals are available, refer to online cognitive behavioral therapy (CBT) tools or therapies
9. Manage emotional aspects of nonpsychiatric disorders
    a. Reflecting content
    b. Reflecting feeling
    c. Reflecting meaning
10. Apply techniques to enhance adherence to medical treatment regimens
11. Initiate management of psychiatric emergencies (e.g., the suicidal patient, the acutely psychotic patient) using crisis intervention skills and resources
12. Properly use psychopharmacologic agents, taking into consideration the following:
    a. Diagnostic indications and contraindications
    b. Dosage, length of use, monitoring of response, side effects, and compliance
    c. Drug interactions
13. Establish and use a collaborative physician-patient relationship to manage mental health disorders
14. Utilize the Transtheoretical Model of Change to support behavioral and lifestyle changes (e.g., smoking cessation, obesity management, medication adherence) and apply appropriate motivational enhancement techniques for specific stage of behavioral change.
    a. Assess the patient's "stage of change" with "readiness ruler"
    b. Assess the patient's "life goal/what is important"
    c. Assess the patient's "confidence in achievement"
15. Apply motivational interviewing techniques
    a. Ask, tell/teach, ask
    b. Open-ended questions, affirmations, reflections, and summary (OARS)
    c. Working with ambivalence: decisional balance work and develop discrepancy between life goal and behavior
    d. Recognize and engage with patient's change talk "desires, abilities, reasons, need (DARN)"

e. Use patient-centered language
f. Build self-efficacy

16. Teach and support stress management techniques as they relate to cognitive behavioral approaches
    a. Breathing: boxed breathing
    b. Muscle relaxation: progressive muscle relaxation
    c. Imagery
    d. Explain connection between thoughts, emotions, and behaviors (cognitive behavioral therapy [CBT])
17. Manage chronic pain
18. Perform crisis counseling
    a. Define the problem
    b. Complete “suicide and homicide” risk assessment
    c. Identify risk and protective factors
    d. Complete safety plan and remove access to lethal means
    e. Provide support
    f. Determine risk and intervention
    g. Document
19. Refer patients to appropriate community resources
    a. Family resources, family meetings
    b. Patient care team of other mental health professionals
    c. Other community resources
20. Practice patient-centered variations in treatment based on the patient’s personality, lifestyle, and family setting
21. Identify and address high-risk alcohol and other drug use and substance use disorders (See Substance Use Disorder Curriculum Guidelines); provide appropriate care of health disorders listed under psychopathology
22. Refer appropriately to ensure continuity of care, provide optimal information sharing, and enhance patient compliance

Implementation

Training in human behavior and mental health should be accomplished in outpatient, inpatient, home-based, nursing home, emergency, and other settings appropriate to residents’ future practice needs. This occurs through a combination of longitudinal experience, supervised experiences, and didactic teaching. This combination should

include experience in diagnostic assessment, psychotherapeutic techniques (person-centered, cognitive behavioral therapy, motivational interviewing, solution focused, self-reflection, narrative medicine, wellness interventions), and psychopharmacologic management. Learning tools such as Balint groups, video review of resident interviews with actual or standardized patients, behavioral medicine clinics, direct observation, feedback, didactics, community-based experiences, and role playing are useful and recommended. Collaborating with multiple mental health professionals and community-based individuals/agencies (e.g., schools, nursing homes/home visits, substance abuse programs, shelters) to work as a team is often essential to providing the most effective, comprehensive, and long-lasting care.

Resources

Anxiety Disorders

Cuijpers P, Gentili C, Banos RM, et al. Relative effects of cognitive and behavioral therapies on generalized anxiety disorder, social anxiety disorder and panic disorder: A meta-analysis. *J Anxiety Disord*. 2016;43:79-89.

Wehry AM, Beesdo-Baum K, Hennelly MM, et al. Assessment and treatment of anxiety disorders in children and adolescents. *Curr Psychiatry Rep*. 2015;17(7):52.

Bipolar and Related Disorders

Bobo W. The diagnosis and management of bipolar I and II disorders: clinical practice update. *Mayo Clin Proc*. 2017;92(10):1532-1551.

Depressive Disorders

Cipriani A, Furukawa TA, Salanti G, et al. Comparative efficacy and acceptability of 21 antidepressant drugs for the acute treatment of adults with major depressive disorder: a systematic review and network meta-analysis. *Lancet*. 2018;391(10128):1357-66.

Maurer DM, Raymond TJ, Davis BN. Depression: screening and diagnosis. *Am Fam Physician*. 2018;98(8):508-515.

Selph SS, McDonagh MS. Depression in children and adolescents: evaluation and treatment. *Am Fam Physician*. 2019;100(10):609-617.

Feeding and Eating Disorders

Brownley KA, Berkman ND, Peat CM, et al. Binge-eating disorder in adults: a systematic review and meta-analysis. *Ann Intern Med*. 2016;165(6):409-420.

Harrington BC, Jimerson M, Haxton C, et al. Initial evaluation, diagnosis, and treatment of anorexia nervosa and bulimia nervosa. *Am Fam Physician*. 2015;91(1):46-52.

Gender Dysphoria

Chew D, Anderson J, Williams K, et al. Hormonal treatment in young people with gender dysphoria: a systematic review. *Pediatrics*. 2018;141(4):e20173742.

Neurodevelopment Disorders

Lurio JG, Peay HL, Mathews KD. Recognition and management of motor delay and muscle weakness in children. *Am Fam Physician*. 2015;91(1):38-44.

Sanchack KE, Thomas CA. Autism spectrum disorder: primary care principles. *Am Fam Physician*. 2016;94(12):972-979.

Thapar A, Cooper M, Rutter M. Neurodevelopmental disorders. *Lancet Psychiatry*. 2017;4(4):339-46.

Personality Disorders

Mulay AL, Waugh MH, Fillauer JP, et al. Borderline personality disorder diagnosis in a new key. *Borderline Personal Disord Emot Dysregul*. 2019;6:18.

Schizophrenia Spectrum and Other Psychotic Disorders

Griswold KS, Del Regno PA, Berger RC. Recognition and differential diagnosis of psychosis in primary care. *Am Fam Physician*. 2015;91(12):856-863.

Sexual Dysfunctions

Bala A, Nguyen HMT, Hellstrom WJ. Post-SSRI sexual dysfunction: a literature review. *Sex Med Rev*. 2018;6(1):29-34.

Sleep-Wake Disorders

Sateia MJ, Buysse DJ, Krystal AD, et al. Clinical practice guideline for the pharmacologic treatment of chronic insomnia in adults: an American Academy of Sleep Medicine clinical practice guideline. *J Clin Sleep Med*. 2017;13(2):307-349.

Somatic Symptom and Related Disorders

Kurlansik SL, Maffei MS. Somatic symptom disorder. *Am Fam Physician*. 2016;93(1):49-54.

Trauma- and Stressor-Related Disorders

Astill Wright L, Sijbrandij M, Sinnerton R, et al. Pharmacological prevention and early treatment of post-traumatic stress disorder and acute stress disorder: a systematic review and meta-analysis. *Transl Psychiatry*. 2019;9(1):334.

Additional Resources

American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*. 5th ed. American Psychiatric Publishing; 2013.

Jacobs C, Brieler JA, Salas J, et al. Integrated behavioral health care in family medicine residencies: A CERA survey. *Fam Med*. 2018;50(5):380-384.

Reed GM, First MB, Kogan CS, et al. Innovations and changes in the ICD-11 classification of mental, behavioural and neurodevelopmental disorders. *World Psychiatry*. 2019;18(1):3-19.

Online and Electronic Resources

Advancing Integrated Mental Health Solutions (AIMS) Center. Evidence-based behavioral interventions in primary care. https://aims.uw.edu/evidence-based-behavioral-interventions-primary-care

American Psychological Association (APA). www.apa.org

Athealth.com. www.athealth.com

Centers for Disease Control and Prevention (CDC). Adverse Childhood Experiences (ACEs). www.cdc.gov/violenceprevention/aces/index.html

Collaborative Family Healthcare Association (CFHA). www.cfha.net

National Council for Behavioral Health. Trauma-Informed Primary Care Initiative. www.thenationalcouncil.org/trauma-informed-primary-care-initiative-learning-community

Substance Abuse and Mental Health Services Administration (SAMHSA). SAFE-T Pocket Card: Suicide Assessment Five-Step Evaluation and Triage for Clinicians. https://store.samhsa.gov/product/SAFE-T-Pocket-Card-Suicide-Assessment-Five-Step-Evaluation-and-Triage-for-Clinicians/sma09-4432

Apps designed to support patients with their mental health: Aloe Bud, CBT-i Coach (for insomnia), Daylio, Happy Not Perfect, Headspace, Insight Timer, Mango Health, Mood Meter, Moodpath, Sanvello, Stoic

Virtual therapy and peer support services:

- Therapy: BetterHelp
- Couples: Regain
- LGBTQIA+: Pride Counseling, Talkspace
- Teens: Teen Counseling
- Peer Support: 7 Cups

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