Recommended curriculum guidelines for family medicine residents

Behavioral health and professional well-being

This document was endorsed by the American Academy of Family Physicians (AAFP).

INTRODUCTION

Each family medicine residency program is responsible for its own curriculum. The AAFP Commission on Education's Subcommittee on Graduate Curriculum has created this guide as an outline for curriculum development, and it should be tailored to the needs of the program.

Through a series of structured and/or longitudinal experiences, the curricula below will support the overall achievement of the core educational competencies defined by the Accreditation Council for Graduate Medical Education (ACGME) and provide guideposts to program requirements specific to family medicine. For updates and details, please refer to the ACGME website at www.acgme.org. Current AAFP curriculum guidelines may be found online at 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.

PREAMBLE

Family physicians incorporate knowledge of behavioral health into their everyday practice of medicine. According to the Joint Principles Working Party, behavioral health includes attention to symptoms of psychosocial distress that cause functional impairment,

psychological symptoms and psychiatric disorders, substance use and health behavior change. This curriculum guideline provides suggestions for appropriate behavioral health curricula for family medicine residents.

The relationship between the patient and the patient's family, environment and social situation is considered fundamental to understanding human behavior and behavioral health throughout the curriculum. The family medicine resident should have sensitivity to and knowledge of the mind-body as a single entity, how it plays out in every aspect of well-being, illness, and family and individual stress, as well as how the mind-body-spirit 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 well-being, so they can develop coping and self-care strategies to commit not only to their patients' lifelong health and well-being, but also to their own. It is essential that residencies include a curriculum regarding physician well-being.

Family physicians must be able to recognize interrelationships among biological, psychological, social, epidemiological 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.

PATIENT CARE

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

1. Apply knowledge of typical and atypical biopsychosocial growth and development across the lifespan to the care of the individual patient
2. Address significant life transitions, including birth, puberty, transition to parenthood, and end-of-life for patients and families proactively and with advanced care planning
3. Recognize the connection between the emotional aspects of illness and the presentation of symptoms
4. Demonstrate empathy and compassion in patient care

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

1. Use evaluation tools and interviewing skills to efficiently collect data and optimize the physician-patient relationship
2. Apply nonjudgmental approaches to physician-patient communication
3. Create an accepting and safe environment that encourages patient openness, including eye contact, sitting at or below eye level of the patient, using open-ended questions, empathy and active listening
4. Develop skills and willingness to engage in conversation around difficult topics, such as vaccine refusal, impact of lifestyle choices on chronic conditions and resistance to

medical management of various forms
5. 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 stages of behavioral change.
6. 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 developing discrepancy between life goals and behavior
   d. Recognize and engage with the patient's change talk
7. Use patient-centered language (patient with depression versus depressed patient)
8. Develop skills and techniques to gain an appropriate context in a physician-patient interaction
9. Perform a mental status examination
10. Educate patients on ways to evaluate websites for reliable medical information
11. Learn the importance of lifestyle interventions for behavioral health, including but not limited to healthy eating, exercise, time in nature, sleep (e.g., cognitive behavioral therapy of insomnia [CBTi]), limiting risky substance use, social connections and managing stress
12. Teach and support CBTi techniques, such as mindful breathing, muscle relaxation, behavioral activation, guided imagery and recognizing cognitive distortions for a variety of patient concerns (e.g., stress management, pain management, negative self-esteem, anxiety, depression)
13. Be familiar with sensory feedback and appropriate uses for it
14. Complete evidence-based "suicide and homicide" risk assessments and evidence-based safety plans
15. Practice patient-centered variations in treatment based on the patient's personality, lifestyle and family setting
16. Identify and address high-risk alcohol and other substance use disorders, including the harm reduction model (See Substance Use Disorder Curriculum Guideline)

MEDICAL KNOWLEDGE

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

1. Describe normal human growth and behavioral development and recognize psychosocial growth and development that is not within normal limits across the lifespan
2. Differentiate between normal child and adolescent behaviors and those that require further assessment, as well as skills to counsel patients and their families in the understanding and management of both types of behavior
3. Understand interrelationships among biological, psychological, spiritual, environmental and social factors in all patients

4. Delineate factors that influence adherence to a management plan (e.g., confidence, health literacy, environmental conditions, social support)
5. Navigate family systems theory and the role of individuals and the family unit in family functioning and interactional patterns that develop to cope with stress, including acute and chronic illness and behavioral health conditions
6. Utilize the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-5) to diagnose mental health disorders, including but not limited to neurodevelopmental disorders, feeding and eating disorders, elimination disorders, sleep-wake disorders, neurocognitive disorders, mood disorders, personality disorders, and substance-related disorders
7. 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
8. Differentiate appropriate emotional response to life events and mental illness (e.g., grief versus major depressive disorder [MDD])
9. Elucidate the differences between DSM-5 diagnoses and educational disabilities, as defined by the Individuals with Disabilities Education Act (IDEA)
10. Appreciate the importance of accurate diagnosis and display competency in withholding diagnosis until multiple encounters and data collection can be obtained for complicated behaviors and behavioral conditions
11. Measure adverse childhood experiences (ACES) using evidence-based assessment and understand their impact on chronic health and behavioral health conditions

INTERPERSONAL COMMUNICATION

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

1. Recognize the impact of internal and external stressors in the life cycles of diverse family structures
2. Recognize the complex bidirectional interaction between family, community, behavioral, social and environmental factors and individual health
3. Show empathy and acceptance of the patient's right to self-determination, combined with patience for the longitudinal nature of and ongoing conversations about behavior change
4. Exhibit sensitivity and acceptance of differences among people, including but not limited to differences in gender, race, age, ethnicity, religion, sexuality and culture
5. Respect and show compassion for the biopsychosocial dynamics that influence human behavior and the physician-patient relationship
6. Elicit and apply information pertaining to cultural values and beliefs, family systems, social history and environmental context to understand patient behavior and develop physician-patient rapport
7. Develop skills in managing strong emotions in patients and themselves, as well as the emotional aspects of nonpsychiatric disorders

8. Promote a safe environment where patients and others involved in their care can actively engage in their care decisions
9. Assist patients and others involved in their care in locating reputable medical information on the internet and other sources
10. Discuss internet safety and protection of health information

SYSTEMS-BASED PRACTICE

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

1. Establish and use a collaborative physician-patient relationship and interdisciplinary team approach to manage behavioral health disorders
2. Describe the impacts of physical and behavioral health disorders on the family unit
3. Differentiate when to refer for psychiatric assessment, neurological assessment, neuropsychological assessment, laboratory testing and imaging
4. Work in interdisciplinary teams with behavioral health professionals
5. Identify and initiate management of psychiatric emergencies (e.g., the patient who is suicidal and/or acutely psychotic) using crisis intervention skills and other resources (e.g., standardized assessment and safety measures when appropriate)
6. Identify, manage and coordinate care for patients experiencing domestic violence, child abuse and disaster situations
7. Use appropriate referrals for a variety of behavioral health supports, such as integrated primary care, outpatient mental health, community resources and psychiatric specialty care to optimize patient health
8. Refer patients to evidence-based apps and other AI or virtual resources (e.g., Veterans Affairs resources, such as COVID Coach, CBT-I Coach, PTSD Coach)

PRACTICE-BASED LEARNING

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

1. Use a variety of evidence-based brief counseling techniques (e.g., motivational interviewing, person-centered counseling, BATHE [Background, Affect, Trouble, Handling, Empathy] technique, solution-focused therapy and cognitive behavioral techniques [behavioral activation, relaxation techniques, cognitive distortions]) to enhance the physician-patient relationships and support health promotion through behavior change
2. Provide measurement-based care using evidence-based screening and assessment tools for the diagnosis and monitoring of behavioral health concerns in a fashion similar to the measurement-based care used for chronic illness
3. Learn to assess behavioral health screening tools for reliability and validity
4. Differentiate between behavioral health screening and assessment measures
5. Explain integrated primary care, why it is important for patients and providers, and

how it differs from traditional outpatient mental health

PROFESSIONALISM

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

1. Demonstrate empathy and compassion in patient care
2. Screen for prior trauma in a sensitive, effective and standardized manner and engage in trauma-informed care to minimize retraumatizing patients
3. Discuss ethical issues in medical practice, including informed consent, patient autonomy, confidentiality, quality of life and end-of-life care
4. Demonstrate awareness of and willingness to overcome personal biases, attitudes and stereotypes regarding mental illness, substance use and diversity
5. Recognize how attitudes and stereotypes affect patient care and their own satisfaction as a physician
6. Exhibit recognition of stressors and signs of burnout in physicians and approaches to effective coping and well-being
7. Demonstrate awareness of implicit bias, particularly in relation to race and ethnicity

IMPLEMENTATION

Training in behavioral health and professional well-being should be accomplished in outpatient (including integrated primary care), inpatient, home, 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, arts and humanities education and well-being interventions) and psychopharmacologic management.

Learning tools, such as Balint or other support groups, video review or direct observation of resident interviews with actual and standardized patients, behavioral health clinics, feedback, didactics, community-based experiences, and role playing are useful and recommended. Collaborating with multiple behavioral health professionals and community-based individuals/agencies (e.g., schools, nursing homes/home visits, substance use 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.

Szuhany KL, Simon NM. Anxiety disorders: a review. *JAMA*. 2022;328(24):2431-2445.

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

Nierenberg AA, Agustini B, Köhler-Forsberg O, et al. Diagnosis and treatment of bipolar disorder: a review. *JAMA.* 2023;330(14):1370-1380.

Marzani G, Price Neff A. Bipolar disorders: evaluation and treatment. *Am Fam Physician*. 2021;103(4):227-239.

Singh B, Swartz HA, Cuellar-Barboza AB, et al. Bipolar disorder. *Lancet*. 2025;22:S0140-6736(25)01140-7.

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.

Qaseem A, Owens DK, Etxeandia-Ikobaltzeta I, et al. Nonpharmacologic and pharmacologic treatments of adults in the acute phase of major depressive disorder: a living clinical guideline from the American College of Physicians. *Ann Intern Med*. 2023;176(2):239-252.

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

Chen D, Berona J, Chan YM, et al. Psychosocial functioning in transgender youth after 2 years of hormones. *N Engl J Med*. 2023 Jan 19;388(3):240-250.

Chew D, Anderson J, Williams K, et al. Hormonal treatment in young people with gender

dysphoria: a systematic review. *Pediatrics*. 2018;141(4):e20173742.

Intrapartum and postpartum mood disorders
Dama MH, Van Lieshout RJ. Perinatal depression: a guide to detection and management in primary care. *J Am Board Fam Med*. 2024;36(6):1071-1086.

Neurodevelopment disorders
Hyman SL, Levy SE, Myers SM, et al. Identification, evaluation, and management of children with autism spectrum disorder. *Pediatrics*. 2020;145(1):e20193447.

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.

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.

deGruy FV, McDaniel SH. Proposed requirements for behavioral health in family medicine residencies. *Fam Med*. 2021;53(7):516-520.

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.

McCulloch J, Ramesar S, Peterson H. Psychotherapy in primary care: the BATHE technique. *Am Fam Physician*. 1998;57(9):2131-2134.

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.

Working Party Group on Integrated Behavioral Healthcare, Baird M, Blount A, et al. Joint principles: integrating behavioral health care into the patient-centered medical home. *Ann Fam Med*. 2014;12(2):183-185.

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

Aims Center. https://aims.uw.edu/

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

Athealth.com. www.athealth.com

Centers for Disease Control and Prevention. Adverse childhood experiences (ACEs). www.cdc.gov/violenceprevention/aces/index.html

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

Colorado Division of Workers' Compensation. Comprehensive psychological testing. Psychological tests commonly used in the assessment of chronic pain. https://healthpsych.com/testing/psychtests.pdf

Integrated Primary Care. Implementing integrated primary care. www.integratedprimarycare.com/implementing-integrated-primary-car

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

Psychology Tools. www.psychologytools.com/downloads/worksheets-exercises-guides-handouts

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, COVID Coach, PTSD Coach

Virtual therapy and peer support services
Couples: Regain

LGBTQIA+: Pride Counseling, Talkspace.com

Peer support: 7 Cups

Teens: Teen Counseling

Therapy: Talkspace.com, online-therapy.com

REVISIONS

First published 9/1986
Revised/Title change 7/1994
Revised 6/2000 Revised 1/2008 by South Bend Family Medicine Residency Program
Revised 6/2011 by Rush-Copley Family Medicine Residency Program
Revised 6/2015 by Phelps Memorial Hospital, Sleepy Hollow, NY
Revised 9/2020 by Lehigh Valley Health Network Family Medicine Residency Program, Allentown, PA
Revised 8/2025 by St. Luke's Anderson Family Medicine Residency Program, Easton, PA