Family interviewing skills in child and adolescent psychiatry

Professor Philip Hazell (Central CS)
Dr Amelia Hill (Northern CS)
University of Sydney
Program

- Overview of principles family interviewing (15 min)
- Role play of family interview (25 min)
- Feedback and summary (5 min)
Overview

• Interviewing family members is essential to practice of child and adolescent psychiatry

• Attends to both content and process (observation and assessment of the interaction)

• Emphasis shifts according to nature of the presenting problem
Spectrum of emphasis

Reactive problems

Hard wired problems

Role of family in genesis and maintenance of the problem

Capacity of the family to adapt, psychoeducation
Overview

• Procedures and approaches not as well standardized as psychiatric interview of the individual, nevertheless there are some common elements

• Colourful history arising from the family therapy movement; structural, systems, Milan, Dulwich. etc
AACAP practice parameters
Content

• Family demographics
• Clinical symptomatology of the child
• Individual parent history
• Parent relationship history
• History of family as a unit
AACAP practice parameters
Family process

• Structure
  – Adaptability
  – Cohesion (connectedness v separateness)
  – Boundaries
• Communication
  – Clarity
  – Emotional expression
  – Problem solving
• Family beliefs
• Family regulation of child development
  – Responsiveness
  – Consistent
  – Degree of regulation
Dear CAMHS Team,

Please see and treat Andrew Martin-Peacock aged 10 years. His mother brought him requesting a referral to you because he is severely anxious and obsessional. Can’t sleep. Worries harm will befall family members. Worse since father took on a new job and is now away a lot.

P = 84/min. BP 90/60 Hgt and wgt 50\textsuperscript{th} centile. Examination normal. Recent sore throat but ASO titres were not raised.

Meds Recent course of amoxycillin, Bricanyl inhaler prn for asthma

Kindly

Lakshmi Pereira MBBS (Hons)
Role play

• Stewart Martin, 32, pharmaceutical rep with nursing background
• Anthea Peacock, 34, psychologist, part time research assistant
• Andrew Martin-Peacock, 10 yrs, yr 5 (IP)
• Bryce Martin-Peacock, 4 yrs, special pre-school
Stewart

• Works for pharmaceutical multinational
• Recent promotion, away from home 2-3 nights per fortnight with meetings, training, workshops
• Sees this as important career move, never considered turning down offer of promotion
• No mental health history
• Used to coach Andrew’s soccer team
• Responds to B’s needs in session only when it is clear Anthea will not eg offers to take B to toilet
Anthea

- Birth of A curtailed psychology career
- Lost 2 pregnancies between A and B
- Publically supports Ss career but is privately resentful-annoyed about lack of consultation. Believes she is the one with the real ‘brains’
- Burned out by As problems and Bs special needs
- As the mental health expert in the family, takes charge of reporting symptoms
- Is somewhat unresponsive to needs expressed by B in the session
- Low level anxiety and depression after each miscarriage, and after birth of B
Andrew’s history

- Expresses fears about intruders
- Worries about noises outside house
- Comes to parent’s bed, wants to sleep in bed. Mum usually allows this if Dad is away. Dad usually reassures, sends him back to his room
- Checking rituals. Involves Mum in the rituals
- Very attentive to B, possibly excessive
Andrew’s past history

- Normal delivery
- Normal milestones
- Some separation anxiety attending preschool and kindergarten
- Minor somatization eg abdo pain
- Has friends but is a bit timid, lets them lead
Andrew

• Year 5, state primary school
• Academically above average
• Likes soccer, Dad used to coach the team
• Get scared a lot. There might be robbers. Mum might get sick. Dad might have accident. Who would look after Bryce?
• Dad usually phones each night when he is away, but last week he forgot
Bryce

- Special preschool 2 days per week
- Mild intellectual delay
- Speaks loudly, poorly modulated voice
- Restless
- Repeats “I need do a wee wee”, intensifies if discussion becomes tense