

Systemic Training for Healthcare Professionals: The Chicago Center for Family Health Approach

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There has been increasing interest in family-centered, collaborative, biopsychosocial models of care by health and mental health professionals and consumers. This trend has led to growing demand and development of specialized training in family systems approaches to health care. This article describes the Families, Illness, and Collaborative Healthcare programs developed at the University of Chicago affiliate, the Chicago Center for Family Health. The program philosophy is guided by the following principles: a systems orientation focused on the family, a Family Systems Illness Model, a family resilience framework, a family-centered collaborative model of health care, and a social justice and advocacy orientation. Specific training components that implement these principles are described, including intensive certificate and fellowships; workshops, conferences, and institutes; and consultation and training services for community-based organizations. Discussion includes professional networking opportunities, funding challenges, and policy recommendations.

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OVERVIEW OF FAMILY SYSTEMS AND HEALTHCARE TRAINING

Over the past 25 years, there has been growing interest in family-centered, collaborative, biopsychosocial models of health care (Bloch, 1993; Blount, 1998; Doherty & Baird, 1983; Engel, 1977; Frank, McDaniel, Bray, & Heldring, 2004; McDaniel, Hepworth, & Doherty, 1992; McDaniel, Campbell, Hepworth, & Lorenz, 2005; Miller, McDaniel, Rolland, & Feetham, in press; Patterson & Garwick, 1994; Rolland, 1994a, 2003; Seaburn, Gunn, Mauksch, Gawinski, & Lorenz, 1996; Wood, 1993). At the same

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time, consumers have increasingly advocated for health care that attends to the physical and psychosocial challenges of major health conditions for all family members. As healthcare systems have tried to integrate biomedical and psychosocial care, it has become clearer that health and mental health professionals in primary or tertiary care settings generally lack sufficient knowledge and skills to work effectively with family-related issues. Many of these professionals are interested in family-centered training in the context of health problems and their healthcare work settings. Additionally, a growing number of psychotherapists are seeking specialized training to work with families coping with chronic illness and disability, terminal illness, and loss.

With these trends, there has been an increasing development of training programs that include or specialize in family systems approaches to health care. Training options may include: (a) courses and field placement opportunities within traditional professional master's and doctoral programs, such as social work and psychology; (b) training tracks within graduate education, such as medical family therapy tracks in marriage and family therapy (MFT) master's (e.g., University of Rochester, University of California at San Diego, Nova Southeastern University, Loma Linda University, Seattle Pacific University, Wake Forest University, University of Minnesota) and doctoral programs (e.g., East Carolina University); and (c) postgraduate continuing education through family therapy training institutes. The latter includes intensive postgraduate fellowships for health (e.g., family physicians) and mental health professionals (e.g., health psychologists) and courses, workshops, and intensive certificates for health and mental health professionals.

Training programs in family systems and health care vary based on their need to be integrated into the culture and structure of a particular discipline, such as family medicine or marriage and family therapy, and on discipline-based competency requirements, such as for psychiatry (Berman & Heru, 2005). Postgraduate training in family systems approaches to health care has the advantage and challenge of drawing trainees from multiple disciplines and healthcare settings (e.g., hospital, hospice, primary care, and specialty services, such as a cancer or rehabilitation center).

This article describes the specialized training program in Families, Illness, and Collaborative Healthcare developed at the Chicago Center for Family Health (CCFH). This program provides one model among training possibilities based in a postmaster's family therapy training institute affiliated with a major urban university. A number of other excellent programs have been developed, most notably the programs based in the Departments of Family Medicine and Psychiatry at the University of Rochester (McDaniel et al., 2005). Our program has a particularly strong focus on practice knowledge and skills to work with chronic illness, disability, and loss. Following a brief overview of CCFH's background, mission, and training, we describe the Center programs in Families, Illness, and Collaborative Healthcare, highlighting our training philosophy and then discussing specific training components: (a) intensive certificate programs and fellowships; (b) workshops, conferences, and summer institutes; and (c) on-site services for community-based organizations. Finally, we discuss some professional networking opportunities and policy recommendations.

CHICAGO CENTER FOR FAMILY HEALTH: OVERVIEW

The Chicago Center for Family Health, founded in 1990 by the codirectors, is a nonprofit independent affiliate of the Center for Family Health of the University of

Chicago. Our core and associate faculty of senior family systems-oriented professionals are affiliated with a number of institutions and agencies in the Chicago area. Our interdisciplinary faculty includes psychiatry, psychology, social work, MFT, nursing, family medicine, and pastoral care. Our programs offer a culturally diverse faculty informed by different experiences and expertise so that trainees can draw from multiple perspectives and therapeutic approaches (e.g., multigenerational life cycle, narrative, integrative). As a common bond, we share a family resilience and social justice orientation.

Mission

CCFH's mission, grounded in our resilience framework, is to provide innovative clinical training, services, consultation, and research to promote healthy family functioning, development, and adaptation to stressful life challenges (Walsh, 1998, 2003). One main objective is to provide a family systems approach to health care, particularly major health conditions, through our Families, Illness, and Collaborative Healthcare program. Our conceptual orientation integrates systems theory and a multigenerational family life cycle framework, attending to the interplay of biological, socioeconomic, cultural, spiritual, and institutional influences. In contrast to the deficit focus of traditional training and clinical services, we emphasize a normative, preventive approach to alleviate human distress by fostering family strengths and resources. Our approach is respectful of the diversity of family forms, values, and life challenges and to the stressful transformations of family life with recent social and economic changes.

Training Programs

Our postgraduate training programs are designed for the continuing education of professionals in mental health, healthcare, social services, and allied fields. Programs include 1-day workshops, 3–5-day intensive institutes, courses, case consultation/supervision groups, and our intensive 1- and 2-year certificate programs in family systems approaches to practice. Certificate programs are structured as a weekly 4-hour intensive learning experience (didactic and group supervision) over 30 weeks. Trainees can specialize in Families, Illness, and Collaborative Healthcare for a 1-year certificate, or take our more comprehensive 2-year certificate program, combining 1 year of basic family systems training with a second year in Families, Illness, and Collaborative Healthcare.

CCFH PROGRAMS IN FAMILIES, ILLNESS, AND COLLABORATIVE HEALTHCARE: TRAINING PHILOSOPHY

Illness, disability, and death are universal experiences in families. Chronic and life-threatening conditions confront all of us with some of life's greatest challenges. The real question is not if we will face these issues, but when in our lives, what kind of condition, how serious, and for how long. With major advances in medical technology, people are living much longer with formerly fatal conditions, such as cancer, heart disease, diabetes, and now AIDS. Many children with chronic conditions that were once fatal or necessitated institutional care are now living into adulthood. The extension of later life has heightened the strain on sons and daughters who must contend with divided loyalties and complex navigation between elder caregiving,

childrearing, and providing financially for the family. Thus, ever-growing numbers of families are living with chronic disorders over an increasingly long time and are struggling to cope with multiple challenges.

Often families must simultaneously manage immediate, intense emotional and practical demands while facing major readjustment issues in their lives, including the uncertainties of a chronic or life-threatening illness and disability or a prolonged recovery period. They must deal with multiple losses and reorganization of role functioning and relationships, and with terminal illness, face end-of-life issues and bereavement. The needs of families too often are unattended in healthcare systems, contributing to serious immediate and long-term complications. Health and mental health professionals who work with chronic conditions, end-of-life, and loss frequently lack sufficient family-oriented training to work effectively with these issues. Our programs are designed to meet this need.

Traditionally, professional services to assist people with serious illness have been limited by a narrow focus on the individual, on late-stage and terminal phases of progressive diseases, and on family deficits or dysfunction. Aiming to transform the culture of training and address the full experience of illness and loss, the CCFH model is distinguished by:

1. Systems orientation focused on the entire family
2. Rolland's Family Systems Illness Model
3. Walsh's Family Resilience Framework
4. Family-centered collaborative model of health care
5. Social justice and advocacy orientation

Systems Orientation Focused on the Entire Family

We define the family or caregiving system rather than the ill individual as the central unit of care (McDaniel et al., 1992). Situations of chronic and life-threatening conditions require a biopsychosocial systems model (Engel, 1977). There is growing evidence for the mutual influence of family functioning and physical illness (Weihs, Fisher, & Baird, 2002) and the usefulness of family-centered interventions with chronic health conditions (Campbell, 2003). This paradigm is in sharp contrast to most existing traditional models of intervention in behavioral medicine, consultation-liaison psychiatry, and psychotherapy that focus narrowly on the patient. At worst, families are marginalized or pathologized as adverse influences on the patient's adjustment. They are not seen as potential resources and as needing help with their own suffering and challenges posed by the illness. Our approach recognizes the importance and "pain" of all family members and galvanizes their potential as a powerful psychosocial unit in the treatment process. We use a broad definition of family, addressing the needs of all family members, including siblings, extended kin, and intimate friends who are affected psychosocially and are part of the caregiving and healing system. We approach successful coping and adaptation based on assessment of family system strengths and vulnerabilities.

Family Systems Illness Model

The training curriculum is centered on the Family Systems Illness Model (FSI) developed by Rolland (1984, 1987, 1994a, 2003, 2004), which provides a useful

framework for resilience-oriented assessment and intervention with families dealing with chronic illness and disability over the life course. The model casts the illness in systemic terms according to its expectable pattern of psychosocial challenges over time. It views the unfolding of chronic illness in a developmental context, addressing the interweaving of illness, individual, and family development. It offers families a psychosocial map to normalize and contextualize their experience. Assessment and intervention are attuned to family challenges in relation to three dimensions: (a) the expectable demands of varied psychosocial types of illness (i.e., patterning of onset [acute vs. gradual], course [progressive vs. constant vs. relapsing], outcome [fatal vs. shortened life expectancy or possible sudden death vs. no effect on longevity], level of disability, and level of uncertainty); (b) the challenges accompanying varied illness phases (initial crisis, chronic, and terminal) over time; and (c) key family system variables, such as multigenerational legacies of coping with illness, loss, and other adversity, and belief systems, including the influences of culture, ethnicity, spirituality, and gender. The FSI model emphasizes the fit between the psychosocial demands of a chronic condition over time and the strengths and vulnerabilities of a particular family. It serves to guide clinical practice, including periodic family consultations, or “psychosocial check-ups,” brief interventions, family therapy, and multifamily discussion groups. Also, it can be used to inform program development, service delivery, policy, and research.

Family Resilience Framework

We find the concept of resilience—strengths in the context of adversity—to be a valuable metaframework for healthcare training and practice. Resilience is the ability to withstand and rebound from serious crises and persistent life challenges (Walsh, 1998). A family resilience framework (Walsh, 1998, 2003) fundamentally alters the traditional deficit-based lens, shifting perspective from viewing patients or their families as *damaged* to seeing them as *challenged* by an illness. A resilience-oriented approach uses concepts and language that humanize the illness experience and accompanying distress. Viewing resilience as relationally based, our approach taps kin and social resources as vital lifelines. This approach is founded in the conviction that both individual and family coping, adaptation, and growth are best forged through collaborative efforts in dealing with major health challenges (Patterson, 2002). Assessment and intervention identify and facilitate key processes that can reduce risk and increase resilience. Family resilience-oriented services bring forth shared hope, develop new and renewed competencies, and build mutual support. With terminal illness, they help families seize opportunities to make the most of precious time and deepen relationships with loved ones, bringing out their best in the worst of times. This approach recognizes that even when medical recovery is beyond control, possibilities for psychosocial-spiritual healing are possible and valuable.

Family-Centered Collaborative Model of Health Care

We regard a collaborative family-centered model of health care as essential (Blount, 1998; McDaniel & Campbell, 1996; Seaburn et al., 1996). This model envisions seamless collaboration between psychosocial, biomedical, nursing, and other healthcare providers, and views patient, family, community, and provider systems as valued participants in the healthcare process. Because clinical events always involve

biological, psychological, and social levels, patient, family, community, and providers of healthcare services should be addressed as a single ecosystem. It is a strongly ethical approach that can conserve resources for all participants: patients and their families, clinical providers, and administrative and financial entities. Above all, it enhances the quality of care and the sense of well-being among all participants. We see the family as the hub of collaboration.

We strongly believe that disease-specific and caregiver-oriented consumer organizations, such as Y-ME the National Breast Cancer Organization, are vital to collaboration. They serve as clearinghouses of information, networking, support, and advocacy—key ways to empower families and counteract isolation. Some who are trained traditionally fear that including families and consumer-based organizations as equal partners in collaboration could diminish their professional identity and power. At CCFH, we believe that health and mental health professionals have the ethical responsibility, when possible, to challenge and change the systems we work in, particularly hierarchical power relationships that marginalize and subordinate the family (Ooms, Rolland, Mintz, & Doppelt, 1995). We view collaboration as a mindful attitude that enables us to resist pressures to dehumanize the experience of illness and reduce the person and a living family system to a diseased patient or disorder.

Social Justice and Advocacy Orientation

A core tenet in our training philosophy is our belief that the future of our profession is tied to our ability to envision and translate systemic thinking into the larger society and issues related to social justice. We believe that systemic thinking beyond the borders of the family can best guide our involvement with families and promote healing and health.

Our current healthcare system perhaps illustrates both the glaring manifestations of social injustice and suffering and the opportunities to bring our systemic knowledge to fuller fruition. As a Center, we advocate that healthcare reform should provide reimbursable, preventively oriented family and relational-centered psychosocial services. Access to psychosocial care, often labeled “mental health services,” needs to be guaranteed and reimbursed on the same basis as physical health care. As a close friend of ours who has had multiple sclerosis for over 30 years states, “A real healing environment needs all system levels to share a belief in health care as a universal human right.”

A serious health problem often confronts families directly for the first time with the inadequacies and injustices of our current healthcare system. Most glaring is the fact that 46 million Americans have no health insurance, and over 65 million are underinsured. Also, for many, insurance is employment based. With illness and disability, the threat of job loss often means the simultaneous loss of health insurance. The paucity of long-term care services frequently overloads families. This problem often leads to anger, self-blame (“I should be able to take *better* care of my ill husband”), despair, and conflict among family members and with providers of care. Where feasible, we believe that it is ethical and responsible to facilitate family understanding of the larger system issues that contribute to these strains. In our training, we explicitly discuss ways to include these kinds of larger system issues in the therapeutic process. This can empower families not only to recognize reasonable expectations for themselves, but also to take action by involvement in myriad organizations that advocate

for change in our healthcare system. In doing so, even when such action may not benefit them directly, they can often find healing in doing something that can benefit others in the future, such as public health policy, research, and treatment options.

TRAINING OFFERINGS IN FAMILIES, ILLNESS, AND COLLABORATIVE HEALTHCARE

Our Families, Illness, and Collaborative Healthcare training offerings are designed to meet the training needs of professionals working with couples and families facing chronic and life-threatening illness, disability, terminal illness, and loss. Our offerings are open to all disciplines and levels of training. Training is tailored to fit varied professional disciplines, work settings, and levels of experience. Our programs are designed to address the needs of culturally diverse, economically disadvantaged, and underserved individuals, couples, and families.

In our programs, trainees' professional discipline, prior levels of experience with family systems concepts, and goals of training are quite varied. Doherty and Baird (1983) described five levels of physician involvement with families that are useful to conceptualize training:

1. Minimal emphasis on the family.
2. Open to engaging families and providing ongoing medical information and advice.
3. Feelings and support: empathic listening; being attentive to feelings; normalizing, and identifying dysfunction; and supporting coping skills.
4. Systematic assessment and planned intervention: skill in managing family interactions and recognizing dysfunctional patterns.
5. Family therapy.

In the design of our programs, our training goals include levels 2 and 3, but the heart of our training is geared toward levels 4 and 5 knowledge and skills within a multidisciplinary collaborative process. Our training is offered in the following formats, which are described below:

- Intensive programs: 30-week certificate and pre- and postdoctoral fellowships.
- Workshops, conferences, and institutes.
- Consultation and training services for community-based organizations.

Intensive Programs

30-week certificate. This certificate program is structured as a weekly 4-hour intensive learning experience that includes a didactic course sequence and ongoing group supervision. We attempt to tailor each trainee's learning experience to fit the expertise needed in his or her role and setting. Approximately half of our trainees are psychotherapists, with whom our goals include level 5 family therapy skills. The other half of our trainees include medical social workers, psychiatrists, family physicians, nurses, and counselors who work in healthcare settings with a high volume and rapid turnover of cases. In most instances, they need skills to do a rapid family-centered assessment, brief intervention, and linkage with appropriate ongoing health and mental health services. Trainees in these positions need to learn level 4 skills,

including how to (a) think contextually in a family-oriented, resilience-based systemic way about healthcare problems; (b) competently convene couples and families for consultation and assessment; (c) provide psychoeducation and brief three-four session interventions; and (d) know when a referral for more intensive family therapy would be appropriate. With these trainees, we do encourage at least some clinical experience providing ongoing family therapy to appreciate the evolving experience of families facing major health conditions. For trainees who want to take our intensive 30-week certificate specialization but who lack prior exposure to a family systems orientation, we suggest our core survey course sequence in family theory and practice. Consultation/supervision groups, described below, present both challenges and opportunities.

Courses. Based on training objectives, professionals can elect to take separate course offerings or, when coupled with a weekly consultation/supervision group, combine them as a 30-week comprehensive course sequence toward an advanced certificate. The format for all courses includes lecture, video, live demonstration interviews, and discussion. The current course offerings and sequence include the following:

1. *Families, Illness, and Disability: Systemic Approaches.* This course provides an application of systems theory with a range of health problems (physical illness, disability, psychosomatic disorders) and healthcare settings to enable clinicians to work more effectively with couples and families dealing with the impact of a child- or adult-onset condition. Topics include psychosocial demands of disorders over time, illness timing in the life cycle, health beliefs, loss, compliance issues, family-provider relationships, collaboration, and clinicians' own issues.
2. *Family Systems and Health: Clinical Approaches With Special Populations.* This course provides skills and techniques for working with specific healthcare problems using a family systems approach. Topics include pain and invisible disorders; psychosomatic problems; sexual issues in illness and disability; infertility and pregnancy loss; HIV/AIDS and other stigmatizing conditions; substance abuse and addictions issues in chronic illness; genetic illness/at-risk testing; and chronic mental disorders.
3. *Helping Families With Death and Loss.* This course presents a systemic approach with death and loss of a partner, parent, child, sibling, or kin. A multigenerational life cycle perspective informs assessment and intervention guidelines with threatened and ambiguous loss; terminal illness; end-of-life decisions and ethical issues; sudden, stigmatized, and traumatic loss; and long-term complications. The course examines beliefs, culture and spirituality, legacies of loss, and healing approaches for recovery and resilience. Experiential opportunities are included to explore personal themes when working with loss and interface issues in varied work settings (e.g., hospital, outpatient, rehabilitation, hospice).

Consultation/supervision groups. Case consultation/supervision groups are designed for professionals working in healthcare settings or with families and couples dealing with chronic, life-threatening, and disabling conditions. The focus is on integration and application of the course material and readings into family systems assessment, treatment planning, and intervention. The groups provide an opportunity to put into practice the core principles of Center programs described above: (a) systems

orientation focused on the family as the unit of care; (b) the Family Systems-Illness Model; (c) a normative family resilience framework; (d) collaboration between the family and healthcare professionals and systems; and (e) a social justice/advocacy orientation. Cases are considered in a social context and developmental (multigenerational family life cycle) perspective. Genograms are used to diagram family system patterns, particularly recent and past illnesses, losses, and other major stressors, and to identify potential resources in kin and social networks. The small group format includes case presentations, live observation and reflecting team feedback, demonstration interviews, simulations, and discussion of socioeconomic and cultural influences and service delivery systems.

Multidisciplinary training rationale. These groups are heterogeneous by design to create a multidisciplinary collaborative team, providing a safe environment for trainees from different cultural and professional disciplines to get acquainted, learn about similarities and differences in their roles and philosophy, and appreciate one another's special areas of expertise. Diverse cultural practices are explored when African American, Indian American, and Korean American trainees discuss healthcare beliefs and practices in their local ethnic communities, such as taboos against informing the patient that his or her illness is terminal, moral and religious beliefs about end-of-life decisions (Walsh, 2004), and use of non-Western healing practices. By bringing varied perspectives to one another's challenging cases, they come to value a team approach to practice. Trainees are encouraged to carry this experience forward into their own work settings.

Combining trainees with differences in professional discipline, prior experience, and training goals (e.g., level 4 or 5 skills) poses some difficulties, but we find it worth the challenge. The group can serve as a microcosm of real clinical settings where differing roles and knowledge are typical. We find that professionals with varied roles and skills benefit a great deal from the supervision and observation of one another's cases and by participating as team consultants. The family therapist can gain appreciation of the complexities for health professionals in integrating the psychosocial dimension when treating a biological disease. Such complexities include severe time constraints, huge caseloads, medical treatment demands, multiple healthcare specialists involved in a case, and the cultures of various medical settings. When a health professional presents a case that may need more intensive family intervention, the expertise of family therapists is better appreciated. Healthcare professionals gain understanding of the complex family challenges accompanying chronic and life-threatening conditions, other major stressors (such as job loss), or influences such as marital conflict or substance abuse and how a family therapist works with those issues. Family therapists in the group benefit from important contributions to case discussion by a health professional (e.g., physician, nurse), such as clarifying biological influences or medication issues that may contribute to physical or psychosocial distress. Pre- and postdoctoral fellows who are learning advanced family therapy skills also have individual supervision to provide further opportunity for a concentrated focus on therapy skills and techniques.

Multisystemic orientation. As part of the consultation group experience, trainees are encouraged to present the strengths and difficulties in their work settings from a systemic perspective and consider larger systems and healthcare policy issues. This

facilitates both discussion of individual cases from a multisystemic perspective and encourages problem-solving and suggestions for systemic interventions within institutional and community-based settings. One trainee, a hospital social worker, was called in to deal with the agitation of an elderly woman recently diagnosed with advanced colon cancer. The worker recognized the systemic problem as a conflict between the recommendations of the surgical staff, the palliative care team, and the patient's nursing home facility, which had increased the distress of the patient and her family. She then facilitated communication and collaboration among the health-care professionals and the family to arrive at a coordinated treatment plan.

Chronic illness, marriage, and policy collide. At times, a broader societal lens is required. In one poignant case, a trainee was working with a multistressed couple. The husband, Jim, had lived with multiple sclerosis for many years. Jim and his wife, Ruth, both deeply religious, had been committed to marry and have a family despite the federal policy that forced Jim to give up his social security disability income and health benefits with legal marriage. This policy caused tremendous financial and psychosocial strain for the couple over the years, especially for Ruth, who became overburdened working full time to support the family, taking major responsibility for childrearing and housework, and providing increasing caregiving to her husband as his condition worsened. The skew in their relationship, common in couples with illness, was reinforced by gender-based societal expectations for "a good wife." Jim tried to find work, but despite his education and competencies, he was offered only low-skilled, low-paying jobs in which he experienced discrimination because of his disabilities. He was finally "let go" for vague "downsizing" reasons. Case discussion and intervention highlighted the adverse impact of governmental policies, healthcare costs, societal stigma, and workplace biases suffered by persons with disability and their families (Olkin, 1999). A resilience approach helped shift the couple from their depressed, stuck, isolated, and helpless position as victims of unjust policies and biases. The trainee encouraged them to seek support from state and city-sponsored programs for families with a disabled member and to join forces with other families in collaborative efforts to challenge discriminatory policies and practices in their community.

Our training program encourages health and mental healthcare professionals to expand the boundaries of their traditional role as clinicians. For instance, we discuss and suggest ways to become involved in advocacy efforts to improve the quality, affordability, and access to health care, such as involvement with Physicians for a National Health Program (PNHP).

Personal themes when working with illness and loss. As part of our training, we believe that it is important for clinicians to gain awareness of any personal issues related to illness or loss that may complicate their clinical effectiveness (Rolland, 1994a, 1994b). Working with illness and loss heightens awareness of our own vulnerability and mortality. We are helping families with issues that are inevitable in our own lives and families. For instance, a clinician's recent or threatened loss might lead him or her to become overly involved or to distance emotionally in working with similar circumstances. A multigenerational history of traumatic loss, family maladaptation, or issues related to blame, shame, or guilt can compromise clinical effectiveness. Such feelings will likely be intensified when a case involves a similar illness. For instance,

one trainee's father had died of cancer despite multiple treatments and optimistic prognoses by a physician. She was uncharacteristically anxious and pessimistic about a case where the father had recently been diagnosed with cancer and had just completed initial treatment. It was important for her to become aware of the connection. We encourage trainees to be mindful of the impact of such situations.

As a central component of our training, trainees take stock of their own belief systems and multigenerational life cycle issues concerning illness and loss. We believe that one's ability to work effectively with illness and loss is largely dependent on personal comfort level with the highly charged emotional issues inherent in this type of work. Also, professional training by its neglect of these issues fosters a form of "psychic numbing" that negatively affects our ability to connect with families facing illness and loss. Medical education often results in this distancing process. Our training attempts to address these issues. Early on in the consultation groups, each trainee presents his or her genogram, highlighting experiences with illness, loss, or adversity (e.g., poverty) and what was learned in terms of strengths, vulnerabilities, and cultural biases. After presenting genograms, the trainees present a case in which their personal experiences came into play, and they are asked to analyze the case from that perspective. We find *The Shared Experience of Illness: Stories of Patients, Families and Their Therapists* (McDaniel, Hepworth, & Doherty, 1997) a particularly useful and unique text for this aspect of the training. This initial experience sets a tone of exploration of the self of the therapist during the training and helps foster an attitude of self-awareness when working with illness and loss. Additional daylong workshops are offered for this purpose.

We also address common experiences, such as compassion fatigue, in working with illness and loss and the importance of self care for clinicians. For instance, clinicians commonly feel torn between actual feelings of overload and a professional belief in the need to remain objective and continue with any case no matter what the circumstances. To behave otherwise often is experienced as a shameful failure. We explore how this is isomorphic with the experience of family caregivers who have unrealistic expectations of competent caregiving and who feel guilty for tending to their own needs or see respite as a shameful sign of weakness and failure. We incorporate in our training the need for self-understanding about illness and loss and acceptance of personal limits that promote a positive professional self-image.

Families, Illness, and Collaborative Healthcare Pre- and Postdoctoral Fellowship

For the past 8 years, CCFH, in partnership with MacNeal hospital, offers two or three full-time fellowships for postdoctoral mental health professionals and doctoral candidates enrolled in marriage and family therapy training programs who seek to satisfy their internship requirement. We also offer one fellow position for a family physician who has completed his or her residency and seeks a postgraduate fellowship specializing in systems approaches to health care. Applicants have a strong career development interest in the integration of family systems approaches in healthcare. The clinical experience emphasizes work with chronic or life-threatening illness, disability, and loss using family, couples, group/multifamily discussion groups, and individual modalities. We want fellows to develop experience in both primary and tertiary care settings with a broad range of disorders across the life cycle. At the Center, the fellows take the intensive course and consultation group sequence

described above and receive weekly individual supervision. Fellows' responsibilities include participation in multidisciplinary teaching conferences, teaching residents and medical students about the integration of family systems approaches in a variety of healthcare settings, and collaboration with healthcare providers. Fellows develop or join ongoing clinical research projects related to families and health care.

Primary placements. Fellows have both primary and secondary clinical placements. One primary placement has been at the MacNeal Hospital Family Practice Center, a teaching site for the Department of Family Medicine and the University of Chicago. The Director of Behavioral Sciences in Family Medicine is the on-site fellowship coordinator. MacNeal has a longstanding reputation of supporting family and psychosocial aspects of health care within a collaborative framework. The hospital serves a predominantly lower income minority (largely Hispanic) community. Through the Family Practice Center, fellows work with various medical specialty services. Additional clinical experience is provided through CCFH's specialized services for families coping with major health conditions.

Each year, we require the fellows to develop a clinical project for several reasons. First, the institution or setting identifies a need and an expressed willingness to develop a family-centered service component. For the fellows, it provides a real-life experience of starting a collaborative project in which they have greater autonomy but typically encounter common challenges in developing collaborative, family-centered services. Some examples have included the following:

1. One fellow developed time-limited multifamily discussion groups to address the burdens of adolescents and their families with poorly controlled asthma—high-frequency users of the emergency room. This involved collaboration with the emergency service, pulmonary care, nursing, social work, and behavioral science director in family medicine. To run the groups, the fellow developed a collaborative cofacilitator relationship with the primary outpatient adolescent asthma service nurse. Recruitment entailed joint efforts by everyone involved in the care of these cases. The motivation and tenacity of the fellow was crucial to the success of this project.
2. Two groups of fellows provided consultation to the fledgling hospice service at MacNeal Hospital. They offered input on the design of the family component of care, including in-service education for the hospice team regarding a family systems approach to end-of-life care, design input in the development of a family assessment/consultation for new admissions to the hospice service, and consultation and clinical services to families in crisis.

Secondary placements. Partnering institutions for secondary placement include the Division of Integrative Medicine and the Center for Compassion in Healthcare at Evanston–Northwestern Healthcare, and Gilda's Club of Chicago. Fellows have learning access to other programs at the University of Chicago, such as the MacLean Center for Clinical Medical Ethics. Secondary placements provide fellows with a more diverse experience beyond traditional hospital-based settings, such as a consumer-based health organization and integrative health care.

Gilda's Club of Chicago is a consumer-developed and run organization. Founded as a cancer support community after the death of comedian Gilda Radner from ovarian cancer, the mission of Gilda's Club is "to provide meeting places where people with

cancer and their families and friends join with others to build social and emotional support as a supplement to medical care” (Bull, 1998, p. 23). People who use Gilda’s Club are called “members.” This is one expression of its strength-based, non-pathologizing orientation. Our mutual core belief in resilience and focus on major health conditions provided the foundation for our collaboration. Although mental health professionals are on staff, Gilda’s Club does not provide traditional clinical services. Their interest in development of more family-oriented education and support groups provided an ideal opportunity for a CCFH fellow to work with a consumer-founded and directed community-based organization and experience a collaboration effort between a mental health (CCFH) and a consumer (Gilda’s Club) system. Over the past 3 years, fellows have facilitated adolescent and family support groups, designed and implemented a time-limited couples’ psychoeducational discussion group and an evening lecture/discussion series on a range of relevant family topics in living with cancer, and developed and implemented preventive, resilience-based services for children, primarily when a parent has cancer. Along with CCFH faculty, consultation has been provided on redesigning their “intake” process to be more family focused. One gratifying result has been Gilda’s Club creating a part-time position and hiring the first fellow consultant.

The Division of Integrative Medicine at Evanston–Northwestern Healthcare (affiliated with Northwestern) is a new program directed by an internist who trained with Andrew Weil, M.D. Eight components of care are provided: spirituality/connection, consciousness/awareness, breath, nutrition, environment, movement/physical activity, rest/relaxation/play, and *relationships*. In exploratory conversations, one need that emerged was their desire to develop the relationship component of care. We all agreed on the centrality of family and significant relationships to health and well-being. One of our incoming doctoral MFT fellows had a strong background and interest in integrative approaches to care, providing an ideal match for such a project. The fellow joined the staff team as the member with expertise in a family-centered approach to the relational component of care. For the fellow, it provided an experience working with an innovative integrative medicine program situated within a large medical center and collaborating with more senior staff experts in the other components. This experience had positive effects both for the Integrative Medicine program and our Center. Over the year, a family-centered component became part of their standard care. For the Center, the fellow taught us more about the possibilities of collaboration between family systems-based practice and integrative medicine. Since her fellowship, she has joined our Center faculty, providing workshops and lectures in the Families, Illness, and Collaborative Healthcare training programs.

Workshops, Institutes, and Conferences

Workshops and conferences. CCFH offers workshops and major conferences related to families and health. For instance, in 2001, the Center, in partnership with the American College of Chest Physicians, the Cancer Wellness Center, and the Chicago End-of-Life Coalition, provided a conference, “Caring for Families at the End of Life.” In 2002, the Center offered a special workshop series in Strengthening Resilience in Family Caregiving Relationships, which included “The Gifts that come with Caring for our Elders,” (Monica McGoldrick, MSW), “Ambiguous Loss: Family Dilemmas When a Loved One Has Dementia” (Pauline Boss, Ph.D.), and “Serious Mental Illness: Helping Families Master the Challenges” (Carol Anderson, Ph.D.).

In 2003, CCFH began offering a new certificate format in a series of monthly workshops. The workshops can be taken independently or combined. A certificate is awarded when the entire series is paired with a monthly case consultation group. This format is intended to create more flexibility for practitioners who want to gain practice knowledge and expertise, but because of time constraints or distance, need more concentrated training sessions than the traditional weekly format. The current series includes the following workshops:

- *Families, Illness, & Disability: An Integrative Approach*. Provides overview and clinical application of Rolland's Family Systems Illness Model.
- *Parental Illness or Disability: Meeting the Challenges of Childrearing*. Addresses issues with children and adolescents (e.g., separation/dependency); separating illness from person; honoring strengths; building community of care; including extended kin.
- *Navigating Turbulent Waters: Adolescents and Young Adults With Illness*. Focuses on such issues as balancing developmental strivings for independence with physical vulnerabilities; treatment compliance; and power struggles.
- *Helping Families When Children Have Chronic or Terminal Illness*. Focuses on such issues as opening communication, sibling concerns, and preparing for a child's death.
- *Aging, Chronic Illness, and Caregiving*. Addresses key challenges: sons and daughters, couples, diverse cultural expectations, challenges with dementia, and balancing eldercare with other life cycle demands.
- *Compassion Fatigue*. Addresses understanding and ways to prevent compassion fatigue and develop a personal wellness plan.
- *Integrative Approaches to Healing: Holistic Methods for Therapists and Professionals*. Provides overview of integrative medicine, use of guided imagery, and relaxation training.
- *Facing the End-of-Life: Clinical and Ethical Dilemmas*. Focuses on issues such as facilitating communication; resolving painful conflicts; secrecy and denial; advance directives; palliative care; and value conflicts.
- *Living and Loving Beyond Loss*. Examines legacies of complicated or traumatic loss; applies Walsh's Family Resilience Framework to foster healing and adaptation.

Summer institute. For the past 7 years, CCFH has offered an intensive 5-day institute (30 CEUs) called Families, Illness, & Disability: An Integrative Treatment Approach. This brief intensive institute format is ideally suited for interested professionals both regionally and nationally who can gain valuable knowledge and skills in a concentrated period away from their job commitments. The content has been designed to provide a concentrated and condensed version of our 30-week intensive training, covering a wide range of topics but in less depth. With the growing interest in working with illness, disability, and loss, we have had increasing requests to provide a more in-depth institute focused on a specific topic, emphasizing therapy skill development. In response, the 2004 summer institute focused on working with couples coping with illness and disability, and the 2005 institute addressed the family journey with cancer.

Consultation and Training Services for Community-Based Organizations

CCFH provides both short- and long-term consultation and training services to community-based healthcare and social service organizations to help create systemic changes that benefit families. These training opportunities are most effective because they are conducted on site in the actual clinical context. The faculty consultants assess “needs,” and then, in collaboration with staff, design and implement training and other interventions tailored to the setting. Consultations might include:

- Program Development—to ensure the centrality of a family-oriented approach.
- Clinical Case Consultation—for difficult or complex family cases.
- Staff Education—regarding family systems and collaborative care.
- Family Education—to develop multifamily groups for support and education regarding the specific illness or disability.
- Community Education—education and outreach to clergy and other community service organizations.
- Intensive Training—to identify individuals on staff as candidates for in-depth training so that they can become the on-site experts.
- Clinical Services—to accept referrals for complex cases.

The following consultation illustrates this approach.

Children’s Memorial Cystic Fibrosis program consultation. In 2000, our Center was approached by the new medical director of the Cystic Fibrosis (CF) program at Children’s Memorial hospital (affiliated with Northwestern University Medical Center). During her pediatric residency training, she had been introduced to basic family knowledge and interviewing skills. This experience led her to advocate for a family-centered model. She described the CF program’s needs as twofold: staff and program development geared toward more family-centered services, and help with two specific populations: (a) parents who recently learned that they have an infant with CF and were themselves carriers of the CF mutation; and (b) difficulties in disease management with adolescents with CF. Funding was secured from a pharmaceutical firm that provides medications for CF management.

To develop a base of knowledge about a family systems approach for staff education, we provided a series of in-service case-based presentations for the entire CF staff, including physicians, nurses, social workers, consulting health psychologists, respiratory therapists, and nutritionists. This provided a common baseline among staff that was essential for future service delivery applications. At the same time, we recommended that the CF social worker take the 1-year Families Illness and Collaborative Healthcare advanced certificate at our Center. This would ensure an on-site family-oriented psychosocial expert within the CF program staff, who would carry forward a significant part of our role as consultants.

This initial in-service component of training transitioned into a monthly family-centered “difficult case” conference led by the medical director and the first author (JR) as a consulting family psychiatrist. Everyone involved in care of the particular child participated in the presentation and case discussion. Our collaborative relationship and the inclusion of all relevant staff were crucial to solidifying family knowledge and skills and implementation of other programmatic changes. The case conference also stimulated referral of challenging cases to our Center

and educated CF staff regarding which cases warranted more intensive family therapy.

Next, general service delivery changes for all CF families were implemented. This included a family intake assessment and consultation by a staff nurse for all parents with a newly diagnosed child with CF or families transferring their care from another healthcare institution. This laid the foundation for joining with families, introducing a family-centered biopsychosocial service delivery model from the beginning of the family's relationship to the CF service, and identifying high-risk families. Second, we designed a prevention-oriented psychoeducational multifamily discussion group (Gonzales & Steinglass, 2002; Steinglass, 1998) four-session module for families with a newly diagnosed infant. A new module was begun approximately every 2 months with 4 to 7 families. Participation in the MFG was introduced by the primary physician at the first meeting and presented as a standard part of entry into the CF program. A pamphlet describing the group was designed and given to parents at the first appointment as a part of the packet of information about CF. This method yielded approximately a 75% rate of participation.

During the first year, the groups were led by the first author (JR), another senior CCFH faculty member, and the CF social worker (who was simultaneously in advanced training at our Center). This allowed an "apprenticeship period" of learning how to facilitate MFG groups. The medical director or head nurse was the featured person at the first meeting, which ensured a high rate of family participation. This first group meeting focused on the integration of the biomedical with the psychosocial aspects of CF. Over the four meetings, other topics addressed included a family systems orientation, initial family challenges of coping with CF, and living with future uncertainty. These initial cohorts of families took initiative in development of an ongoing monthly family support group with the CF social worker serving as group facilitator. Topics were decided together by participating families and various staff of the CF service (e.g., nutritionist). CCFH faculty were invited as guest experts to lead discussion on specific topics (e.g., preserving marriage when raising a child with chronic illness). At the fourth (and last) meeting of each initial MFG module, a family from the ongoing support group would come to provide information about the monthly group.

It proved far more challenging to implement a psychoeducational module for adolescents with CF and their families. Ultimately, an afternoon module was piggy-backed onto periodic Saturday gatherings sponsored by the CF Foundation. Traditionally, these meetings are designed to give the latest information about advances in CF research and treatment, and they serve a social-networking function for CF families in the Chicago region. Typically, an evening event for adolescents at the end of the day offers an incentive to attend the daylong gathering.

PROFESSIONAL NETWORKING

Often, we find that professionals who try to use this family-oriented model of care feel isolated from other like-minded colleagues and want to learn more about state-of-the-art research, theory, and clinical practice advances in family systems in health care. We introduce trainees to *Families, Systems, & Health: The Journal of Collaborative Family Healthcare* (<http://www.apa.org/journals/fsh/>) and the Collaborative Family Healthcare Association (<http://www.cfha.net>) as outstanding and unique resources.

Families, Systems, & Health: The Journal of Collaborative Family Healthcare (previously *Family Systems Medicine*), founded 22 years ago with Donald Bloch, M.D., providing the vision as the founding editor, is currently coedited by Susan McDaniel, Ph.D., and Tom Campbell, M.D. The journal's vision is to serve "as a vehicle to express the voices of change in the healthcare system and with a focus on family, the biopsychosocial model, and collaboration; and to participate in making those changes more humane for patients, families, and healthcare professionals." This journal has been truly multidisciplinary in its origins, development, leadership, and scholarly contributions.

The Collaborative Family Healthcare Association, founded in 1993, is a diverse group of physicians, nurses, psychologists, social workers, family therapists, and other healthcare workers in both primary and tertiary care settings who study, implement, and advocate for the collaborative family healthcare paradigm. The association functions as a communication clearinghouse by holding an annual conference, maintaining Web site databases and listings, and publishing the monthly *CFHA Gazette* online. Regional chapters convene regularly in areas such as Minneapolis, Seattle, and eastern Massachusetts.

CCFH provides a networking hub for faculty members who have developed collaborative relationships, creative training, and clinical initiatives. Trainees often develop professional relationships that continue beyond the training period, providing mutual support—and, alumni become part of CCFH's "kindred spirit" extended family.

PROGRAM EVALUATION

For all program offerings, each trainee completes an anonymous evaluation form requesting an overall rating and the effectiveness and quality of each faculty member and segment of the program. This includes scales ranging from 1 (*poor*) to 5 (*excellent*). On the form, trainees are also asked to provide narrative feedback about the best parts of the training, suggestions for improvement, knowledge and skills gained, relevance and utility in their work setting, and ideas about future CCFH program offerings. The evaluations are compiled to guide our future program direction. In addition, trainees participating in our intensive certificate and fellowship programs have periodic individual evaluation meetings with their supervisors.

PROGRAM FUNDING

In a society that has privatized health care and does not value funding for training, the financial base of these vital programs and fellowships poses an ongoing challenge. In recent focus group interviews with senior staff in local healthcare settings, we found strong interest in, and indeed a vital need for, programs such as ours. Trainee evaluations of the value of our programs are overwhelmingly positive. However, with managed care, healthcare professionals are both underpaid and carrying greater workloads than ever before, hindering their ability to avail themselves of our programs. Increasingly, foundation and donor support are essential for scholarship funds to enable healthcare institutions and community-based social service staff to benefit from valuable training.

CONCLUSION

This article has described our innovative programs in Families, Illness, and Collaborative Healthcare. Our experience has strengthened our conviction in the following principles:

Professional education and service delivery models need to better address the psychosocial needs of families facing major health problems. Basic knowledge about family systems and the normative psychosocial demands of various health problems over the life course of an illness or disability should be included in the education of all health and mental health professionals.

Efficient collaborative models that include the breadth of biomedical and psychosocial providers with patients and their families need to be further developed. Collaborative models that include healthcare institutions, families, and communities can significantly reduce direct and indirect costs, and enhance family well-being.

Family-centered health policies are needed. These should address the immediate and long-term needs of families and their members facing chronic illness, disability, and loss. The definition of family should be broad to encompass the diversity of family forms and kin networks in contemporary society.

And finally, *health care reform should provide universal care that includes reimbursable, preventively oriented family and relational-centered psychosocial services.* Access to psychosocial care needs to be guaranteed and reimbursed on the same basis as physical health care for the well-being of families, and ultimately, of our society.

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