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Daniel Carlat, MD
Editor-in-Chief

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IN THIS ISSUE

Focus of the Month:
Working With Families

Learning Objectives
After reading these articles, you should be able to:

1. Discuss the effects of involving a patient's family in the assessment and treatment of an illness.
2. Describe some of the ways clinicians can approach and conduct family meetings to maximize patient outcomes.
3. Summarize some of the current findings in the literature regarding psychiatric treatment.

Involving Families Enhances Patient Outcomes

Alison Heru, MD. Professor and interim chair, Department of Psychiatry, University of Colorado School of Medicine.

Dr. Heru has disclosed that she has no relevant financial or other interests in any commercial companies pertaining to this educational activity.

You are treating Mr. A for a depressive disorder, and you ask if he can bring his wife to his next appointment. When the couple arrives, you say to Mrs. A, "Welcome, and thank you for coming with your husband today. You've known him longer than I have, and I'm sure you'll have some important observations. You can also ask your husband whether he'd like you to help him manage his illness." You then tell Mrs. A to feel

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In Summary

- Patient adherence to treatment improves when the family or spouse is involved in the patient assessment and treatment planning.
- Since interviewing family members is key to gaining a better understanding of a patient's level of functioning, family meetings should be a routine part of the overall care plan.
- Many times, family meetings are contentious and difficult, so it's important that the clinician keeps things on track.

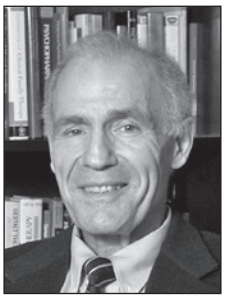
Q&A With the Expert

Holding Effective Family Meetings

Gabor I. Keitner, MD

Director, Family Therapy program at Rhode Island Hospital. Professor, Department of Psychiatry, Brown University.

Dr. Keitner has disclosed that he has no relevant financial or other interests in any commercial companies pertaining to this educational activity.



TCPR: Why is it important for psychiatrists to meet with families of patients?
Dr. Keitner: If you want to comprehensively understand your patients and modify variables that might impact treatment and outcome, it's important to understand families. There has been a lot of research showing that the family environment can have a significant influence on the course of an illness, either in a protective or risk-inducing way (Weihs K et al, *Health and Behavior* 2002;20:7–46).
TCPR: But often clinicians don't meet with families.
Dr. Keitner: That's true, and there are many reasons why. I think the main reason is that a lot of families are anxious about psychiatric illness and worry that the meeting will get out of control, or that it will just take too long.
TCPR: So, how would you suggest we approach family meetings?
Dr. Keitner: I work mainly in the inpatient setting, so most of my patients are acutely ill with depression, bipolar disorder, schizophrenia, substance abuse, and so forth. I meet with the families of about 70% of my patients as a way of trying to understand their problems. I explain that this is part

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Involving Families Enhances Patient Outcomes

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free to take notes, ask questions, and be part of the decision-making.

Involving families is a very important part of treating your patients. When the family or spouse is included with the patient in the assessment, decision-making, and treatment planning, the patient's adherence to treatment improves regardless of diagnosis (Wolff JL et al, *Health Expect* 2015;18:188–198).

Family members can tell you about patients' level of functioning, and how they spend the day. They can confirm sleeping and eating schedules. Family members can raise questions about cultural beliefs and values that you may not have time to assess in a first interview. Family inclusion does not require specific training, and it should be a routine component of your overall care plan.

Mailing Information

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The family meeting process

Start by asking the following questions to get a high-level understanding of how a family is dealing with a patient's diagnosis:

- Do you all agree on when your family member has symptoms?
- Do you all agree on how to manage the symptoms?
- Is there a treatment plan, and do you know what it is?

After that, continue with the following assessments:

Assess global family functioning. The illness affects the patient, who then affects family members, who then further impact the patient. In order to avoid any suggestions of blame, externalize the illness. Ask family members, "How are you coping with the illness? How is the illness affecting you as a family? How is the illness interfering with your ability to live your lives? How is the illness interfering with retirement, schooling, etc? Are there unresolved issues/feelings that you as a family have about the illness?"

Assess caregiver burden. Patients' families can be overwhelmed with physical, emotional, or financial demands—which can impact caregivers' health and mental well-being. With this in mind, ask the family caregivers how they are coping with providing care for the patient (Heru AM, *J Psychiatr Pract* 2015; 21(5):381–388).

Assess educational needs. Ask family members, "Would you like more education about the illness? Would you like someone to consult with your family about the emotional side of dealing with the disease?" Providing written information about referrals also helps normalize the process. Family psychoeducation means providing illness education, as well as giving family members the opportunity to express their feelings and discuss their difficulties managing the illness.

Assess the family's ability to identify problems. Ask, "How do you generally solve family problems? Who has the final say? Which problems are easy to resolve, and which ones are difficult?" Family members typically need to address practical problems, such as helping the patient get medications from the pharmacy, making time to attend appointments, and arranging day care for children.

Ask about other family problems. In addition to common practical and emotion problems, you should try to learn about additional issues by asking, "Are there other family problems that you are coping with at this time? Do other people in the family have illnesses or problems they are struggling with?" If family problems predate the illness, then recommend family therapy.

Advice for keeping the family meeting on track

Many times, family meetings can become contentious and difficult, thereby diminishing their utility as part of the treatment plan. Here are a few tips on how to keep the meetings headed in the right direction:

1. Listen to the family story. A family story or narrative about an illness is a window into the family's general sense of confidence and efficacy in managing chronic illness (Heru AM (Ed.), *Working With Families in Medical Settings.* New York, NY: Routledge; 2013). The presence of a coherent story indicates a low-risk family. High-risk families appear disorganized and/or traumatized, and have no coherent illness management plan.

   Ask: "How will you manage an emergency, such as a relapse or an acute attack?"

2. Watch the family interactions. The way in which family members interact during a routine interview helps determine family needs. If the family shows significant conflict, overtly disagrees about how to manage the illness, or admits to family problems that were present before the illness, consider a referral to a family therapist.

   Ask: "Would you like some additional help to talk through the issues that are getting in the way of managing this illness?"

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Involving Families Enhances Patient Outcomes

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3. Control the interview: If a family member is talking too much and does not respond to 2 escalating requests to give the patient time to talk, ask that person to step out of the room. Say that you will bring the family member back in at the end, but that you need time alone with the patient. If the patient is verbally attacking the family member, this is also a time to ask that family member to step out. Patients' or families' inability to make use of a family interview is a clear sign that additional intervention is needed.

Ask: "Would you like some additional help to talk through the issues that are getting in the way of managing this illness?" Or more forcefully: "I want to refer you to my colleague, Dr. X, for help with managing family conflict." As an example, family therapists practice a specific type of family treatment called family systems therapy (FST), which aims to change dysfunctional family transactions. FST is effective in improving outcomes for patients with many psychiatric illnesses (Von Sydow K et al, *Fam Process* 2010;49(4):457–485).

TCPR VERDICT: Involving families in the overall care plan of your patient can be critical to effective treatment outcomes. But for family meetings to be successful, you need to prepare yourself to be able to ask the right questions and adequately control the meeting environment.

Tips for Effective Family Meetings

Alison Heru, MD, *gives the following additional advice for conducting effective family meetings:*

- **Meet with your patient's family members at the initial assessment.** I usually then touch base with the family members intermittently and tell them they are welcome at any time. In a family meeting, you should reassure everyone—including the patient—that the main reason for the meeting is to discuss diagnosis and management of the patient's illness.
- **Plan for future emergencies.** If family members have concerns, I tell them that they can call me at any time. With the permission of the patient through a release of information (ROI) consent form, I tell them that I can discuss details of the patient's care and that I am always happy to listen to them. Discussion topics can include examples of medication side effects, other family members' illnesses, and transportation difficulties.
- **Consider a psychiatric advance directive.** I introduce the topic this way: If Mr. A develops mania, such as impulsive spending, not sleeping, or excessive use of alcohol, then we can all agree that this is serious and that Mr. A needs to come to the hospital. I will say, "Mr. A, I know that you get belligerent and are reluctant to come to the hospital when you are manic. Now that you are stable, what do you think your relative should do when you get manic?" Mr. A will likely say, "They should bring me to the hospital." At this point, I'll be able to ask him and his relative to sign an advanced directive indicating that this is his wish.
- **Take time to clarify coping skills.** Ask about individual, dyadic, and family coping skills. Ask, "How does this family cope? Do people use their own individual coping skills, or do they try to cope as a couple or a family together?" If problems arise, facilitate the family in a problem-solving session in your office.
- **Consider a self-report tool.** Examples include the Family Assessment Device (see http://bit.ly/2zCDZNL), which can be used in clinical settings. This tool can differentiate healthy from unhealthy families. The Distress Thermometer, another simple tool that is used in many chronic illness settings, has a brief family section (Donovan KA et al, *Psychooncology* 2014;23:241–250). The thermometer alerts you to the presence of family problems, but it does not identify family strengths, a crucial component of family-based interventions.

Expert Interview

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of the routine, which normalizes the process and reduces their apprehension. Most of the time, the patients are grateful and are interested in having a meeting. In addition, the notion that the meeting will take too long is based mostly on worries about being able to conduct the meeting effectively and efficiently. Once you acquire the skill, it doesn't take any longer to meet with families than it does to meet with patients. In the long run, it actually saves a lot of time if you get the family to cooperate with you to effectively and comprehensively understand the problem.

TCPR: Whom do you invite for a family meeting?

Dr. Keitner: I like to ask people to bring in whomever is important to them, and it doesn't have to be an immediate family member. It could be a best friend, somebody at work, or anyone whom patients identify as closely familiar and supportive.

TCPR: And how do you begin the meeting? What do you say?

Dr. Keitner: The most important part is orienting the group to the purpose of the meeting. I start by welcoming everybody in, then introducing myself and the people who are with me, such as trainees or a social worker. I thank them for coming in and explain to them that the goal of the meeting is to provide an environment where everyone can describe what their concerns are without being blamed, criticized, or invalidated. I tell everybody that they'll have a chance to tell me how they see the problems and that they'll have a chance to ask me questions—which is important because they always have questions. Finally, I say that I'll try to present my understanding of the problem, and then together we'll make some decisions about what we should do. I find that when we orient the families that way and they know what to expect, they really settle down and are much more likely to take turns and participate in a constructive way because they know they're going to be heard.

"One of the key issues in meeting with couples and families is that the therapist must be in control of the process and provide a safe environment for people to be able to express themselves without being attacked or criticized or hurt."

Gabor I. Keitner, MD

TCPR: After an initial family orientation, what are the first questions you ask?

Dr. Keitner: I ask, "What are the problems?" And then I say, "Who wants to go first?" Usually, I tell patients that they're going to go last because I've already heard from them, and I want to hear from the others. I do this also because I want the others in the meeting to see that I'm not there just as an advocate for the patient, and that I'm trying to understand everyone's concerns. I also tell the group that I'd like to hear from just one person at a time; when people start interrupting and arguing, that's usually how these meetings get off track. I let people know that I'm not a judge and the idea is not to find out who's right or wrong, but to be able to hear everyone's perspective. That way, we can all appreciate how everyone's looking at the situation.

TCPR: What sorts of issues tend to come up in a family meeting?

Dr. Keitner: The problems that family members identify invariably relate to why the patient is in the hospital. And in the process of that, I'll get a much more comprehensive history of the set of events that—at least from the family's perspective—landed the person in the hospital. I'll usually follow up with questions I still have about the onset and the course of the illness. Then, I'll ask the family members in turn to give their viewpoint on the nature of the problem. My experience is that most groups end up concentrating on only 3, 4, or 5 issues, and that they either agree or disagree with each other, but they get a clarification of the situation. And in the process of getting each other's perspective, they are better able to fine-tune their own thinking about it.

TCPR: One of my experiences in working in inpatient units is that meetings with patients often revolve around the fact that they want to leave the hospital as soon as possible. How should we deal with this?

Dr. Keitner: It's true that a lot of patients don't want to be in the hospital, and I often tell them that the fastest way to get out of the hospital is to have a meeting with the family so that we can get a better understanding of what happened and be reassured about their safety once they leave. This often incentivizes them to participate in a meeting. Sometimes patients are reluctant to have family meetings because they're afraid that nobody's going to show up; they're afraid it's going to validate their worst fear that nobody cares. But that rarely happens. In fact, most often they're pleasantly surprised by how many people are concerned and come in to support them. And, finally, I think they're worried that the family is going to say things that are opposite to what they've been telling us, and that maybe they're going to look worse than they would like to present themselves. But if you run the meeting in a collaborative way, these things won't happen.

TCPR: Can you give us an example of a meeting where some issues were resolved?

Dr. Keitner: Sure; here's a story of a patient in trauma therapy. The therapist had started going over the patient's history of physical abuse. The patient wrote a trauma journal, and in the process she got progressively worse, until she became suicidal and required admission. Nobody in the outpatient team had called the family. So, we had a family meeting with her husband, her parents, and her daughter. I asked all of them what they thought the problems were, and they all felt that she tried to take too much pressure off everybody else and place it all on herself; that she didn't tell anybody what was burdening her.

TCPR: How did the patient respond?

Dr. Keitner: She was able to explain that the reason she didn't talk about her worries was that she had been so traumatized that she was conditioned to avoid displeasing anybody. She was afraid that, if she talked about the

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Expert Interview

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trauma, they would abandon her. She was able to talk to her husband about their financial difficulties, and she talked about not wanting to upset her daughter by opening up about how abusive her former husband had been. The feedback from the family was that her in-laws were ready to support her, and that her daughter was supportive. I discharged her after the meeting. We finally understood where the patient's trauma was coming from—what was forbidden and hidden before, and that it was potentially toxic in her mind. She had a here-and-now experience of realizing that that wasn't the case, and the husband reassured her that he loved her, would never leave her, and wasn't blaming her for anything.

TCPR: This worked out well. What are you trying to accomplish, in general, with these meetings?

Dr. Keitner: I get everybody to tell me what their problems are. I validate everybody's perspective. I get them to talk about the issues with each other. I try to formulate for them what I heard from what they've told me to see if they agree with it and if it makes sense to them. I then ask the group what they want to do about it and how I can help them. And, I would say that most of the time, something constructive comes out of it. They come up with a plan that makes sense for them or validates what their perceptions are.

TCPR: What should we do in situations where the meeting becomes argumentative or heated between different family members? I think, because we don't know how to handle that, a lot of us are a little scared of family meetings.

Dr. Keitner: Yes. I think that's a very common problem. So, one of the key issues in meeting with couples and families—and this is sort of a subtle point—is that the therapist must be in control of the process. The therapist is not in control of the content, so it's not for me to determine what people should and shouldn't say. But it's my job to provide a safe environment for people to be able to express themselves without being attacked or criticized or hurt. People should agree to only have one person speak at a time, and to disagree in a respectful way. If they don't do that, I terminate the meeting.

TCPR: How do you terminate the meeting? What do you say?

Dr. Keitner: If the family members become argumentative, I say to them, "Is this what happens when you try to talk about problems at home?" And, of course, it is. And then I say to them, "Look, if you want help, then you must try to do things differently. If you're going to keep doing the same thing that you were doing at home, then there is no reason for us to meet." Or I might say, "The meeting is over. This is not helpful. You aren't ready to work on this in a constructive way, so I think this is a waste of time. When you're ready to work together, let me know, but until then, this is all I can do to be helpful." So, I put the responsibility back on them to control themselves.

TCPR: What about family meetings in the outpatient setting? How do they work?

Dr. Keitner: When I see outpatients for the first time, I like to meet with their significant other or family member at least once as part of the assessment. This does not mean family treatment. Not every family needs family therapy. I would say that—in at least 60% to 70% of the cases—the families are functioning well (Friedmann MS et al, *Fam Process* 1997;36:357–367). I just reinforce that and support them to continue to do that. Even with high-functioning families, it's good to give them the opportunity to ask questions and to be more active in understanding what's going on.

TCPR: How do these meetings inform your treatment and your understanding of the patient?

Dr. Keitner: In general, I find that family meetings are like a shortcut to understanding the patient. Because they are embarrassed or anxious, there are things that patients may not tell you for months in individual therapy. Then, when you bring in significant others, they just tell you. I find that meeting with a significant other always enhances my understanding of what's happening with the patient, and it gets to the point much quicker. It's an opportunity for both the patient and the family to identify in a safe setting the things that are causing concern. So, my job really is not to be an interrogator. My job is to create an environment where people feel comfortable talking about the things that they are worried about.

TCPR: That's good advice. I also want to ask you about logistics. I've had families come in during a time when I was doing 20- or 30-minute medication sessions, and found that it usually wasn't enough time. How much time should we budget for these family meetings?

Dr. Keitner: Before I answer the question, I don't want to give the impression that family treatment is the end-all and be-all. It's just one part of a comprehensive treatment plan. It works in combination with biological treatments and psychotherapy as needed. Now, in terms of time with the initial family assessment, it depends on how comfortable you are and how well you can do it. But the initial assessment, depending on how complicated the problem is, can take between an hour and 90 minutes. Subsequent follow-up meetings can take as long as an hour or be as short as 15 to 20 minutes.

TCPR: How many meetings with family is enough?

Dr. Keitner: Well, I would say that with many family meetings, 1 is enough. If a family is functioning pretty well and they have an opportunity to address their problems together, listen to each other, and pay attention, then they'll carry on from there after 1 meeting with you. So, I would say that most of the time, if there are no significant family issues, a single meeting is enough. For some families, you may need to meet 3 or 4 times until they feel that they have a better handle on how they're going to work on their problematic issues. So, I think it really depends on the severity of the problem and on the family's level of problem solving skills.

TCPR: Thank you for your time, Dr. Keitner.

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Research Updates IN PSYCHIATRY

DEPRESSION

Does Vagus Nerve Stimulation Work for Treatment-Resistant Depression?

REVIEW OF: Aaronson ST et al, *Am J Psychiatry* 2017;174(7):640–648

Treatment-resistant depression (TRD) is typically defined as a major depression that fails to remit after at least 2 trials of 2 different classes of antidepressants. Other than electroconvulsive therapy (ECT), there remain few evidence-based biological treatment options for TRD.

In 2005, the FDA approved vagus nerve stimulation (VNS), where a small stimulator device is surgically implanted in the chest, with three small electrodes wrapped around the vagus nerve. The device was originally approved for use with treatment-refractory epilepsy, although the approval was very controversial due to the poor quality of the data. *TCPR* was unconvinced that VNS had shown any evidence of being more effective for depression than sham treatment (see *TCPR*, January 2006). As a condition of approval, the FDA required post-marketing surveillance, and so the Treatment-Resistant Depression Registry was established.

The authors of this study, a 5-year longitudinal observational study conducted at 61 separate U.S. sites, used the registry to follow the clinical course and outcome of 2 large groups of patients diagnosed with TRD. One group received adjunctive VNS, and the other group received treatment as usual (TAU).

The patients could select their treatment—VNS or TAU—and 795 patients were included (495 patients in the VNS arm and 301 in the TAU arm). All patients had previously failed 4 or more treatments, with an average of 8.2 failed treatments. Response was defined as a decrease of > 50% in baseline Montgomery-Åsberg Depression Rating Scale (MADRS) score, and remission was based on a MADRS score ≤ 9.

The adjunctive VNS group had better clinical outcomes than the TAU group, including a significantly higher 5-year cumulative response rate (67.6% compared to 40.9%, $p < 0.001$), and a significantly higher remission rate (43.3% compared to 25.7%, $p < 0.001$).

TCPR'S TAKE

This study suggests that VNS is effective for TRD, but this treatment does not work quickly. Differences did not emerge until 6–9 months after treatment. Further, the study design had many limitations. Patients were not randomly assigned to treatment groups, there was no sham "placebo" comparison, and neither patients nor researchers were blinded to treatment. In addition, the study was funded by Cyberonics, the manufacturer of the device. While commercial funding does not necessarily imply that a study's results are invalid, it does behoove us to give the results extra scrutiny.

VNS is a complicated surgical procedure requiring a large investment in both time and money. Whether the potential benefits are worth the costs must be weighed individually for each patient. This study does suggest, however, that VNS is a potentially useful treatment for a small group of patients with treatment-refractory depression.

—Adam Strassberg, MD

Dr. Strassberg has disclosed that he has no relevant financial or other interests in any commercial companies pertaining to this educational activity.

PANIC DISORDER

Is D-Cycloserine Useful for Panic Disorder Treatment Augmentation?

REVIEW OF: Hofmeijer-Sevink MK et al, *J Clin Psychopharmacol* 2017;37(5):531–539

The mainstay of current treatment for panic disorder involves SSRIs and psychotherapy, specifically either cognitive behavioral therapy (CBT) or exposure with response prevention (ERP) therapy. D-cycloserine (DCS) is a partial N-methyl-D-aspartate (NMDA) receptor agonist that may enhance extinction learning—the gradual decrease in the panic response during ERP. Several studies have evaluated whether adding DCS to ERP therapy might enhance the effectiveness of the therapy, but there have been mixed results.

Conducted at outpatient clinics at 3 mental health care institutions in the Netherlands, this study was a randomized, double-blinded, placebo-controlled study of the effectiveness of adding DCS to panic disorder treatment. Fifty-seven patients with panic disorder and agoraphobia were randomized to 1 of 3 treatment arms: DCS before the ERP session, DCS after the ERP session, or placebo.

DCS or placebo was administered orally in a single 125 mg fixed dose, either at the beginning or the end of treatment, depending on the condition. All study participants underwent 12 weekly, 90-minute individual ERP sessions. The primary outcome was the mean score on the "alone" subscale of the Mobility Inventory (MI), which is a self-report tool used to measure agoraphobic avoidance behavior in various situations. Measurements were taken at baseline and during sessions 4, 8, and 12, and then at 3- and 6-month follow-up.

There was no difference in the primary outcome between those who received DCS (either pre- or post-ERP session) and placebo. However, within the two DCS treatment groups, the DCS post-ERP group showed a significant improvement in the primary outcome ($p = 0.009$; effect size = 0.6) measured at 3-month follow-up compared to the DCS pre-ERP group.

TCPR'S TAKE

DCS augmentation of psychotherapy for anxiety disorders sounds plausible in theory, but many studies, including this one, don't show a significant difference when comparing DCS to placebo. However, the authors mention that

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CME Post-Test

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For those seeking ABPN Self-Assessment (MOC) credit, a pre- and post-test must be taken online at http://thecarlatcmeinstitute.com/self-assessment/

Below are the questions for this month's CME/CE post-test. This page is intended as a study guide. Please complete the test online at www.TheCarlatReport.com. Note: Learning Objectives are listed on page 1.

1. Which of the following statements is true about family involvement in a patient's assessment, decision-making, and treatment planning? (LO #1)

   [ ] a. A patient's adherence to treatment shows improvement if diagnosis is made in patients under 25
   [ ] b. A patient's adherence to treatment shows moderate improvement for cases of mood disorder diagnosis
   [ ] c. A patient's adherence to treatment shows mild to moderate improvement specifically in cases of dual diagnosis
   [ ] d. A patient's adherence to treatment improves regardless of diagnosis

2. According to Dr. Keitner, the most effective way to start a family meeting is to: (LO #2)

   [ ] a. Establish at the onset that if name-calling or accusations occur, the meeting will be terminated
   [ ] b. Ask patients to share their interpretation of the diagnosis with the family
   [ ] c. Orient the group to the purpose of the meeting
   [ ] d. Have each family member establish how the patient's illness has affected the group

3. A type of family treatment shown to be effective in improving outcomes for patients with psychiatric illnesses, with the goal of changing dysfunctional family transactions, is called: (LO #1)

   [ ] a. Dialectical behavior therapy
   [ ] b. Behavioral family therapy
   [ ] c. Family systems therapy
   [ ] d. Structural family therapy

4. According to Dr. Heru, if a coherent family story or narrative about an illness emerges during a family meeting, this is indicative of a high-risk family. (LO #1)

   [ ] a. True
   [ ] b. False

5. According to a recent study, how did patients receiving vagus nerve stimulation (VNS) for treatment-resistant depression compare to those receiving treatment as usual (TAU)? (LO #3)

   [ ] a. VNS patients had both a significantly higher 5-year cumulative response rate and a higher remission rate than the TAU group
   [ ] b. VNS patients had a higher 5-year cumulative response rate but a lower remission rate than the TAU group
   [ ] c. VNS patients had a lower 5-year cumulative response rate but a higher remission rate than the TAU group
   [ ] d. VNS patients had the same 5-year cumulative response rate and remission rate as the TAU group

Is D-Cycloserine Useful for Panic Disorder Treatment Augmentation?

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this study had many limitations. First, the study may have been too small to show an effect—the researchers' power calculations called for 20 subjects per treatment arm, but only 19 were randomized to each arm. Second, the dosing of 125 mg of DCS may have been too high. This may sound illogical, but the way DCS is thought to work is by activating the NMDA receptor. At higher doses, though, DCS has partial NMDA receptor antagonist effects, which reduces its effect on extinction learning. Also, with higher doses and more administrations, patients are more likely to develop tolerance to DCS.

It's interesting that this study showed a small signal that DCS might be effective after treatment, but we'll need larger studies with more robust results before recommending that you start using DCS in your practice.

—Thomas Jordan, MD

Dr. Jordan has disclosed that he has no relevant financial or other interests in any commercial companies pertaining to this educational activity.

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This Month's Focus:
Working With Families

Next month in *The Carlat Psychiatry Report:*
Antipsychotics Update

Note From the Editor-in-Chief

For this month's issue, I asked two experts in family and couples therapy to remind us of how crucial it is to communicate with family members of patients. In the rush of a clinical day, it's often easiest to simply deal with whomever shows up to the appointment—typically just the patient. I plead guilty. Recently I evaluated a man in his 60s who presented with depression. There was no prior psychiatric history, and his medical history was significant for successful removal of prostate cancer. The cause of his depression was a puzzle until his concerned wife called me, wondering if he had told me that—ever since his prostate surgery—he had erectile dysfunction. The patient had not shared this information, and further conversations revealed that his self-esteem and sense of masculinity had taken a hit, leading to depression. A combination of medications and empathy improved his mood, and the experience reminded me that my default procedure with all patients should be to at least touch base with the family. Do you typically involve family members or significant others in treatment? Let me know your thoughts at dcarlat@thecarlatreport.com.

Best,
Danny Carlat