Training Child Psychiatrists in Family-Based Integrated Care

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KEYWORDS

• Family systems • Family therapy • Family-based treatment • Integrated care
• Patient-centered care • Patient- and family-centered care • Child psychiatry training

KEY POINTS

- Evidence supports that family-based assessment and intervention are essential skills for child psychiatrists.
- Family-based training can occur in child psychiatry residency in a way that complements other aspects of training and equips trainees for a broad range of real-world practice settings.
- The heuristic model of family-based integrated care (FBIC) guides case formulation in the context of family beliefs and relationships in support of productive joining with families and optimal integration of treatment across illnesses and levels of care.
- The application of the FBIC model is effective in the management of several broadly experienced challenges that occur in child psychiatry practice. Some of these challenges include family conflict over treatment recommendations, parental avoidance of limit setting, and family relationships impaired by destructive affect and disconnection.
- Trainees exposed to this FBIC training report positive impact from the training in their ongoing professional activities in a variety of settings.

OVERVIEW

This issue of *Child and Adolescent Psychiatric Clinics of North America* makes the case that child psychiatrists, to have an ongoing and significant impact on the children they treat, must include family context considerations in all aspects of practice. Few fellowship training programs adequately prepare trainees to think and respond systemically. Child Psychiatry as a field has been challenged to integrate family therapy

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Abbreviations

ADHD	Attention-deficit hyperactivity disorder
CBT	Cognitive-behavioral therapy
HCPHP	Hasbro Children's Partial Hospital Program
DBT	Dialectical-behavior therapy
FBIC	Family-based integrated care

comfortably from the outset. Ehrlich described this in a 1972 paper. "There appears to be an uneasiness in finding a place for family therapy in child psychiatry."[1] He continued, "It is our impression that family interviewing is considered a special and difficult procedure to be undertaken only by those with particular interest, skill, or experience."[1] At the time, tension centered on the conceptual shift away from psychoanalytically oriented psychotherapy. There has been a trend toward substantially less overall psychotherapy training in both General and Child Psychiatry Residency Training programs.[2–7] Pressures contributing to this trend include the rapidly growing volume of neurodevelopmental, genetic, epigenetic, and pharmacologic information; the relative shortage of child psychiatrists; and the practice of psychotherapy by a range of other disciplines.[8] Upcoming shifts toward recently modified core competencies in child psychiatry training and the transition to Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, offer an opportunity to reorganize training in this area.[9–16]

Despite this trend, there is growing evidence supporting the critical impact of the family on children's mental health.[8,17–22] This impact is seen in research involving epigenetics, the effects of toxic stress and parental mental illness, and interventions involving family-based treatment. Psychosocially oriented evidence-based treatments often focus on the details of the illness or symptoms without an eye to context. However, as addressed in other articles in this issue, these interventions function better when they incorporate family systems components.

THE TRAINING MODEL: HOW TRAINEES ARE EXPOSED TO FAMILY SYSTEMS THINKING

We developed the Family Therapy Training program for the Child Psychiatry and Triple Board Residency Programs of The Alpert School of Medicine of Brown University during a 15-year period between 1998 and 2013 (Other contributors to the development of the training program include Charles Malone, MD [1998–2002]; Robert Pazulinec, PhD [2001–2009]; and David McConville PhD [2010–present]). The program was part of a comprehensive training experience that included exposure to a variety of psychotherapeutic interventions, psychopharmacologic treatments, and experience in several practice settings. It was our task and our desire to develop a training experience that complemented what colleagues were teaching the trainees. We set out to add family systems thinking to the world view our trainees were exposed to as they readied themselves to practice child psychiatry. Other programs have reported on the productive use of "family evaluation clinics"[3] and an "experiential interdisciplinary course,"[2] but a survey of 7 US child psychiatry training programs in 2011 found that, although fellows considered exposure to family intervention valuable, most had not seen more than 1 outpatient family with supervision during their training.[6]

The training model incorporates the following:

- Ten hours of didactics on family therapy concepts
- One year experience in a family therapy training clinic
- Two years of group supervision