PSYCHOTHERAPY COLUMN

The State of Family Therapy Training in the US (A Survey of Family Therapy Training in US Child Psychiatry Residency Programs)

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Family therapy has long been integrated into child and adolescent psychiatry (CAP) training because there often is a strong association between dysfunction in family relationships and a child's presenting psychiatric symptoms. Furthermore, family involvement in treatment across a wide range of child and adolescent psychiatric illnesses leads to better outcomes.[1,2] Therefore, family based interventions are critical tools that child and adolescent psychiatrists need to incorporate into their clinical practice. Over time, CAP training programs have placed less emphasis on family therapy, as they have for psychotherapy as a whole, and more on psychopharmacology.[3] The current Accreditation Council for Graduate Medical Education (ACGME) guidelines for CAP training do write a non-specific program requirement for CAP trainees to develop "proficiency" in family therapy but they do not include family therapy among its prescribed milestones for CAP trainees.[4,5] While abundant evidence supports family-based interventions as valuable treatments for childhood mental illnesses, minimal literature explores the decreased curricular emphasis on family-based treatment among child and adolescent psychiatrists. Several factors may be contributing to this trend: 1) An increasing prevalence of child and adolescent mental illnesses combined with an inadequate workforce have placed increased time constraints on child psychiatrists, 2) Reimbursement models preferentially cover medication management visits, and 3) The rapid growth of clinical evidence for psychopharmacologic and other neurobiologic treatments. Douglas Rait of Stanford University, one of the few exploring this gradual dissonance within the field, surveyed current CAP trainees in several training programs to assess their impressions of their family therapy training. His study found that most trainees felt that family therapy was a necessary competency for child psychiatrists and was beneficial for patient care, but they also felt that their proficiency in this area was relatively inadequate in comparison to other clinical skills.[6] Additionally a retrospective survey of graduates of Brown University's Child Psychiatry Fellowship and Triple Board Training Program demonstrated highly positive reports regarding the utility of their family therapy training across a broad range of current practice settings.[7] Thus far, no published study actually quantifies and characterizes the current state of family therapy training curricula offered throughout CAP fellowship programs nationwide.

Therefore, I conducted a small, cross-sectional, seven-question-survey of CAP program directors to assess where our field is in now training child and adolescent psychiatrists in family therapy skills. The survey assessed basic demographics of each training program (size and setting) and then characterized their family therapy curriculums in terms of the type of curriculum (didactic only vs experiential vs a combined approach), the number of hours dedicated to training, the professional designation of those teaching it, if or not trainees participated directly in family therapy, and the program director's perception of how prepared their trainees were to incorporate family therapy skills into clinical practice. 53 of 139 US CAP program directors responded (38 percent response rate). Of those, 17 percent reported only didactic teaching of family therapy. In addition, over the two years of fellowship, 23 percent of these 53 programs dedicated five or fewer hours to family therapy training. A psychologist or licensed marital family therapist (59 percent) taught the vast majority of these curricula; psychiatrists taught only 25 percent. Social workers or a team of clinicians taught the remaining 17 percent. Another finding was that during training, only 64 percent of these programs indicated that trainees had any direct participation in family therapy while 31 percent stated that their trainees had no direct participation in family therapy during the two years of their fellowship. Overall, percent of the responding program directors felt that their trainees were adequately prepared to incorporate family therapy skills into their training programs.

We used the data to assess associations. They revealed the following: The hours of training dedicated to family therapy were directly associated with the program director's perception of their trainees being prepared to incorporate family therapy skills into their practice. To explain, 67 percent of the programs in which program directors felt their trainees were adequately prepared had at least 11 hours of training dedicated to family therapy teaching. Significantly, direct trainee participation in family therapy was associated with the program director's perception of trainee preparedness; 79 percent of program directors who felt their trainees were adequately prepared in these skills had direct trainee participation in family therapy in their fellowship programs. The hours the program devoted to family therapy training was also associated with direct trainee participation. 75 percent of the programs that had direct trainee participation in family therapy had at least 11 hours of training dedicated to family therapy.

This survey has several take away conclusions. Only just over half of program directors who responded actually felt that their trainees were adequately prepared to incorporate family therapy skills into their clinical practice. This, coupled with the guideline of family therapy being considered a CAP milestone, indicates that we need to broadly evaluate our current child and adolescent psychiatry training. Programs with 10 or fewer hours dedicated to family therapy curricula were also much less likely to offer any direct trainee experience in family therapy. It was primarily those programs that devoted more time and could accommodate direct participation in family therapy that had program directors who felt their trainees were prepared to incorporate these skills into their clinical practice.

Obviously, this small survey has several limitations including the low response rate of 38 percent, the fact that the trainee perspective was not surveyed, and that there was a large range of time above the 10 hour mark (11-100 hours) within which this survey was not able to delineate what the impact might be of a low versus high dose of training exposure. In addition this survey did not include questions exploring the barriers to providing family therapy training in programs. This study highlights the need for more clearly delineated guidelines for family therapy training in CAP fellowships that includes a minimum recommendation of both the amount and "type" of hours in CAP curriculums that can ensure that child and adolescent psychiatrists leave training adequately prepared to incorporate these skills into practice.

Given that the nature of modern psychiatric practice often leads to the CAP workforce being focused more heavily on medication management than psychotherapy intervention in daily practice, we need to include this exploration in a larger re-evaluation of the goals of psychotherapy training for psychiatrists. The sum of data in our field points to a family systems lens as being essential in assessing, managing, and treating psychiatric illness. Doing so maximizes optimal outcomes for our patients. The idea is not necessarily to "make child psychiatrists family therapists," but to ensure that in addition to prescribing, child and adolescents psychiatrists are also equipped to both be psychotherapeutic in their interactions with children and families, and to understand how to therapeutically navigate complex family dynamics in their clinical practice, even if they are in a primarily "prescriber-focused" practice. ■

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