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

- Four hours of didactics on couples' therapy
- Elective exposure to individual supervision with a family therapy supervisor

This schedule approximates 140 to 160 hours of direct instruction during 2 years. There are 5 child psychiatry fellows and 3 Triple Board residents per year in each year of the 2-year training. Group supervision is divided by training year: the first year fellows combine with fourth year Triple Board residents and second year fellows with fifth year Triple Board residents. Thus, cohorts are 8 trainees per year.

The 10 hours of teaching on family therapy concepts occurs in 3 workshop sessions in July-August of the academic year for the cohort entering their first year of child psychiatry fellowship and fourth year of Triple Board residency. The faculty agreed that early training in family concepts was a necessary part of the tool kit every child psychiatrist in training needs as he or she begins fellowship.

INTRODUCTORY SEMINARS

Major topic areas in these first seminars include Genograms; Joining Strategies; Pattern Identification in Family Systems; and Interventive Interviewing techniques.[23] Sessions are team taught by us and a staff psychologist who runs the family therapy training clinic. Use of videotaped examples of family therapy sessions, demonstration interviews, and role plays are incorporated into these sessions.

By creating genograms, trainees make a commitment to understanding the child in a family context. Joining skill building focuses on the challenge of connecting simultaneously with multiple family members in a developmentally appropriate way. In role plays and discussions about the joining process, residents learn how to gain an understanding of family belief systems in a manner that is experienced as supportive by the family. Practice with pattern identification in families serves to develop a working vocabulary of relationally focused terms and to establish comfort for the trainee in observing painful or otherwise challenging relationship patterns. The introduction to interventive interviewing techniques gives a preview for the trainees to the power of language as therapists help families find new patterns of thinking, feeling, and behaving. Residents are encouraged to shift from a default linear viewpoint of causation to a circular and reflexive vision. This is the most challenging piece of the introductory curriculum.

COGNITIVE AND AFFECTIVE/SPATIAL DIMENSIONS IN FAMILY SYSTEMS THERAPY

It is in this introduction to family systems therapy that we first use "the graph." (**Fig. 1**) While recognizing there are many dimensions that describe the quality of life in families, if students are encouraged to pay attention to a cognitive dimension (eg, the presence of ongoing beliefs either shared or idiosyncratic to 1 family member) and an affective/spatial dimension (eg, relationships between family members that generate emotional states and affect the ability to problem solve), then the students have a way to evaluate where the child and family is at the start of treatment and at any time along the course of treatment. A significant portion of this article is dedicated to demonstrating how these concepts translate into treatment strategies.

The family therapy training clinic in which residents participate during the first year of this 2-year curriculum is supervised by an outpatient staff psychologist. All residents engage in 1 to 2 hours per week of family therapy with direct supervision from the psychology attending during at least half of each session. Residents are encouraged to practice family formulation and joining and to be focused on "where the family is" with beliefs and relationships. Trainees typically rely more on the

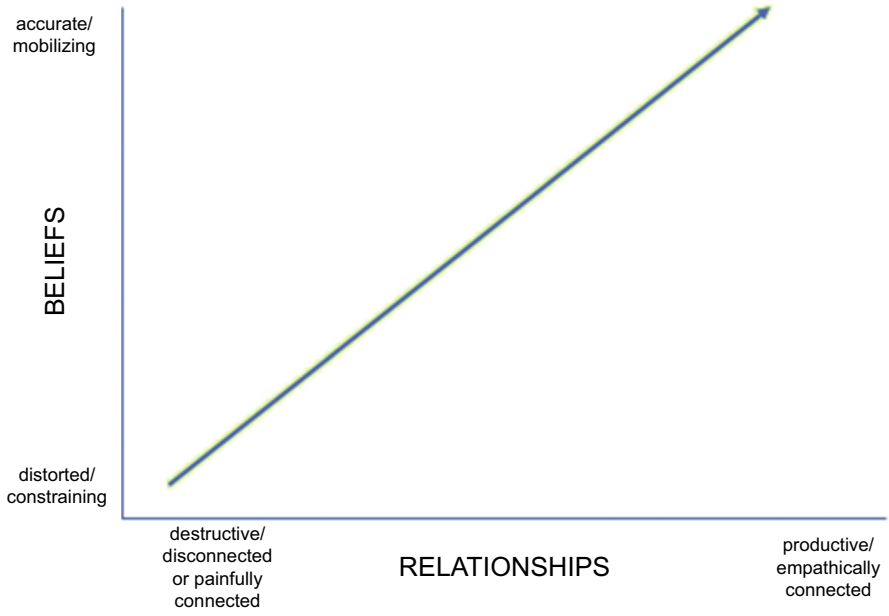

Fig. 1. Family-based integrated care graph.

experienced faculty member in the beginning as they practice shifting from linear interviewing to systems theory–directed observation and interviewing. Sessions are videotaped with family consent. In addition to direct supervision, further discussion occurs before or after sessions as well as in the context of group supervision during which time videotape is reviewed in detail.

Group supervision during the first and second year of the curriculum involves trainees taking turns sharing case material from families they are actively treating. Although most commonly cases are from their outpatient panels, they are encouraged to bring cases that they are treating in any context for support around family-based treatment. It is not unusual that trainees may bring for supervision a patient they initially began treating with individual therapy but have realized that further family involvement is essential. A common tool in the group supervision setting is the use of role playing the same moment seen on video, in real time, with the group brainstorming productive questions to highlight the therapeutic message that will broaden the family's perspective. There is repeated emphasis on using the FBIC model, and referring to the graph, to center the trainees' formulation as they enter each session and to use this as an anchor to preplan a set of circular and reflexive questions that support family movement toward mobilizing beliefs and empathic connections.

The second year of group supervision has the same structure as the first. During the second year, residents are much more comfortable with seeing family context as foreground with respect to symptoms. With the second year, trainee discussion shifts toward more complex strategizing to support family movement away from beliefs that are constraining or inaccurate and toward more empathic and growth-promoting relationships. Rather than practicing circular and reflexive questions that help clarify the relationship and belief status quo as was the case in the first year, the emphasis is on creating momentum for family-based shifts from observed patterns to more functional ones. The other conceptual leap that residents at this

level of training embrace is the application of family systems concepts to the bigger picture of coordination of care for patients as well as to their own functioning in systems of care in the hospital system. Couples' therapy didactic sessions are interwoven in the second year of group supervision sessions.

THE TRAINING MODEL: WHAT TRAINEES NEED TO LEARN

Hasbro Children's Partial Hospital Program

Most trainees receiving instruction in family systems also do clinical rotations on the Hasbro Children's Partial Hospital Program (HCPHP) whereby they have an opportunity to observe and participate in FBIC being delivered to children and teens with complex pediatric illness.[24] This hospital program, also developed by us, provides a living laboratory where trainees can see the concepts taught in seminars and supervision in action with children and their families receiving an intense intervention for longstanding medical and psychiatric issues.

It is often while working on the HCPHP that trainees come to appreciate that FBIC is not simply involving the family in a child's treatment plan. It is not just using family therapy as a treatment modality. It is a meta viewpoint from which every treatment decision is made, taking into consideration that family relationships and family beliefs about the illness together constitute the most powerful force in illness management and recovery.[25–27] Integrated care is more than jointly conceptualizing physical and psychological issues. Integration in this model involves the coordination of all modalities of care through communication across providers and the provision of a common message about illness and treatment to patients and families.

Symptoms in Family-Based Cognitive Relational Context

The graph is a constant reminder to trainees that symptoms must be placed in a family-based cognitive, relational context. Although we have used the graph as a teaching tool with naive groups as an introduction to family systems thinking, as we did in the first weeks of fellowship training, our trainees come to appreciate complexity in family organization by coming back to the graph over and over, with new understanding as they see more families in treatment.

Trainees come to see that the expression of the symptom or presenting problem, which is not even included on the graph, is deeply affected by where a family is plotted on the 2 dimensions.

They come to see that a focus on symptoms/illness outside of the multidimensional context represented by the graph has the potential to grant the illness more power over the patient and family's life rather than less. An example of this common to child psychiatric practice is the process of decision making around suicidality and level of care. There are situations in which context dictates that, even when suicidality is intense, the most therapeutic option is for a patient to remain home surrounded by family support. Meanwhile, other situations in which suicidality is less intense but family relationships are less nurturing necessitates an inpatient level of care.

Subjectivity in Observations

There is occasional criticism that a therapist is being judgmental by plotting observed beliefs or relationships; that rating, for example, a certain belief as falling somewhere along a continuum between "distorted/constraining versus accurate/mobilizing." There is an element of judgment involved. However, when a family is asked, "is this belief you just expressed more likely to keep things from getting better or to help you move in new directions," most families agree with the therapist's judgment.

We feel safe to say, and our trainees come to believe this as well, that whatever illness that is causing pain and distress, movement toward accurate illness beliefs and empathic, productive relationships diminish pain and distress for the patient.

Dynamic Beliefs and Relationships

Beliefs and relationships have lives of their own. But they are not static. They respond to life circumstances, new evidence, and even therapeutic interventions. They shift, and so the plotting of an individual or shared belief can change, sometimes in front of our eyes, and the therapist must be constantly able to shift his or her evaluation of what is happening as this is taking place.

We teach trainees to be on the look out for contradictory beliefs within the same family or even within one individual. Such beliefs are not likely to provide aid in problem solving. Likewise, we pay special attention to relationship constellations that push for less versus more empathy. As a trainee comes to know a family better, multiple points can be plotted for beliefs in any given family as is the case for recognizing multiple relationships with varying characteristics.

Evaluating families asking for help for their child in this way has several advantages that become apparent with experience. It inherently generates a feeling in families that someone is listening to them. It allows for a richer discussion between disciplines and smoother transitions across levels of care. It provides a sense of reassurance for both treatment providers and those receiving treatment that we know where we are at any given time in treatment. Taken together, these features result in improved morale, both for the treatment team and for the family. It allows our trainee to step back from the distorted thinking and painful relationships in the therapy room and say, "well at least I know where we are and where we need to go," which can be an incredibly freeing experience.

Understanding where a family is on the graph, understanding the context on at least two dimensions in which symptoms are being expressed, is especially important in one all too common experience in child psychiatry; this is the ability to avoid having patients with a clearly diagnosed illness be discharged with "better controlled symptoms" while little is understood about the context they are returning to at home. These children all too often have exacerbations of symptoms resulting in readmission to the hospital.

Advantages of Family-Based Model to Psychiatrist-Trainee

For trainees, in particular, the FBIC model can help combat an expectable sense of helplessness as well as the tendency to overfocus on symptoms and illness categories rather than on the patient who has the illness. The meta view of "knowing where the family is," even if it is a troubled, painful place, is a relief as it naturally implies a path forward. In addition, although trainees may often feel daunted by the power of any particular illness entity, they can shift to feeling empowered with the understanding that regardless of the severity of the illness they can intervene in the family system in a manner that offers relief while the patient and family live with the illness.

The child fellow and Triple Board trainees trained in this program should be able to use their skills and new way of thinking across the entirety of their child psychiatry practice. We believe the exposure to the FBIC model provides a core belief system to guide treatment decisions across schools of psychotherapy and levels of care. It offers a scaffolding to which they can affix a broad range of interventions that they are adding to their tool kit including evidence-based psychopharmacology and manualized models of cognitive-behavioral therapy (CBT) and dialectical-behavior therapy (DBT). Any of these specific interventions can be mapped onto the patient and family

treatment trajectory as guided by the graph. When anchored to the real context, trainees have a greater sense of competence in making each decision in a therapeutic way across a trajectory of treatment.

By the beginning of the second year of training, our students are ready to assess and make interventions in situations that cause many experienced clinicians to feel challenged and sometimes defeated. We are seeing repeated scenarios such as the ones described here. The process we follow in walking them through the challenging situations is discussed further.

THE TRAINING MODEL: CLINICAL APPLICATIONS

Family Conflict About Treatment Recommendations

Case Vignette

A 9-year-old boy presents for treatment of long-standing hyperactive and impulsive behavior at home and school. He has been diagnosed with attention-deficit hyperactivity disorder (ADHD) in past evaluations and has reportedly had little success to date with either stimulant trials or therapy focused on parental behavior management. In the interview, Mom is focused on finding the right medication, whereas Dad is hopeless that anything will help his out of control son.

The belief axis

In this family, both parents present with different strong beliefs that leave them feeling disempowered in different ways. Mom's overfocus on medication as the complete solution leaves her missing the bigger picture that for children with ADHD the structure and messages provided by their environment are critical to supporting their growth in self-control. Dad's expressed hopelessness reflects his belief that neither his son nor he has any ability to make choices that might lead to control of these overwhelming symptoms. Both parents' beliefs likely predispose them to offer messages to their son that convey both he and they are helpless in the face of symptoms, likely leaving him demoralized and disempowered as well. This belief context is one that provides fertile ground for oppositional behavior patterns and depressive symptoms, common comorbidities with ADHD, to take root and flourish.

The relationship axis

The relationship between the parents in this scenario is characterized by distance and disagreement. This situation likely has led to conflict between them and mixed messages from them to their son. It is also likely that each parent's relationship with their son is characterized by distance and distress, potentially leading him to feel blamed for his symptoms being out of control, promoting anger and further acting out on his part, thereby leading to symptom magnification rather than reduction.

FBIC intervention

The goal in this situation is to generate a shift toward a broader family view of factors that influence the child's behavior, higher joining and lower conflict between parents, and empathic clear messages about taking responsibility from parents to child.

Circular questions that offer a frame to expand beliefs include the following:

- Recently, when the medication for his ADHD was not working, how much of his outbursts do you believe he can control versus not control?

- What percentage of his behavior being under good control feels like it comes from medication versus his own efforts versus your coaching him in calming down?
- As we work together to identify the right medication to help with the part of the ADHD that is out of all of your control, what message do you want your son to get about what you can do to help him with this challenge? What message do you want him to get about what he can do to help?
- Circular questions aimed at addressing distant and unempathic relationships include "When your son's behavior is most out of control, what is the saddest part for him?"
- Mom (or Dad), what does your husband (or wife) most misunderstand about what is hardest for you in parenting your son?
- When the household is under pressure given how out of control things have felt, would your son say it pulls you two closer together to be a team managing things or pushes you apart because of frustration?

This version of interventive interviewing allows the clinician to obtain more detailed information about family beliefs and relationships and introduce expanded beliefs and bridges between family members in an immediately productive way.

The Family Protection Fallacy

Case Vignette

Married parents present to the crisis clinic with their 12-year-old son who has recently been refusing to attend school. He has been irritable and shut down at home. Parents feel helpless and afraid and note "but he has always been such a good student." Mom was recently diagnosed with breast cancer for which she is to begin treatment next week.

The belief axis

At first glance it seems that the parents in this situation may not believe that their son's behavior is connected to the bigger picture of family distress. It is also likely that they believe that shielding him from discussion about Mom's cancer will make it easier for him. Common reasons for children to be shut down in this situation may include a belief that "talking won't make anything better" and that if they share their upset "it will just make my parents more upset and they're already going through a lot."

The relationship axis

Family member's attempts to shield each other from pain by not talking about upsetting topics can lead to more distance between people, which magnifies pain rather than reduces it. Families with strongly empathic connections at baseline are at risk of falling into this family protection fallacy. It is also likely that in this scenario, parent's sensitivity to their son's upset about his mother's condition, although perhaps not discussed, is leading them to back off on usual limits and expectations that would support his school attendance. They might note, "we know he is dealing with so much already."

FBIC intervention

In this scenario, shifting the family's belief about shielding each other from pain by not discussing it to the empowered stance that being together in pain diminishes its destructive force is paramount.

Examples of questions focused on supporting this belief shift include the following:

- What is your Dad worried would happen if he were able to let you know just how upset he is about your mom's cancer diagnosis?
- If your son told you his greatest fear about your cancer what is he worried might happen?

A question focused on shifting relationships to maximize empathy and closeness in such a situation includes multiple versions of the following:

- A large stress like adjusting to a cancer diagnosis can pull families together, push them apart, or both. What would your son/husband/wife/mother/father say is happening with your family?

Embedded within these questions is a normalizing framework that offers a message of respecting the care family members have for each other while encouraging them to rely on that strength most productively in this crisis.

Family Impairment Related to Destructive Affect: Blame

Case Vignette

Married parents bring their 13-year-old daughter for an outpatient evaluation after catching her smoking marijuana. The father is frequently absent from home because of a demanding schedule of work-related travel. The mother blames his lack of presence in the home for his daughter's behavior. Dad openly blames Mom for not being a firm limit setter.

The belief axis

Both parents in this situation are conveying a belief that they are not part of the problem and thereby cannot be a part of the solution. This blame deadlock is thereby profoundly disempowering as it leaves each feeling helpless. Any message they may attempt to give their daughter about her taking responsibility for her behavior is meaningless in this culture of blame. Her belief likely will be that everyone else is to blame except her.

The relationship axis

Blame creates smoke that prevents family members from addressing their own guilt and shame, which most often is what interferes with their ability to take responsibility for their part. Without taking responsibility mobilization is not possible, which can then magnify blame cycles. This dynamic necessarily distances family members from each other, leaving them alone and defensive rather than connected and able to address their vulnerabilities.

FBIC intervention

In this common scenario, conversation that supports each family member shifting from blaming others to taking responsibility for his or her own contribution to the crisis at hand is the key. That belief shift can lead to stronger parent joining and clearer messages to children. Such a shift can allow family members to feel better about themselves and each other, generating healthier relationships.

Two versions of a core question aimed at supporting this belief and relationship shift are as follows:

- "As much as you blame your husband's lack of availability for your daughter's self-destructive behavior, what is the piece you are most faulting yourself for?"

- "As much as your husband blames your softness with limits for your daughter's self-destructive behavior, what is he most beating himself up for in this situation?"

Although both questions offer a frame to support each person sharing their vulnerability in an effort to become more empowered, the latter delivers more relationship impact by creating a potential bridge between parents while the same theme is explored.

Other examples that bridge to the daughter as well are the following:

- "Does your daughter struggle more with anger at others because she blames them for her current crisis, or more with anger at herself over the situation?"
- "What is the saddest part for your daughter as she sits here and hears the two of you blame each other for her self-destructive behavior?"

The use of questions that support frame shifting as well as bridging between family members is a powerful tool for guiding families out of the nonproductive loop of blame.

Family Impairment Related to Destructive Affect: Anger

Case Vignette

Recently divorced parents of a 16-year-old girl admitted inpatient after a potentially lethal suicide attempt via acetaminophen (Tylenol) overdose present for a family meeting in the inpatient psychiatric unit. The parents expression of intense anger toward each other leaves their daughter in tears and resistant to participating in the discussion.

The belief axis

In situations of unmitigated rage between parents, there is often either tunnel vision or complete blindness limiting their ability to believe that their anger is destructive to their children. The above-mentioned situation also likely has a good dose of counterproductive blame beliefs mixed in as well. This level of destructive anger most often leaves children with the belief that their parents do not care about them.

The relationship axis

Anger pushes other people away. Family members blinded by rage often get further and further apart at times when a sense of connection is desperately needed. Although this intensity of animosity can often lead clinicians to reflexively pull back, leaning in to the underlying issues is an opportunity to bridge family members. Often, there is an underlying fear of loss or actual loss that fuels this intensity of anger.

FBIC intervention

In a family blinded and disempowered by rage, the clinician's goal is to support heightened awareness around the belief that parental animosity and hatred is toxic for children. In addition, the goal is to bring out the underlying loss and sadness that provide fuel for the anger.

Questions aimed at heightening parents' awareness around the impact of their anger on their children include the following:

- "What is the saddest part for your daughter when she sees the two of you ripping into each other the way that you are?"
- "Does your daughter become more angry or sad when she hears the two of you fighting like this?"

The assumption of the daughter's sadness is not in question; rather it is embedded in the question, which serves to join with her while you are directing the question toward the parents.

Questions aimed at addressing the underlying issues limiting connection between family members include the following:

- "As pissed off as you are right now at your ex-wife, what is the part that you are feeling saddest about for your family at this moment?"
- "If the anger between you wasn't so intense how might you be working together right now to support your daughter after her suicide attempt?"

It is critical that discussions in such circumstances acknowledge the real presence and impact of destructive anger and are aimed at joining with all family members around the underlying pain and sadness. In such circumstances, the therapist has a line of vision that the family does not.

Stress-Related Tunnel Vision

Case Vignette

A 16-year-old boy recently diagnosed with type I diabetes presents to the crisis clinic with his mother because of explosive behavior and frequent violation of his curfew. His elevated blood sugars have almost led to medical admission in recent weeks. The teenager reports that "when I'm home my mother is constantly making me check my blood sugar…she is out of control!" This is a single parent household.

The belief axis

It is common in the setting of medical illness like diabetes for parents to have catastrophic thinking about their teenager managing the illness. For example, this Mom might say, "If I let him out of my sight I worry he might die." Meanwhile, teen bravado commonly colors beliefs toward risky denial. This teen might state, "I don't need to check my blood sugar, I can tell what it is by how I feel." A common pattern in families is that the overreactive beliefs of one member can magnify the underreactive beliefs of another.

The relationship axis

Variations in stress responsiveness or lack of understanding each other's perspectives can foster conflict and disconnection in situations in which teamwork is essential. It is common in such scenarios for the normal privacy of teenagers to become magnified into secrecy, which creates distance in relationships, thus removing the protectiveness that is essential in parent-child relationships.

FBIC intervention

The goal here is to generate dialogue that promotes awareness about how extremes of beliefs can limit mobilization. In addition, the focus is on discussion of the inadvertent distance that differential coping with crisis can generate.

The following are examples of questions aimed at less constraining and more realistic beliefs:

- "For some people understanding how serious diabetes can be can be mobilizing and lead to action while for others it can be overwhelming to a point that they can become paralyzed. Sometimes it can be both. What would your son/mother say is happening for you?"

- "As much as your mother worries how you handle your diabetes when you are out on your own, what part does she trust you most with?"
- "As much as your son can tend to blow off caring for his diabetes, and sometimes pretend like he doesn't have it, what part scares him the most?"

Discussion aimed at relationship valence in this situation might include questions such as the following:

- "Does the fact that your son knows how scared you are about him dying from his diabetes make it more or less likely that he is comfortable asking for your help with it day to day?"
- "If I asked your mother whether the stress of diabetes was more pulling you two together or pushing you apart or both, what would she say?"

Even when people seem to have extreme beliefs, they can often appreciate or understand a conflicting belief in someone with whom they are close. Making room for this in discussions with families can allow them to feel more connected even when some disagreement persists.

THE TRAINING MODEL: EVALUATING THE LONG-TERM OUTCOME

The Brown Family Therapy Training Program functioned consistently from 1998 to 2013. In preparation for this publication, we wanted to learn the effect the training had on the trainees now out in the real world. To accomplish this, we collaborated with The Brown University Child Psychiatry and Triple Board Residency Training Director in conducting a survey distributed via e-mail in June 2014. The survey was distributed to N = 126 graduates of the Brown Child Psychiatry and Triple Board Residency Programs. Contact information was not available for a small proportion of trainees (N = 10) who were not included in the survey. Of those surveyed, there was a 91% response rate (N = 115) (**Table 1**).

Given the high response rate and acceptable distribution, the data are considered to be a valid representation of opinions for graduates of the Brown Training Program during this period.

The respondents represent a broad range of practice settings and modalities of practice (**Tables 2** and **3**).

Respondent practicing with a range of treatment modalities and roles is typical in current child psychiatric practice.

Questions about the utility of their family therapy training yielded consistently high ratings across respondents (**Table 4**).

Most of those who responded to the training survey considered their family therapy training to be useful in their professional life. This data serves to support the idea that FBIC 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.

Table 1
Respondents to the Brown 2014 Training Impact Survey

Response Rate	91% (N = 115)
Child Psychiatry Residency Graduates	57% (N = 66)
Triple Board Residency Graduates	43% (N = 39)

Table 2
Practice settings of survey respondents

Full-time practice	67.9%
Academic affiliation	37.9%
Hospital based	43.2%
Community based	20.7%
Private practice	25.9%
Inpatient	27.6%
Outpatient	50%
Partial programs	15.5%

Table 3
Practice modalities of survey respondents

Pharmacologic treatment	91.4%
Individual therapy	67.2%
Family therapy	60.3%
Group therapy	13.8%
Pediatric consultation	34.5%
School consultation	20.7%
Administration	44.8%
Teaching	65.5%
Research	29.3%

Table 4
Utility of family systems training to current practice

Experience/Skill	Somewhat Useful (%)	Very Useful (%)	Composite Usefulness (%)
Didactics	20	79	99
Group supervision	25	68	93
Individual supervision	15	85	100
Couples' therapy Didactics/supervision	57	34	91
Joining	27	69	96
Assessment	14	86	100
Circular questioning	25	72	97
Family therapy as primary modality	40	56	96

SUMMARY

Despite the trend toward a decreased emphasis on family therapy training in child psychiatry during the past 2 decades, evidence from a small retrospective survey about a model program at Brown University during the same period demonstrates that training in family assessment and intervention can be integrated into residency and provide skills that are considered highly useful across postgraduate practice settings. Although the lack of a sample of similar data across training programs nationally prevents determination of whether trainees exposed to less robust family-based training feel ill-equipped in practice, the near unanimity of positive response is notable.[1,2,18,23]

The heuristic model of FBIC has the potential to provide a scaffold from which to construct an updated curriculum for child psychiatry residents in training that meets modern challenges. It demonstrates the flexibility to provide a family-based vision that can be incorporated across modalities and levels of care. In addition, the FBIC model may be useful across mental health disciplines as a training paradigm on which a broad range of evidence-based models of intervention can be graphed. Treatment ranging from individually delivered CBT or DBT to parent training to pharmacotherapy all have a place within this broader vision. Knowing where the family is on the FBIC graph can help organize joining, cross-discipline communication, and level-of-care decisions in a manner that may maximize family mobilization and thereby support optimal patient outcomes.

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