INTRODUCTION OF FAMILY THERAPY INTO CHILD PSYCHIATRY TRAINING:

TWO STYLES OF CHANGE

Wells Goodrich, M. D.

Chestnut Lodge

Rockville, Maryland

Prior to 1967, I was based at the National Institute of Mental Health for 15 years, and was involved in psychoanalytically-oriented adult psychiatry, child development studies, and family therapy. During the decade following 1967, I spent five years each at two teaching hospitals in New York City* and at Rochester, New York.** At each of these hospitals, a new family training program was introduced where there had been none previously. Finally, in 1978, I returned to Washington and, for the third time, was asked to introduce family therapy into an ongoing child psychiatry fellowship program at Georgetown University Medical Center. In this paper, I will take the opportunity to reflect upon these three experiences. They illustrate two contrasting styles of introducing family therapy training into training programs in psychiatry, programs which had previously concentrated primarily upon individual diagnosis and therapy.

These two styles of change will be referred to as partial

*This was Montefiore Hospital (Albert Einstein College of Medicine) in Bronx, New York; the period of time was 1968 to 1971 when Morton Reiser, M. D. was Chairman of that Department of Psychiatry.

**The program change discussed here occurred at the University of Rochester Medical Center within the Child and Adolescent Psychiatry Division under my direction and with the active support of the Chairman, Lyman C. Wynne, M.D., Ph.D., and with the assistance of Steven Munson, M.D., Christopher Hodgman, M.D., Roger Shapiro, Ph.D. and Elta Green, M.S.W.
introduction of family therapy versus complete introduction of family therapy. The complete introduction may be contrasted with the partial introduction in the following sense: A complete introduction of family therapy training would mean that, following the change in the program, all patients seen by trainees would routinely have a family diagnostic evaluation and would be considered for possible family therapy. The trainee would continue to receive the traditional training in individual diagnosis and learn indications and considerations for individual therapy. Thus, in the complete form, the students are taught a both-and approach by combining family diagnosis and therapy with individual therapy or with other therapeutic modalities. By contrast, in the partial introduction, family therapy techniques are considered only as a special approach for those few selected cases in which obvious involvement of multiple family members in the individual patient's pathology makes traditional individual treatment clearly unrewarding, if not impossible, and for families in which two or more members are currently symptomatic and in acute need of treatment.

The psychiatric department is not yet ready to employ family diagnosis routinely in every case, nor is family therapy considered equally to individual therapy as a possible routine intervention for all new cases seen in the outpatient clinic or in the hospital.

I should make clear at this point that my own view of these complex choices is that in selected cases, family diagnosis and therapy may have much to add to more traditional psychiatric treatment. The value of the older forms of treatment, such as group therapy, individual therapy, hospital care, psychopharmacology, etc. have, of course, been proven. Therefore, in all three experiences of introducing family therapy for the first time, what I had aimed for was a broadening of the scope of clinical observation, as well as broadening the number and complexity of therapeutic choices available to the staff and to the trainees. This orientation introduces greater complexity into the clinical process. Clinical options and choices involved in treatment planning become apparent, even for situations for which no clear-cut guidelines as yet exist. What I refer to here has to do with criteria for assignment of cases to one or other treatment modalities at a given stage of a particular form of pathology either in the individual and/or in the family. Overall, my impression is that, while a complete introduction of family therapy has a number of advantages from a theoretical point of view and should be the ultimate goal of the program change, the style of starting with partial introduction is administratively easier to manage and is psychologically much less stressful on faculty.

The ultimate decision for change depends largely on the conviction and style of the Chairman of the Department. The rapid changes at Rochester in introducing a much more complete