FAMILY COMMITTEE

A Family Practice Model of Child and Adolescent Psychiatry

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Introduction

My approach to child and adolescent psychiatry, derived from a “family practice model of child psychiatry,” stems from multiple sources including the following:

1) A general practitioner in Ohio (whose name I no longer remember) who insisted the first interview with a new patient include the whole family.

2) Carl Whitaker, M.D., at the University of Wisconsin, who taught that the family was a single biological entity and thus the smallest biological unit constituting a patient. Individuals were described as “fragments” of that entity (Whitaker 1976).

3) Dennis Cantwell, M.D., one of the more prominent child psychiatrists of the latter third of the twentieth century, who often commented with a glimmer in his eye, “Child psychiatrists are fully trained psychiatrists.”

Although my practice has evolved over the years, it includes elements derived from two and a half year’s experience practicing aerospace medicine, four and a half year’s practicing emergency medicine, and thirty-two year’s practicing emergency medicine, four and a half year’s practicing aerospace medicine, four and a half year’s practicing emergency medicine, and thus the smallest biological unit constituting a patient. Individuals were described as “fragments” of that entity (Whitaker 1976).

General Principles

1) Initial interviews with a child and adolescent psychiatrist include all members that would constitute the whole family. Usually, this includes all of the people living together or routinely interacting with each other as well as parents and siblings who live in separate households. It usually is not too difficult to determine who should be present at the first appointment. The expectation does not need to be rigid—just a starting point—but erring larger than smaller (Kramer 2001, 2006).

2) To the extent possible given myriad potential considerations, the psychiatric care of all family members in the treatment situation is the responsibility of the treating child psychiatrist, i.e., the “fully trained psychiatrist.”

3) Just as with family practice medicine, the responsibility does not end with the treatment of the family member initially referred. New episodes of care for family members should be referred to the same child and adolescent psychiatrist, and the treatment unit, i.e., the “whole family,” is then reconvened. Just as in family practice or other primary care specialties, there is a “psychiatric care provider.” Why subdivide the care of a family to multiple psychiatrists and non-physician therapists because of the passage of time or the emergence of other family members needing treatment?

4) When I am asked to see an adult patient as an initial referral, I employ exactly the same family approach to begin the evaluation. I am in position at a later date to provide “family practice psychiatry” for other family members. Since general psychiatry residents have training in child and adolescent psychiatry, and general psychiatrists are often asked to see patients 14 years-of-age and older, it would not be unreasonable to implement a psychiatric family practice model in general psychiatry residency training.

Potential Efficiencies and Quality Multipliers in a Family Practice Approach

1) A more comprehensive family history is obtained for the identified patient because both parents and sometimes a grandparent or two may be present. If only one parent brings a child to the initial interview, the result is typically that the biopsychosocial family history is mostly about one-half of the extended family. I have had many initial interviews with whole families where important extended family history was first learned by both the other parent and the children in that initial interview. (This is a comprehensive biopsychosocial approach.)

2) Multiple aspects of family interactions, including approaches to parenting, can be observed in an environment approximating a normal milieu for the child and other family members. After all, the milieu is more about the relationships than the geographic location. (This is consistent with an ecological approach.)

3) The child’s behavior, including variations contingent on relationships with specific family members, may be observed, which permits a firsthand understanding of the child in his or her natural environment. (This might be called an ethological approach, i.e., the study of behavior in the natural setting.)

4) It is not uncommon that other children in a family also have a psychiatric disorder. To the extent these can be evaluated and managed
within the family practice approach, duplication of service and possible mixed messages may be avoided. A separate, new patient appointment is not needed. The waiting time for a new patient appointment with another psychiatrist is eliminated. A typical situation occurs when a parent is asked to read about a condition, often attention-deficit/hyperactivity disorder, or sometimes an anxiety disorder, and comes back saying that the material not only describes the child but also the parent. Many aspects of the history are already known, including the family, parenting, social, cultural, and medical components, as well as at least a hint of the genetic factors. This adds efficiency, early diagnosis, and a built-in therapeutic alliance. (This is a family practice approach.)

**Conclusion**

Mental health disorders are not randomly distributed amongst families while most health systems in this country operate as though family members were unrelated. The ability to avoid multiple complete evaluations and multiple providers makes evaluation and treatment more efficient and unclogs mental health systems for other patients.

**References**


Dr. Kramer is clinical professor emeritus at the University of Wisconsin School of Medicine and Public Health. He is co-chair, with John Sargent, M.D., of the AACAP Family Committee. Comments on family assessment and intervention are welcome: dakrame1@wisc.edu.