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IN BRIEF REPORT

Mental Health Trainee Facilitation of Sibling Support Groups: Understanding its Influence on Views and Skills of Family-Centered Care

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Abstract

Objectives Prior research suggests family-centered interventions are among the least taught yet most needed skills for practicing psychiatry. In this study, we evaluated whether having mental health trainees lead a sibling support group could serve as a method to promote family-centered care among trainees.

Methods All trainees in psychiatry, psychology, and social work were invited to participate as sibling support group facilitators. Both facilitator and non-facilitator trainees were then surveyed using a questionnaire inquiring about exposure to family-centered care, comfort level in providing family-centered care, attitudes regarding the importance of family-centered care, and desire to provide family-centered care in the future. A second survey was administered to the facilitator trainees to assess their perceptions of the sibling group leader experience.

Results Facilitator trainees reported increased engagement in family-centered activities during training ($p < 0.05$), expressed greater confidence in their family-centered care skills ($p < 0.05$), and reported stronger intentions to practice in a family-centered way ($p < 0.05$). Facilitator trainees were overwhelmingly positive about their experience with the sibling support program and reported it strengthened their commitment to addressing the needs of siblings as a part of family-centered care.

Conclusions Facilitating a sibling support group may be an effective way for mental health trainees to gain skills and confidence in delivering family-centered care. Mental health training programs aiming to imbue trainees with the importance of family-centered care may consider creating opportunities for trainees to facilitate sibling support groups.

Keywords Family-centered mental health care · Sibling support group · Mental health training

Family environment affects the development and relapse of mental illness for patients of all ages [1]. Among pediatric psychiatric patients, family-focused interventions can improve outcomes compared to individual treatments alone [2]. Given the importance of family factors on illness outcomes, the Accreditation Council for Graduate Medical Education has included family involvement and interactions into the core competencies outlined for psychiatric residency training programs [3, 4]. Many training programs address family factors with some level of instruction on family therapy, usually in the form of educational didactics [5]. Training opportunities with families occur on inpatient units, consultation-liaison rotations, and outpatient clinics [4].

Clinicians often cite the importance and overall usefulness of skills gained by working with families during training, but report these are among the least taught skills for practicing

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psychiatry [6–8]. A poll of 31 residents from one program showed that 55% rated "all" of the family-focused training as valuable in their work with individuals. Another poll of 21 residents from a different program found 19 used their family therapy training "extensively," even though 76% worked mainly with individuals [7]. Useful skills included having a "systemic perspective" in patient assessment and formulation, and learning to use the family unit to support patient recovery [7, 8].

Data on trainees' experiences working with siblings of children with mental illness is limited. Little is known about trainees' exposure to siblings in clinical settings and among the studies evaluating sibling interventions and support groups, few discuss the experience of the facilitator. A review by Tudor and Lerner [9] on the results of sibling support groups for siblings of children with developmental disabilities showed that of 16 studies reviewed, 5 studies did not indicate facilitators' qualifications. Of the 11 studies with provider qualifications, the majority of interventions were led by psychologists or "miscellaneous" staff. Only 3 studies included trainee facilitators in the areas of psychology, psychiatry, and counseling, though none of those studies evaluated the trainee experience. Lobato and Kao [10] used 2 doctoral-level trainees in psychology or psychiatry to facilitate six 90-min support group sessions for youth ages 8–13 years old who had siblings with chronic illnesses or developmental disabilities. Fanos et al. [11] evaluated *The Sibling Center*, including narrative data on the experience of trainees that facilitated 4 individual sessions with siblings of children with chronic or serious illnesses. These trainees described initial concerns with their ability to manage the emotionality of the siblings, but found that their confidence grew and the work was rewarding.

Given the importance of imbuing family-centered care into mental health training and the limited opportunities for participating in family-centered care, we sought to evaluate whether a sibling support group led by psychiatry, psychology, and social work trainees at Cambridge Health Alliance could serve this unmet need. The sibling support group program evaluated in this study, Sibling Support Program: A Family-Centered Mental Health Initiative (formerly known as the Sibling Support Demonstration Project), was developed at the Eunice Kennedy Shriver Center at the University of Massachusetts Medical School and has been described previously by Rubin et al. [12].

This paper evaluates the views of family-centered care among psychiatry, psychology, and social work trainees. It also assesses whether facilitating a sibling support group influenced these views among trainees and whether participation in a sibling support program encouraged trainees to commit to family-centered care practices in the future.

Methods

This study was conducted at a single site, Cambridge Hospital, a community teaching hospital affiliated with Harvard Medical School, and part of Cambridge Health Alliance in Cambridge, Massachusetts. Sibling support groups were facilitated by 1–2 mental health trainees and/or staff employed by Cambridge Health Alliance. The primary activity in the sibling group revolved around discussion questions, adapted from the *Sibshop* curriculum [13]. During this group, siblings have the opportunity to share their stories about growing up with a brother or sister in mental health care and to develop ways to cope with their brother's or sister's illness. Group participants ranged from 5 to 18 years old, and the typical size of a support group was 3 to 4 siblings. Prior to leading groups independently, trainees observed 2 groups where they shadowed senior facilitators. Following each group, facilitators participated in short debrief sessions and had access to clinical supervision from a senior staff psychiatrist on the study team.

As part of a program improvement activity, two different surveys were used to gather data about trainees' experiences in the sibling support program. The Trainee Comparison Survey specifically assessed beliefs and experiences in family-centered care, while the Group Facilitator Survey elicited qualitative descriptions of facilitator trainees' experiences leading groups.

Seventeen facilitator trainees and 82 non-facilitator mental health trainees were contacted by email to electronically complete the Trainee Comparison Survey. Trainees from the following programs were contacted through program-specific listservs: Adult Psychiatry Residency, Child and Adolescent Psychiatry Fellowship, Geriatric Psychiatry Fellowship, Consultation-Liaison Psychiatry Fellowship, Social Work Training Program, Psychology Post-Doctoral Fellowship Program, and Psychology Internship Program. A statement including multiple elements of consent was presented at the beginning of the survey, giving participants an option to not respond. Participants were also informed of the risks and benefits of completing the survey and the measures in place to protect privacy. All survey responses were collected anonymously using SurveyMonkey®.

The Trainee Comparison Survey consisted of 20 questions that assessed trainee experiences in family-centered care during training, comfort level with providing family-centered care, attitudes regarding the importance of family-centered care, and desire to continue providing family-centered care. Questions utilized a combination of Likert scale and yes/no questions. Four questions assessed respondent exposure to working with siblings and families during training. Five questions were adapted from the validated Measure of Beliefs about Participation in Family-Centered Service (MB-FCS) by King and colleagues [14]. These questions employed a

Likert scale to assess beliefs about family-centered philosophy and principles, positive and negative outcomes, personal competencies, and barriers to family-centered care. Four questions assessed views on working with underserved populations after training in a community hospital setting. Three questions directed at non-facilitators clarified why they chose not to participate in the program.

The Group Facilitator Survey was given to all group facilitators separately. This survey covered the experience of trainees after participation in the Sibling Support Program using Likert scale questions gauging how strongly facilitating groups affected their understanding of siblings' needs and their commitment to working with siblings in the future. Additionally, four free response questions asked facilitators what they gained from participating in the program and if they would recommend improvements to it.

Differences between groups were assessed using chi-squared analyses for yes/no questions and two-tailed *t* tests assuming unequal variances for Likert scale responses. Descriptive information provided by trainees were analyzed to identify common themes.

Both surveys were reviewed and approved by the Institutional Review Board at Cambridge Health Alliance. Trainee respondents were informed that both surveys were intended to gather results to help the study team better understand the experience of trainees. Participation was voluntary, and trainees were informed they could stop answering questions at any time. Trainees were informed that responses would be de-identified, and their answers would be kept confidential.

Results

In total, 17 facilitator trainees and 32 non-facilitator trainees answered the survey for response rates of 100% and 39%, respectively. Of the facilitator trainees, 5 were psychiatry residents, 4 were child psychiatry fellows, 2 were social work interns, 1 was a psychology trainee, and 5 identified as "other." Among the non-facilitator trainees, 9 were psychiatry residents, 7 were psychology fellows, 9 were social work interns, 4 were psychology interns, 1 was a child psychiatry fellow, 1 was a psychology practicum trainee, and 1 identified as "other." Respondents were equally split across gender for facilitator trainees, but more non-facilitator trainees identified as female (72%) than male (25%). The majority of respondents in both groups were between the ages of 30–39 (67% and 82%), followed by 20–29 (12% and 28%). The majority of respondents in both groups identified as white non-Hispanic (71% and 81%). The facilitator trainees had slightly more responses from Asian trainees (24% vs 6%) and slightly fewer responses from trainees identifying as Hispanic (6% vs 13%).

Facilitator trainees were statistically more likely to report greater exposure to working with siblings ($p < 0.00001$; Table 1) and to family-centered mental health activities ($p = 0.008$) across their training experiences than non-facilitators. Facilitator trainees also felt more confident in their skills and abilities to work with families compared to non-facilitators ($p < 0.001$; Table 2) and reported stronger intentions to participate in services with a family-centered approach compared to non-facilitators ($p = 0.01$). No significant differences were observed between trainee groups in their future intentions to work in underserved communities or whether they reported feeling overwhelmed by larger social conditions facing patients.

Seventeen facilitator trainees provided additional descriptive data about their experiences through the Group Facilitator Survey: 12 psychiatry residents, 4 psychology trainees, and 1 social work intern. Seventy percent reported learning "a great deal" about the impact of a child's mental illness on siblings. Almost 95% agreed that their participation strengthened commitment to address the needs of siblings. Similarly, almost 95% agreed this was an important part of their clinical experience and suggested it improved their ability to provide quality mental health care for their own patients. All respondents reported resolve to ask about siblings in their role as mental health care professionals.

Through free response, facilitator trainees further characterized the insights they gained. Some spoke directly to the varied experiences and needs of siblings, such as "Siblings of patients in inpatient care need as much attention as patients in the hospital." Another offered the following assessment: "I was surprised to learn how often siblings are given little to no information about what's going on … and how often they are asked not to talk about it with others by parents. It helped me appreciate the need for these groups!" Respondents also discussed how their experiences will influence their future practices: "… I will definitely inquire about siblings of patients and if they are receiving enough support of their own."

Discussion

Through participation as sibling group facilitators, trainees learned firsthand how a child's mental illness affects the whole family, directly addressing the gap in training identified by previous reports [6–8]. The unique focus on siblings allowed participants to gain particular insight into an often-overlooked population. Insights included the high rate of siblings' sense of isolation, the variability of information shared with them

Table 1 Demographics of trainee respondents

		Facilitator Trainees		Non-facilitator Trainees	
		N	%	*N*	%
Current position	Psychiatry resident	5	29.4%	9	28.1%
	Child/adolescent psychiatry fellow	4	23.5%	1	3.1%
	Psychology practicum student	1	5.9%	1	3.1%
	Psychology pre-doctoral intern	0	0.0%	4	12.5%
	Psychology post-doctoral fellows	0	0.0%	7	21.9%
	Social work intern	2	11.8%	9	28.1%
	Staff clinician	1	5.9%	0	0.0%
	Other	4	23.5%	1	3.1%
Gender	Male	8	47.1%	8	25.0%
	Female	9	52.9%	23	71.8%
	Transgender	0	0.0%	1	3.1%
Age	20–29	2	11.8%	9	28.1%
	30–39	14	82.4%	21	65.6%
	40–49	1	5.9%	1	3.1%
	50–59	0	0.0%	1	3.1%
Race/ethnicity[a]	Hispanic/Latino	1	5.9%	4	12.5%
	Asian	4	23.5%	2	6.3%
	Middle Eastern/North African (MENA)	0	0.0%	1	3.1%
	American Indian/Alaskan Native	0	0.0%	1	3.1%
	Native Hawaiian or other Pacific Islander	1	5.9%	0	0.0%
	African American/Black	2	11.8%	3	9.4%
	White	12	70.6%	26	81.3%

[a] Please note that 2 respondents entered multiple responses for the category of race/ethnicity

about the patient, and the frequent instruction from parents to not discuss the situation with others. Facilitators appreciated the need for siblings to have a space to process their feelings among peers with similar lived experiences and resolved to inquire about siblings' well-being in future practice. Future investigations could employ facilitator trainee focus groups to better understand these insights and clarify common themes related to this experience.

Exposure to sibling support groups also resulted in stronger intentions among trainees to provide family-centered mental health care, and facilitators indicated these skills would allow them to provide higher quality care to their patients. This finding echoes previous reports that even practitioners conducting mostly individual work utilize family-centered training and skills extensively in practice [7].

Trainee facilitators had greater confidence in practicing family-centered work compared to non-facilitators (Table 2); these data complement the above-mentioned results of *The Sibling Center* study by Fanos et al. [11], where trainee therapists reported greater confidence in their ability to work with families. It also highlights the opportunity training programs have in bolstering the family-centered skills of their trainees, which are often cited as one of the most useful but least taught skills among mental health trainees [6–8].

Several limitations should be noted with the results of this study. First, not all trainees were required to complete the survey, resulting in low response rates. Second, the comparison between facilitators versus non-facilitators may be limited by selection bias; it is possible that trainees who chose to facilitate the sibling group were more likely to have positive views of and greater skills in family-centered care compared to non-facilitators prior to participating in the Sibling Support Program. A future study design could include pre- and post-participation data to better determine whether it was participation in the sibling group itself that influenced this difference. However, the facilitator experience descriptions provide evidence to suggest that participating in the sibling group program influenced the views of trainee facilitators.

Third, while the majority of trainee facilitators were psychiatry residents, there were comparable numbers of psychiatry, psychology, and social work trainees among the non-facilitators. This potentially confounding variable raises the possibility that the results may be influenced by differences in training program curriculum rather than participation in the sibling group alone.

Table 2 Experiences and beliefs of trainee respondents

	Facilitator trainees		Non-facilitator trainees		Significance
Family-centered mental health experience: experience in family-centered mental health care for facilitator trainees and non-facilitator trainees					
No. and percentage answering affirmatively					
Trainees met with siblings of child/adolescent patients individually or in small groups.	17	100%	4	12.5%	< 0.00001
Trainees heard siblings share their stories about growing up with a brother/sister admitted to the child/adolescent unit.	17	100%	3	9.4%	< 0.00001
Trainees had direct experience helping siblings cope with their brother/sister's illness.	17	100%	5	15.6%	< 0.00001
Trainees participated in activities specifically focused on family-centered mental health care.	15	88.2%	16	50.0%	0.008225
Beliefs on family-centered care and underserved populations: beliefs on family-centered mental health care skills and working with underserved populations for participant trainees and nonparticipant trainees.					
Mean response (1 = strongly disagree, 7 = strongly agree)					
During my training, I increased my understanding of the impact of mental illness on siblings.	6.2		2.6		< 0.00001
I am able to do the things expected of me according to a family-centered approach.	5.4		3.7		0.0007
I am confident that I am able to work with others in a family-centered way.	5.7		4.0		0.0001
I have the skills and abilities needed to participate in a family-centered approach to service.	5.5		4.0		0.001
I intend to participate in services in a family-centered way.	6.1		4.9		0.011
I plan to practice in an underserved area once I am done with my training.	5.9		6.1		0.702
I feel overwhelmed by the larger social conditions that impede the physical and emotional health of my patients and their families.	5.0		5.3		0.548

Lastly, facilitator trainees likely had variable lengths of involvement with the sibling support program, and it is not clear what effect length of participation may have on the results of this study. Future investigations could look at length of participation as a separate variable within the facilitator cohort to address this question.

Mental health training programs have limited opportunities to expose trainees to family-centered interventions. This study offers a unique opportunity for trainees to develop competency and confidence in providing family-centered care by facilitating a sibling support group. The facilitator trainees in this study, who had hands-on practice in delivering family-centered mental health care, had greater confidence in practicing family-centered care, stronger intention to practice family-centered care in the future, and increased exposure to family-centered interventions. This training experience fills an important gap and builds critical skills, which translates into a significant impact on trainees and a meaningful addition to the trainee curriculum. Training programs should consider implementing similar sibling support group programs to address the void in family-centered care opportunities for their trainees.

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Compliance with Ethical Standards

Ethics A statement including multiple elements of consent was presented at the beginning of the survey, giving participants an option to not respond. Participants were also informed of the risks and benefits of completing the survey and the measures in place to protect participant privacy. All survey responses were collected anonymously using SurveyMonkey® to help ensure privacy and confidentiality.

Disclosures On behalf of the authors, the corresponding author states that there is no conflict of interest.

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