Evidence-Based Practices: An Opportunity to Enhance Psychiatric Residency Training

Rachel H. Olfson, MD

Staring back at me through the Zoom interface was a small, thin-faced boy, too nervous and overwhelmed to tell me anything more than his own name and the name of his dog: Cooper. This was the first child therapy case I was assigned as a resident trainee. He was a young adolescent with acute lymphoblastic leukemia. Two years ago, he was outgoing, playful, and sociable. Now he apprehensively stared at me, underweight and highly anxious. He was experiencing medical trauma through countless hospital admissions for chemotherapy and opportunistic infections during the ongoing global pandemic. At the time he was transferred to my care, he carried multiple psychiatric diagnoses, including generalized anxiety disorder, major depressive disorder, and posttraumatic stress disorder. I had no idea where to begin. Though I was in my third year of Triple Board training, which includes adult psychiatry, pediatrics, and child psychiatry fellowship, I felt unprepared. My education and exposure to psychotherapy had been somewhat limited; but even still, I knew that learning effective, evidence-based therapeutic skills would not be straightforward.

This early experience led to some reflections on the role of psychotherapy education in psychiatric residency training, and the divergent views on this topic. Some educators feel that psychotherapy is an integral part of the origins and practice of psychiatry; it distinguishes psychiatry from other fields of medicine. While others view contemporary psychiatry as rooted in the neurobiological understanding of mental disorders as well as expertise in the management of psychopharmacology. Through this lens, psychotherapy may be seen as the domain of other practitioners on the mental health team, such as psychologists and social workers.[1] Nonetheless, psychotherapy is considered a core competency for psychiatrists and an essential treatment modality in the field of practicing child and adolescent psychiatry according to the American Academy of Child and Adolescent Psychiatry (AACAP).[2]

As a psychiatric resident there is a sense of pressure in the time-limited nature of training. There is an emphasis on the importance of mandatory clinical rotations, which are key to clinical practice. Though there are opportunities for longitudinal care of patients, exposure to and instruction around well-researched psychotherapeutic tools, such as evidenced-based practices (EBPs) are limited. In the final year of my training, reflecting on these experiences sparked my interest in learning more about EBPs and how they might be integrated into residency training programs.

EBPs apply empirically supported principles of assessment, intervention, and care. They are typically delivered in a structured or semi-structured approach.[3] Over the past 50 years, a variety of EBPs have been developed through rigorous research for youths struggling with an array of mental and behavioral health challenges, and there is evidence that EBPs outperform usual care.[4]

The demand for child mental health care has become increasingly emergent during the COVID-19 pandemic. In October of 2021, a national emergency in child and adolescent mental health was jointly declared by the American Academy of Pediatrics (AAP), AACAP, and the Children's Hospital Association (CHA).[5] This included advocacy for increased governmental funding for access to "evidence-based mental health screening, diagnosis, and treatment." Thus, there exists a timely opportunity to invest in the integration of EBPs into the education of psychiatric trainees.

A critique of EBPs is that they have not been extensively implemented or studied among ethnically diverse

populations; moreover, there exist disparities in access to quality mental health services for racial/ethnic minority children compared to White peers.[6] Nonetheless, there is some evidence that EBPs are effective and generalizable among a diverse population of children. In a retrospective, multi-year cohort study in youths across 25 community-based outpatient mental health clinics, it was found that EBPs were generally associated with similar improvements across racial/ethnic groups. As assessed by caregiver report scales, Hispanic youths tended to benefit more from EBPs, than treatment without EBPs, and they had similar outcomes to non-Hispanic, White youths.[7]

I was reminded of my complex oncologic patient when I later learned about the Modular Approach to Therapy for Children with Anxiety, Depression, Traumatic Stress or Conduct Problems (MATCH-ADTC).[8] The MATCH program integrates components of widely used EBPs for anxiety, depression, trauma, and conduct problems. Though I did not have the training at the time to employ such tools in his treatment, it led to an interest in learning more about how such a therapeutic modality might be integrated into psychiatric training.

The MATCH program uses a modular approach, as opposed to the standard manual-based approach, and integrates components broadly used in EBPs. As MATCH was designed to combine common, evidence-based elements of treatment for multiple diagnoses, it circumvents the extensive time and monetary investment that would be needed to train providers in multiple EBPs. Thus, it allows the provider to not only treat patients with overlapping diagnoses, but also affords opportunities to address fluctuations in presenting symptoms that may emerge during treatment.

MATCH is efficient. It has been shown to provide youth and families with a quicker rate of improvement, in a shorter duration of care, as well as greater reduction in number of problem areas compared to usual care.[9] It has lasting effects. Research supports that the improvements that resulted from the MATCH modality, compared to usual care, are still present after two years.[10] Furthermore, while the program was designed and tested on children aged 6-15, aspects may be adapted for youth up to age 17.[8] In addition, there is evidence that children treated with MATCH compared to standard care were less likely to be additionally treated with a variety of psychotropic medications.[11]

Though there are a variety of barriers that exist to integrating the use of such an EBP into psychiatric residency training, a pilot study has shown that such training is not only possible, but also in line with Practice-Based Learning and Improvement (PBLI), competencies required by Accreditation Council for Graduate Medical Education (ACGME). This pilot involved 12 child psychiatry trainees receiving training, supervision, and delivering Managing and Adapting Practice (MAP), which is similar to MATCH, in a year-long outpatient teaching clinic.[12]

Preliminary findings supported that trainee use of MAP provided useful tools and structures that addressed the core components of PBLI in child psychiatry training. Nonetheless, even in a pilot form, there existed a notable investment in time and resources, such as 5 full days of fellow training, existing experienced supervisors, and further trainee protected time and resources in ongoing support of implementing MAP.

Patients such as my first child therapy case continue to teach me that the practice of psychiatry, and particularly psychotherapeutic techniques, are an exercise in life-long learning. Though it is not clear exactly how EBPs can be effectively integrated into psychiatric training programs, it is worth considering how impactful such an investment could be. With a national shortage of mental health providers, each trained child and adolescent psychiatrist represents an opportunity to help multiple children, not just as a direct provider, but also as a mental health team leader. Even though many child psychiatrists may not go on to regularly practice psychotherapy, it is important that their training provides them with tools to understand, support and collaborate with practitioners who use evidence-based practices, especially in a time of such growing need for child mental health care.

References

1. Fefergrad M, Mulsant B. Psychotherapy training in a competency-based medical education psychiatry residency: a proposal for a practical and socially responsible model. *Can J Psychiatry*. 2022;67(6):423-427. https://doi.org/10.1177/07067437211063096
2. Aacap.org. *Psychotherapy as a Core Competence of Child and Adolescent Psychiatrist.* 2022. Accessed August 30, 2022. https://www.aacap.org/AACAP//Policy_Statements/2014/Psychotherapy_as_a_Core_Competence_of_Child_and_Adolescent_Psychiatrist.aspx
3. APA. Policy Statement on Evidence-Based Practice in Psychology. *American Psychological Association*, American Psychological Association, https://www.apa.org/practice/guidelines/evidence-based-statement.
4. Weisz, John R., et al. Performance of Evidence-Based Youth Psychotherapies Compared with Usual Clinical Care. *JAMA Psychiatry*, vol. 70, no. 7, 2013, p. 750., https://doi.org/10.1001/jamapsychiatry.2013.1176
5. American Academy of Pediatrics. AAP-AACAP-CHA Declaration of a National Emergency in Child and Adolescent Mental Health. Updated October 19, 2021. Accessed August 31, 2022. https://www.aap.org/en/advocacy/child-and-adolescent-healthy-mental-development/aap-aacap-cha-declaration-of-a-national-emergency-in-child-and-adolescent-mental-health/
6. Alegria M, Vallas M, Pumariega AJ. Racial and Ethnic Disparities in Pediatric Mental Health. *Child and Adolescent Psychiatric Clinics of North America*. 2010;19(4):759-774. https://doi.org/10.1016/j.chc.2010.07.001
7. Lang JM, Lee P, Connell CM, Marshall T, Vanderploeg JJ. Outcomes, evidence-based treatments, and disparities in a statewide outpatient children's behavioral health system. *Children and Youth Services Review*. 2021;120:105-729. https://doi.org/10.1016/j.childyouth.2020.105729
8. Judge Baker Children's Center. The Modular Approach to Therapy for Children (MATCH) with Anxiety, Depression, Traumatic Stress, or Conduct Problems. Updated 2015.
9. Weisz JR. Testing Standard and Modular Designs for Psychotherapy Treating Depression, Anxiety, and Conduct Problems in Youth. *Archives of General Psychiatry*. 2012;69(3):274. https://doi.org/10.1001/archgenpsychiatry.2011.147
10. Chorpita BF, Weisz JR, Daleiden EL, *et al.* Long-term outcomes for the Child STEPs randomized effectiveness trial: A comparison of modular and standard treatment designs with usual care. *Journal of Consulting and Clinical Psychology*. 2013;81(6):999-1009. https://doi.org/10.1037/a0034200
11. Chorpita BF, Daleiden EL, Park AL, *et al*. Child steps in California: a cluster randomized effectiveness trial comparing modular treatment with community implemented treatment for youth with anxiety, depression, conduct problems, or traumatic stress. *Journal of Consulting and Clinical Psychology* 2017;85(1):13-25. https://doi.org/10.1037/ccp0000133
12. Kataoka SH, Podell JL, Zima BT, Best K, Sidhu S, Jura MB. map as a model for practice-based learning and improvement in child psychiatry training. J*ournal of Clinical Child & Adolescent Psychology.* 2013;43(2):312-322. https://doi.org/10.1080/15374416.2013.848773

Take Home Summary

Evidence-based practices (EBPs) represent therapeutic approaches that apply empirically supported principles of assessment, intervention, and care for youths. Though a variety of barriers exist, there are also notable potential benefits of integrating EBPs into child and adolescent psychiatric training programs.

About the Authors

Rachel Olfson, MD, is a child and adolescent psychiatrist with Bradley Hospital's outpatient services team and the Intensive Program for Obsessive Compulsive Disorder and Related Disorders. She is a clinical instructor in Brown University's Department of Psychiatry and Human Behavior. She completed training through the Triple Board Program at Tufts Medical Center in Boston, MA, and served as chief resident during her final year.

The author has reported no funding for this work.

The author would like to extend a special thank you for support from Christopher Bellonci, MD, Matthew Pecoraro, MSW, and the Judge Baker Center for Children and Families.

Disclosure: Dr. Olfson has reported no biomedical financial interests or potential conflicts of interest.

Correspondence to Rachel H. Olfson, MD; e-mail: **ROlfson@Lifespan.org**

This article was edited by Duy Nguyen, MD.