

Report of the Psychotherapy Task Force of the American Academy of Child and Adolescent Psychiatry

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In this task force report, the authors define the field of child and adolescent psychotherapy; review the state of the field with respect to advocacy, training, research, and clinical practice; and recommend steps to ensure that psychotherapy remains a core competence of child and adolescent psychiatrists.

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[In recent years, as with adult psychiatry, there has been increasing discussion about the role of psychotherapy in the treatment of psychiatric disorders in children and adolescents. This discussion has been further complicated by the influence of the shift to a managed care delivery system. Managed care programs, as is well known, often confine reimbursement for child and adolescent psychiatrists to pharmacologic management. Because this issue is of such critical importance for ensuring a high quality of psychiatric care for children and adolescents, the editors feel it is important to publish the policy developed by the American Academy of Child and Adolescent Psychiatry regarding the role of psychotherapy in treating this patient population. We believe you will find this report enlightening and useful.]

—Allan Tasman, M.D., Deputy Editor

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In May 1997, the Task Force on Psychotherapy was formed to determine the value of psychotherapy to the profession of child and adolescent psychiatry and to make recommendations regarding psychotherapy's contribution to and place within child and adolescent psychiatry. The Task Force studied these matters and has prepared a policy statement, "Psychotherapy as a Core Competence of Child and Adolescent Psychiatrists" (Appendix A), which we urge the Council [of the American Academy of Child and Adolescent Psychiatry (AACAP)] to approve.

Council approval of the policy statement will send a clear message of support for psychotherapy as an essential component of the child and adolescent psychiatrist's scope of practice. This message is intended to inform licensing and credentialing organizations and the medical, mental health, child welfare, and educational communities of the breadth of our training and practice. Further, this statement guides Academy components as they undertake their charges.

The Task Force began its work by reviewing the efforts already made by the Academy to enhance psychotherapy. Over a period of years, the Academy has initiated specific programs to advance research and training in psychotherapy. Most notably, in 1996 the Academy created the Psychotherapy Award for the best paper on psychotherapy to appear in the *Journal of the American Academy of Child and Adolescent Psychiatry*. The award has bestowed needed recognition on several researchers, but the volume of psychotherapy papers submitted to the Journal has remained low. Additionally, a two-year psychotherapy training institute for early career child and adolescent psychiatrists was offered in New York City. Although deemed a success by the participants, the program has not been offered again in New York or elsewhere.

Psychotherapy is promoted through a number of Academy activities. The Annual Review course devotes one-fifth of its time to inpatient treatment, residential treatment, individual psychotherapy, cognitive-behavioral therapies, family therapy, and group therapy. Several "Facts for Families" pamphlets offer the public information on psychotherapy. Yet in many Academy endeavors, psychotherapy seems to be fading from view. No recent Midyear Institute or Research Forum has been devoted to psychotherapy. In the recently published "Reviews in Child and Adolescent Psychiatry,"¹ psychotherapy is not indexed as such. No specific psychotherapies (not even cognitive-behavioral therapy, which is specifically and

consistently identified in the articles by name) are indexed. On the other hand, there are 49 indexed entries of medications by name or class of drug. Although the way in which psychotherapy has slipped into the background of many Academy products and projects is subtle and inadvertent, the impact has been significant and demoralizing to some of the membership. . . .

[The authors request that AACAP create and provide support for a combined Task Force/Committee on Psychotherapy, subject to reassessment after five years.]

ADVOCACY FOR CHILD AND ADOLESCENT PSYCHOTHERAPY

The Task Force chose to construe the meaning of "psychotherapy" broadly. There has colloquially been a tendency to use "psychotherapy" narrowly as synonymous with "psychodynamic" or "psychoanalytic" psychotherapy. This Task Force feels that it is important that the Academy not view psychotherapy in this way. Further, there has been a tendency to use the term "psychosocial intervention" as a synonym for psychotherapy. Such usage obscures the recognition of the psychotherapies as a set of psychosocial interventions with distinguishing characteristics. Roth and Fonagy,² drawing on the work of Strupp, identify three defining characteristics of psychotherapy:

1. The presence of a therapist-patient relationship.
2. The interpersonal context of the psychotherapies.
3. Implied by the notion of training and professionalism, the sense that therapies are conducted according to a model that guides the therapist's actions.

Psychotherapies are defined in part by their setting and in part by the presence of an explicit model of psychopathology, which in turn generates procedures for relieving distress.²

Where these authors refer to "explicit model of psychopathology," other authors include models of "internal psychological processes [that] mediate between the social environment and the child's emotional experience and behavior" (Shirk and Russell,³ p. 9) or models of psychological development.

Confusion in the use of the term "psychotherapy" results from the large number of different interventions (in one study as many as 400) that can be labeled psychotherapy, even when these three characteristics are

considered. However, this problem can be resolved by grouping the psychotherapies into classes by their orientation to any one of the three factors. Most often, a theoretical model is used to classify psychotherapies, although we are all familiar with grouping "therapies" by the interpersonal context (e.g., individual, group, or family). Roth and Fonagy² chose the following major classes, although they were not looking specifically at treatment of children and adolescents when they selected them:

- Psychodynamic psychotherapy.
- Behavioral and cognitive-behavioral psychotherapy.
- Interpersonal psychotherapy.
- Strategic or systemic psychotherapies.
- Supportive and experiential psychotherapies.
- Group therapies.

The Task Force recommends that we develop and present for Council approval a nomenclature for classifying child psychotherapies that could provide consistency of definition of the psychotherapies for Academy endeavors. Optimally, the editorial board of the Journal and the Work Groups on Training and Research would provide input, to obtain categories that would be useful in all contexts of the Academy's endeavors. This would facilitate consistency in the indexing of the psychotherapies in Academy publications such as the *Proceedings of the Annual Meeting*.

TRAINING

The appointment of John Sargent, M.D., Chair of the Work Group on Training, to our Task Force greatly facilitated exploration of the difficulties facing child and adolescent psychiatry training programs and, specifically, the impact of these on psychotherapy training. The continuing education of child and adolescent psychiatrists after the completion of their mandate is a prime function of the Academy that we explore in terms of the successes and difficulties facing continuing education in psychotherapy theory and technique.

Child psychiatry residents are faced with the challenge of securing a well-rounded education during a time when mental health care delivery is rapidly changing. Market forces, political forces, and the explosion of novel psychopharmacologic treatments have threatened the training of child psychiatry residents as competent psychotherapists. However, specific problems were identified that contribute to the current crisis in psychotherapy

training for residents.

Psychiatric educators have not yet developed a consensus on objective criteria for determining levels of trainee competence in the psychotherapies. The Psychotherapy Task Force of the American Association of Directors of Psychiatric Residency Training (AADPRT) has initiated a survey of psychotherapy educators intending to establish a consensus regarding skills in individual psychodynamic therapy to be expected of all general psychiatry residents upon completion of training. Similarly, there are no uniform standards for training or evaluating the competence of psychotherapy supervisors.

Overall, there is a lack of consistency in the psychotherapy education being offered in residency programs around the country. This inconsistency is seen both in the teaching of theory and the teaching of therapeutic skills.

The allocation of time to psychotherapy training is felt by both trainees and educators to be inadequate. In child and adolescent psychiatry, psychotherapy training is usually where trainees learn to adjust their approach to the patient to the developmental level of the child. The situation is exacerbated further by inadequate financial resources on the part of patients and of training institutions to support long-term therapy cases. A concern particular to child psychiatry is that deficiencies in exposure to long-term cases detract from the trainee's opportunity to observe developmental processes unfolding and to observe the interplay of development and therapy.

It is the impression of the Work Group on Training and the Task Force that these inadequacies in resident education in psychotherapy contribute to the decreased pass rates on both the general and child psychiatry boards. A similar conclusion has been drawn in the 1995 and 1996 "Reports on the Oral Examinations in Psychiatry" of the Royal College of Physicians and Surgeons of Canada, which states, "There is a sense that candidates have had inadequate experience with sufficient numbers of patients over a long enough period of time for them to be comfortable in the future role as a consultant/clinician" (E. Sperling, personal communication).

The Task Force recommends that the Council direct the Psychotherapy Task Force/Committee and the Work Group on Training to develop programs to address these difficulties. Cooperation with AADPRT and the Society of Professors of Psychiatry would be expected. Possible approaches could include the following:

- Developing a resource document establishing minimal and optimal time standards for training programs in psychotherapy and a means for evaluating competence of trainees and supervisors.
- Offering didactic workshops for educators and supervisors, including how to teach psychotherapy skills within rotations that emphasize assessment and psychopharmacology.
- Developing financial supports for long-term psychotherapy training cases.
- Writing psychotherapy questions for the Psychiatry Residency In-Training Examination (PRITE).
- Studying the reasons for the continued decrease in the pass rate on the child boards.

The provision of continuing medical education to its members is a major function of the Academy. The Task Force was not able to determine how widespread was the desire for more continuing education in psychotherapy or what format or topics the membership would find most appealing and useful. We propose to develop questions for the membership survey on the dues statement to clarify these points.

RESEARCH

Psychotherapy cannot remain a core competence of child and adolescent psychiatrists without a vital, growing research base. A medical discipline rapidly becomes a reflection of its research base. In this time of idealization of “evidence-based practice,”⁴ this transformation occurs even more rapidly than in times past. Not only has the vitality of research in psychotherapy been flagging, but the research that is being done is not done by child and adolescent psychiatrists.

Additionally, because child psychotherapy research is done by allied professions, it does not appear in the child and adolescent psychiatry literature.

It is easier to observe the lack of research in child psychotherapy than to identify all the factors that have contributed to the withering of psychotherapy research, which was flourishing several decades ago. The Task Force considers three factors—lack of financial support, lack of professional support, and an uncongenial paradigm shift in psychiatry that was ushered in with DSM-III⁵—to be at least part of the problem.

Whereas there is considerable support from pharmaceutical companies for research in drug therapies and the Food and Drug Administration and National Institute

of Mental Health (NIMH) are moving to ensure that this support extends to research in the use of psychopharmacologic agents in children, there is no large corporate interest in research and development of psychotherapy. In addition, psychotherapy research is methodologically complex and has a longer timeframe of study compared with other branches of psychiatric research. Methodological complexity means that there is a significant expense involved in developing research proposals, as well as in carrying them out and analyzing the data. This expense in the development of proposals may account in part for the dearth of applications for grant money even when it is available.

The Academy tried to remedy some of the lack of professional support for psychotherapy research with its creation of the Psychotherapy Award. We are unaware of any training programs that teach methods of psychotherapy research, and experience in psychotherapy research does not appear to be considered necessary for a successful career in child and adolescent psychiatry. By comparison, in allied fields, research in psychotherapy may be a graduation requirement. Institutional support for psychotherapy research by child and adolescent psychiatrists is limited and poorly coordinated.

Beginning with DSM-III, psychiatric research, including child and adolescent psychiatric research, has become focused on addressing problems on a symptom level rather than at the level of underlying pathogenic mechanisms.³ Cohen⁶ notes, “Child psychiatrists are now burdened by the success of the DSM approach to diagnosis, in which specific symptoms are used to specify discrete disorders” (p. 2). Theories of child and adolescent psychotherapy are closely tied to etiological models and conceptualizations of underlying pathogenic processes. The research base for child and adolescent psychotherapy is largely in the study of normal development and aberrations in developmental pathways. As psychiatric researchers and those who support psychiatric research embraced the DSM system, they moved away from developing the questions and methodologies needed to examine the effectiveness of child psychotherapy and expand psychotherapeutic technique. Psychotherapy research has been hampered by an emphasis on a categorical diagnostic framework and a lack of focus on studies of risk and resiliency, longitudinal studies, studies of developmental psychopathology, and examination of outcome by assessment of function rather than symptomatology.

The Academy can play an important role in coordinating the efforts needed to revitalize psychotherapy research by child and adolescent psychiatrists and to bring current and future psychotherapy research findings to the attention of its members. The Psychotherapy Task Force/Committee, working closely with the Work Group on Research, the editors of the Journal, and the Program Committee, can develop programs, articles, and presentations to further psychotherapy research. A cooperative effort such as this is best done with clear support and encouragement from the Council and officers. Additionally, the President and President-elect should consider, when making appointments to these components, selecting an appropriate individual who can be a point person within each of these three bodies for advancing psychotherapy research and can serve as liaison with the Psychotherapy Task Force/Committee. For example, winners of the Psychotherapy Award could provide a pool of candidates for appointment to the Work Group on Research.

The Psychotherapy Task Force/Committee, in order to address the need to build consensus across different professional groups to support further psychotherapy research and inclusion of psychodynamic perspectives in child and adolescent psychiatric research, recommends that we initiate a meeting with Peter Jensen, M.D., of NIMH, and then—based on consultation with him, members of the Academy staff, and the Work Group on Research—meet with Deborah Zarin, M.D., of the APA and with representatives of the major allied mental health organizations to draw attention to this issue.

Additionally or alternatively, the Academy could undertake an initiative aimed directly at generating researchers and research programs in child and adolescent psychotherapy by establishing an “incubator program” for child and adolescent psychiatrist psychotherapy researchers. Funds would be sought to set up a two-year (possibly ongoing) program for five to seven researchers to develop an ongoing plan for psychotherapy research as well as individual research projects. Researchers from other disciplines who can present relevant new methodologies could be brought to these meetings. Special consideration might be given to play therapy, which is widely performed and little studied. If the Council approved of the thrust of this initiative, we would proceed to work with the Work Group on Research and the AACAP Research Department to develop specific proposals and determine their cost. Alternatively, the Academy might develop and fund a postgraduate fellowship in psychotherapy research.

We recommend that the Psychotherapy Task Force/Committee work closely with the editors and editorial board of the Journal to encourage submission of appropriate psychotherapy articles for the Journal, including recertification reviews, clinical perspectives, research reviews, and seminal articles, in addition to reports of research studies.

The Task Force is currently working to pull together a bibliography on child and adolescent psychotherapy research that can be made available to members through the Academy web page. An author is being sought to write a summary paper of the current state of child psychotherapy research.

An important function of the Psychotherapy Committee has been preparing programs for the AACAP Annual Meeting. At present, work is going forward to develop a Research Forum on Psychotherapy Research. In conjunction with the Work Group on Quality Issues, a symposium on treatments for depression was submitted. Development of Special Interest Study Groups in child psychotherapy is under consideration. In summary, the Journal, the newsletter, the web site, and the annual meeting each offer an avenue to bring psychotherapy research to the attention of the membership.

CLINICAL AFFAIRS

The Task Force attempted to clarify circumstances in the current turmoil in the health care system that may specifically affect the vitality of psychotherapy practice for child and adolescent psychiatrists. Richard Rubin, M.D., from the Work Group on Healthcare Reform and Financing, met with the Task Force and assisted greatly in focusing this process and delineating realistic interventions.

One problem faced by child and adolescent psychiatrists is an assumption that clinicians other than psychiatrists are typically providers of psychotherapy and that such providers are less expensive. The shortage of child and adolescent psychiatrists, rather than improving our leverage in the psychotherapy marketplace, actually at present undermines psychotherapy practice because the child psychiatrist's time is at a premium for providing medication.

There is significant pressure from the National Committee on Quality Assurance (NCQA) for managed care organizations to establish credentialing for their providers. There is considerable confusion among the public and practitioners regarding the training that child

psychotherapists in different disciplines have received. The Academy can serve a valuable function by bringing the disciplines together to clarify training standards. The Task Force/Committee could liaison with other professional organizations to this end. The Work Group on Healthcare Reform and Financing could work toward an NCQA set of credentialing standards specific to psychotherapy with children and adolescents.

The Academy is in the process of developing outcome measures and a clearer understanding of what we do as a profession through the Task Force on Outcomes Research. The Psychotherapy Task Force/Committee could provide consultation to this Task Force to aid them in adequately assessing our members' practice of psychotherapy. Development of a model that members could use in their practices for collecting outcome data on child psychotherapy treatments is possibly a project for the Task Force on Outcomes Research and the Private Practice Committee, with the Psychotherapy Task Force/Committee and the Work Group on Healthcare Reform and Financing providing consultation.

An issue that is ripe for study from both a cost and a clinical effectiveness perspective is the provision of combined medication and psychotherapy treatment by one practitioner or split treatment with different clinicians providing psychotherapy and medication management. The relative undersupply of child and adolescent psychiatrists ensures that some split treatment is unavoidable. Advocacy by the Academy through its members, its leadership, and its Work Group on Healthcare Reform and Financing for adequate time for evaluation and for work with both the parent and the child when prescribing medication will also help make combining therapy and medication management more cost-effective.

The practice of psychotherapy with children and adolescents and the attendant work with parents and educators requires both training and the outlay of time that is not the same as that in work with adults. The Academy should develop guidelines for mental health benefit packages for children and adolescents. In the short term, the Academy should promote, as a standard for quality in managed care and point of service plans, a clear separation in the description and administration of child and adolescent mental health benefits from adult mental health benefits.

Interactive psychotherapy is a medical procedure

that our members are uniquely qualified to provide. It is rated in the Resource-Based Relative Value Scale for greater reimbursement than standard psychotherapy because of both the training and the supplies required. It is unrealistic to expect individual members to begin using this code when they are uncertain of its reception by the insurance companies. Use of the code would draw attention to the need for specific treatments for children and would facilitate tracking this procedure for outcome studies. The Task Force/Committee would like to engage the Codes and Reimbursement Committee to work with major insurers or employers to support use of this code by our members. Then an educational campaign could be begun with target Regional Councils. Follow-up could be provided through the Managed Care Complaint Service.

The Academy was prescient in the development of practice parameters, which are now much in demand as organizations like NCQA press for standards for care. The Task Force/Committee could be an ongoing resource to the Work Group on Quality Issues as they develop these parameters. Particularly challenging for this group has been the integration of clinical consensus into the current research data. One of the inadvertent ways in which psychotherapy has been undermined is the time horizon chosen for research reviews for development of the parameters. Because research in psychiatry took a dramatic turn in the 1980s, research reviews that go back only 10 or 15 years neglect the bulk of psychotherapy research and clinical literature that still informs clinical practice. The Task Force/Committee has worked to provide a counterbalance.

CONCLUSION

The profession of the child and adolescent psychiatrist in the United States is at a critical juncture. Forces within and without are drawing into question our role in the care of America's children and our scope of practice. It is the conclusion of the Task Force on Psychotherapy that psychotherapy is and must remain a core competence of child and adolescent psychiatrists. We have determined that there is a pressing need for the Academy to actively support and promote the continued development of psychotherapy as a core competence and function of child and adolescent psychiatrists committed to a biopsychosocial and developmental approach to the mental health of children and adolescents.

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[Appendix A begins on page 100.]

APPENDIX A. American Academy of Child and Adolescent Psychiatry: policy statement on psychotherapy as a core competence of child and adolescent psychiatrists

Policy Statement:
 Psychotherapy as a Core Competence of
 Child and Adolescent Psychiatrists

Approved by Council June 27, 1998

Psychotherapy is and must remain a core skill and central to the practice of child and adolescent psychiatry. The psychotherapies¹ remain essential treatment modalities for children's cognitive, emotional and behavioral problems. Additionally, psychotherapy knowledge and skills inform all psychiatric clinical activities, including diagnostic assessment, pharmacotherapy, and consultation to agencies, schools, and other physicians, as well as collaboration with and supervision of staff and trainees. Child and adolescent psychiatrists are trained to differentiate the presentation and treatment of other medical illnesses from psychiatric and developmental disorders, including psychological factors affecting somatic complaints, and to integrate psychotherapeutic with biological and social interventions. Child and adolescent psychiatrists, by the nature of their training, inextricably combine the skills, knowledge, and mind set of physician and psychotherapist.

Psychotherapy is not a skill that is learned and then either "used" or "not used." Psychotherapy concepts, including psychodynamic concepts, should be an integral part of the thinking of the psychiatrist in all endeavors, including medication management. The ability consistently to incorporate psychodynamic principles and psychotherapeutic techniques in the physician-patient interaction is one of the skills that differentiates the child and adolescent psychiatrist from the pediatrician or other physician. Similarly, the ability to incorporate a knowledge of biology, physiology, pathology, and the various domains of medicine into these interactions differentiates child and adolescent psychiatrists from other mental health professionals.

¹"The psychotherapies" refers broadly to the many established schools of psychotherapy, including but not limited to psychodynamic psychotherapies, psychoanalysis, behavioral and cognitive therapies, family therapies, and group therapies.

Supporting Documentation for the
 Policy Statement

AACAP Psychotherapy Task Force, June 1998

We are at a significant juncture, a time to reassert the scope of practice of child and adolescent psychiatry. We find this need compelling and imperative. Our field is threatened by the political and economic forces in our current environment and by tensions between the drive to understand the brain in this "decade of the brain" and the tendency in so doing to de-emphasize the psychological understanding of the mind. These tensions affect all aspects of child and adolescent psychiatry: clinical practice, training, and research. The Academy has previously delineated the responsibilities and scope of practice of the child and adolescent psychiatrist (AACAP, 1995):

The child and adolescent psychiatrist . . . specializes in the diagnosis and treatment of disorders of thinking, feeling or behavior. . . . [After] a comprehensive diagnostic examination . . . with attention to [the] physical, genetic, developmental, emotional, cognitive, educational, family, peer and social components, arriving at a diagnosis and diagnostic formulation. . . . The child and adolescent psychiatrist then designs a treatment plan which considers all the components. . . . An integrated approach may involve . . . psychotherapy; medication; or consultation with other physicians or professionals from schools, juvenile courts, social agencies or other community organizations

In response to statements made regarding the scope of the practice of child and adolescent psychiatry (Certification Committee, 1997), we must clarify that "developmental" includes the appreciation of temperament and maturational factors on each of the components delineated above (Cohen, 1993). Similarly, "emotional" involves the person's psychological makeup, including means of coping with various stressors. Children come for treatment with wide ranging symptomatology influenced by complex variables, often involving comorbidity. They are frequently involved in several social systems, including the family, school, and community agencies. We recognize that the DSM-IV does not completely describe the range of disorders experienced by

APPENDIX A. American Academy of Child and Adolescent Psychiatry: policy statement on psychotherapy as a core competence of child and adolescent psychiatrists (continued)

children. The Classification of Child and Adolescent Mental Diagnoses in Primary Care (AAP, 1996) is more comprehensive, including risk and resiliency factors as well as the impact of the family on the child or adolescent. As such, it better approaches the scope of the differential diagnoses and therapeutic interventions that we provide.

A review of the literature finds that several authors have recently examined the roles and responsibilities of the general or child and adolescent psychiatrist (March, 1995; Beinart and Lukeman, 1997; Cottrell, 1997; Goodman, 1997; Harrison, 1997; Messent, 1997; Sledge, 1997; Weissman, 1997; Sherman, 1998; Worcester, 1998; Target and Fonagy, 1997). The changing nature of the practice of psychiatry is well recognized. In his review of the literature supporting the American Psychiatric Association's Position Statement on Medical Psychotherapy, Sledge (1997) reports:

The psychiatrist brings to the psychotherapeutic work specialized knowledge, techniques, and clinical experience grounded in the physician's medical expertise and guarded by professional standards. (p. 124)

Harrison (1997) insinuates that in the 21st Century, the psychiatrist is unlikely to have a practice in which psychotherapy is the sole treatment. However, he also reminds us that:

It should not be forgotten that supervised psychotherapy in residency education has and continues to nurture and hone clinicians' skills in [clinical assessment/intervention strategy planning] interviewing. . . . there is no better educational methodology than supervised psychotherapy for learning how to relate in a clinical interview with children and to gather meaning from what the child says and does, or does not say and does not do. (p. 33)

Many predict (Pardes, 1996; Goodman, 1997; Harrison, 1997) that eventually the primary role of the child and adolescent psychiatrist will be to coordinate the clinical team; insofar as that is true, an in-depth understanding of the psychotherapies (as with the other "tools" used in mental health) is necessary to appropriately prescribe this intervention in order that others may render it (Lieberman and Rush, 1996; Pardes, 1996; Harrison, 1997; Messent, 1997). This is also true in instances in which the

psychiatrist supervises practitioners of other disciplines (Mohl, Lomax, Tasman, et al., 1990; Cottrell, 1997). There is indication that at times more complicated psychotherapies require performance by a psychiatrist for efficacy (Lieberman and Rush, 1997). Expectations of knowledge and competency also affect perceived efficacy of treatment (Messant, 1997), necessitating the use of different psychotherapy tools or their implementation by psychiatrists. The child and adolescent psychiatrist needs psychotherapy skills in order to recognize and integrate the cultural aspects of a patient's presentation (E. James Anthony, M.D., personal communication, 1997).

Other writers describe the efficacy of the psychiatrist providing both psychotherapy and medication management in terms of financial costs (Dewan, 1997) and pragmatism (Busch and MacKinnon, 1997; Sledge, 1997). Continual integration of pharmacotherapy and psychotherapy helps all treatment, and is not currently the norm; having one clinician well trained to integrate both nearly always has significant advantages over plural clinicians and split functions. The foundation of our profession, responsibility for meeting the needs of children from the perspective of the whole child in an integrated manner, is reiterated (Richmond and Harper, 1996). It is noted that to forget the extent of the scope of the practice of psychiatry leads one to marginalize its importance in mental health care (Weissman, 1997).

The psychotherapies alone are an effective remedy for many psychiatric disorders (Mohl, Lomax, Tasman et al., 1990; March, 1995; Sledge, 1997; Worcester, 1998), including large numbers of the mild and moderately disordered (who are far more numerous than the severely disordered); these include many depressions and anxiety disorders as well as many character disorders and family disorders and children who have been physically or sexually abused or neglected. This population comprises a significant portion of the patient population of the child and adolescent psychiatrist. The psychiatrist often serves a coordinating role in the multidisciplinary treatment of these children and adolescents. The use of the psychotherapies is also a mainstay in work with children and adolescents who have developmental disabilities or are mentally retarded (Feinstein, 1997).

(continued)

APPENDIX A. American Academy of Child and Adolescent Psychiatry: policy statement on psychotherapy as a core competence of child and adolescent psychiatrists (continued)

Children's play was recently proven statistically to be an effective predictor of psychopathology (Warren, 1996); this is a confirmation of the very large literature and even larger clinical experience of those who have used play therapy techniques for most of this century (Lewis, 1997). In combination with pharmacotherapy, the psychotherapies are effective in numerous other disorders (March, 1995; O'Brien and Perlmutter, 1997; Sledge, 1997; Worcester, 1998).

Further, the use of the psychotherapies increases compliance with pharmacotherapy (O'Brien and Perlmutter, 1997). To eliminate or even significantly dimin-

ish the psychotherapies from the arsenal of the child and adolescent psychiatrist would be severely to decrease the ability to provide the highest level, or even an ethical and professional level, of clinical care.

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