

**UMASS Medical School, Department of Psychiatry**  
**Child and Adolescent Residency Training Program**

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**A Teaching Curriculum of Psychodynamic Psychopharmacology for Children and Adolescents: Bridging the Past to the Future**

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## **BACKGROUND**

This curriculum was developed over the course of Dr. Sitthichai's one-year award from AACAP's Psychodynamic Faculty Training and Mentorship Initiative. Dr. Sitthichai collaborated with an assigned mentor, Dr. Horacio Hojman, to create this curriculum within UMass Child and Adolescent Psychiatry training program where he is on faculty and supervisor at Child Psychiatry Community Clinic. Dr. Ahn played an advisory role in editing and reviewing the curriculum content, and as Dr. Sitthichai's departmental mentor.

This curriculum is designed to enhance the training experience by incorporating psychodynamic theory to guide psychopharmacological treatment when dealing with treatment-resistant or high-risk patients, or when the biopsychosocial or cultural formulations are very complex. The majority of children and families who are referred to the community outpatient clinics affiliated to an academic setting often have complex presentations. They have been labeled with multiple DSM diagnoses and are considered "high risk" due to the history of suicidal and other destructive behaviors. They often have experienced some degree of exposure to trauma, including violence in their families and communities. The knowledge in psychodynamic psychopharmacology will help trainees deepen their understanding of their patients and prescribe medications more effectively. Applying psychodynamic concepts during psychopharmacology encounter will offer an opportunity to address the problems of medication adherence issues, polypharmacy or inadequate treatment with psychotropic medications that are often seen in psychiatry practice.

### **RATIONALE OF TEACHING PSYCHODYNAMIC PSYCHOPHARMACOLOGY**

Practicing child psychiatry has become more challenging. The expanding array of psychotropic medications and excitement of neurobiological science combined with the reimbursement issues/high costs of an outpatient child psychiatry program have unduly changed the role of child psychiatrists. Child psychiatrists are often expected to "practice at the top of their licenses" and primarily provide somatic interventions. Psychotherapy encounters in many outpatient settings are commonly assigned to non-physicians.

The child and adolescent psychiatry fellows have to learn in a short 2 year training the increasingly complex and evolving fields neurobiology and psychopharmacology as well as how to practice integrated care in an actively changing administrative environment. Program directors of training programs and their Child Psychiatry Program Educational Committees (PECs) must make tough curricular choices on what areas to prioritize. In addition, as academic settings have shrinking (or no) child psychiatry faculty who practice or supervise psychodynamic psychotherapy, trainees become less exposed to didactics or experiences in developmental psychology and psychodynamic concepts. The Accreditation Council for Graduate Medical Education (ACGME) has also emphasized the need for psychiatry trainees to develop competencies in psychotherapy and in the combination of medications and psychotherapy. In addition, applying psychodynamic understanding and techniques may help residents become

effective prescribers; the residents will maintain their self-esteem and may prevent their burn out (Mintz 2006; Mintz and Ryan 2012). Therefore, teaching psychodynamic psychopharmacology would allow fellows to understand the relevant applications of psychodynamic thinking in a variety of clinical settings. Traditionally, psychodynamic psychotherapy is taught in a “silo” of experiences specific only to therapy cases rather than generalizing it to the broader role of child and adolescent psychiatrists.

### **CURRICULUM OVERVIEW**

The traditional child and adolescent psychopharmacology curricula focus on teaching “what medications should we prescribe?”; the residents and fellows will learn the medical sciences that form the basis for utilizing biological interventions in a safe and effective manner in treatment of child and adolescent psychopathology. This innovative psychodynamic psychopharmacology curriculum will be complementary to the traditional psychopharmacology curriculum; the residents and fellows will learn the importance of establishing a therapeutic alliance and recognizing the meanings, both conscious and symbolic, of medication to everyone in the system in the process of prescribing medications.

This curriculum consists of 3 teaching modules including 1) didactic seminar, 2) collaboration process and interdisciplinary team discussion and 3) supervision. The teaching program can implement some modules or the whole curriculum depends on the structure and faculty availability of each training program. Although this curriculum has been designed to best fit Child and Adolescent Psychiatry residents, it can be adapted and used for General Psychiatry residents as well as medical students.

We hope that this psychodynamic psychotherapy curriculum can be a model of effective teaching of psychopharmacology that child and adolescent fellows can learn a practical approach to the fundamental principles of discussing, prescribing, and maintaining patients on psychiatric medications. Ultimately, the mutual knowledge of the psychodynamic aspects of prescribing can be an important factor in improving collaboration between the therapists and prescribers as well as using psychodynamic theory to guide treatment, resulting in better outcomes for children and families.

**GOALS AND OBJECTIVES:**

1. Advance an integrated model for psychopharmacology.
2. Teach evidence-based prescribing: prescribing the effective medications and addressing psychological and interpersonal aspects of medication response.
3. Educate child psychiatrists to be psychologically minded in their prescribing.

**KNOWLEDGE:**

1. Describe attachment theory and techniques in strength-based interviewing of children, adolescents and families to establish a therapeutic alliance.
2. Explain developmental psychodynamic theory and the ability to trace a patient's developmental trajectory.
3. Describe the role of therapeutic alliance and psychopharmacology treatment outcome.

**SKILLS:**

1. Integrate a psychodynamic formulation that informs the treatment plan.
2. Explore unconscious motivations and understand the nature of the child's affective communication, the analysis of defense in children.
3. Work through transferences and counter-transferences during a psychopharmacology encounter.

**ATTITUDES:**

1. Describe the complexities created by split treatments.
2. Identify and explain the intra-psychic and interpersonal conflicts during psychopharmacological encounter.
3. Recognize symbolic meaning of medications as well as the placebo and nocebo effect.

## OUTLINE OF TEACHING METHOD

Module 1: Didactics Seminar; 1-hour x 3 sessions
Overview of psychodynamic psychopharmacology
Therapeutic alliance and therapeutic communication
Meaning of medications
Module 2: Collaboration and Interdisciplinary team case discussion
Develop effective referral process and treatment framework of split treatment model
Promote collaborative and working relationship with therapist and psychiatrist
Module 3: Supervision
Individual supervision
Group supervision

## MODULE 1

### DIDACTIC SEMINAR:

#### *Part I: Overview of psychodynamic psychopharmacology*

- PowerPoint Slides
  - Required reading
    - Mallo C.J., Mintz D., Teaching All the Evidence Bases: Reintegrating Psychodynamic Aspects of Prescribing into Psychopharmacology Training. *Psychodynamics. Journal of The American Academy of Psychoanalysis and Dynamic Psychiatry*, 41(1) 13-38, 2013
    - Chubinsky P., Hojman H., Psychodynamic Perspectives on Psychotropic Medications for Children and Adolescents. *Child and Adolescent Psychiatric Clinics of North America* 2013; 22: 351–366
    - Weinberg E., Mintz d., The Overall Diagnosis: Psychodynamic Psychiatry, Six-Minute Psychotherapy, and Patient-Centered Care. *Psychiatric Clinic of North America* 41 (2018) 263–275
  - Supplemental reading
    - Mintz D., Psychodynamic Trojan Horses: Using Psychopharmacology to Teach Psychodynamics. *Journal of The American Academy of Psychoanalysis and Dynamic Psychiatry*, 34(1) 151-161, 2006
    - Mintz D, Ryan D. How (not what) to prescribe: nonpharmacologic aspects of psychopharmacology. *Psychiatric Clinics of North America* 2012;35(1):143–53.
    - Noam, G. G., & Malti, T. (2008). Responding to the crisis: RALLY's developmental and relational approach. *New Directions for Youth Development*, 2008(120), 31–55.
    - Plakun E, Sudak DM, Goldberg D (2009) The Y model: an integrated, evidence-based approach to teaching psychotherapy competencies. *J Psychiatric Practice* 15(1):5-1
- Questions and clinical cases for further discussion
  - What is your most challenging experience as a trainee in psychiatry?
  - List the positive and negative aspects of split treatment in psychiatry practice.
  - Psychiatrists doing integrated treatment should define routine ways of addressing medications during psychotherapy. When, for example, should medications be discussed - at the beginning of the session or at the end? What are the advantages and disadvantages of each?
  - List the limitations of psychopharmacological treatment.
  - List nonpharmacological factors that affect treatment response in psychopharmacology.
  - 9-year-old Latino boy, 4th grade student presents with significant ADHD symptoms, he struggles at school both in academic function and peer relationship. He is small built in comparison to his peers. We consider starting

stimulant medication for ADHD. What are possible developmental trajectories in this child if we treat or do not treat ADHD with stimulant medication?

- 16-year-old Caucasian girl presents with significant neurovegetative symptoms of depression. Her mother is agreeable to start an anti-depressant. However, the patient refuses to take medications because she is extremely worried about side effects. What are some of the possible reasons the patient would become so focused on potential side effects?
- 17-year-old intelligent Asian American man refuses to manage his own medications, instead relying upon his parents to provide them both morning and evening. He often gets angry with his parents for what he perceives as their neglect of him. What could be the meaning of having his parents provide him medications, and what should be the focus during the psychopharmacology encounter?

### *Part II: Therapeutic alliance and therapeutic communication*

- PowerPoint Slides
  - Required reading
    - Auchincloss E. New Development of the Therapeutic Alliance (TA): Good News for Psychodynamic Psychiatry. *Psychodynamic Psychiatry*, 44(1) 105-116, 2016
    - Fonagy P., Allison E. The Role of Mentalization and Epistemic Trust in the Therapeutic Relationship. *Psychotherapy* 2014, Vol. 51, No. 3, 372–380
    - Zicha-Mano S, Roose SP, Brown PJ and Rutherford BR (2019). Not just Nonspecific Factors: The roles of Alliance and Expectancy in Treatment, and Their Neurobiological Underpinnings. *Frontier in Behavioral Neuroscience*, 12:293.
  - Supplemental reading
    - Alfonso C.A. (2011) Understanding the psychodynamics of non-adherence, *Psychiatric Times*, May 2011, Volume 28: 22-23
    - Bowlby J (1988) *A secure base*. New York: Basic Books
    - Cortina M. The Use of Attachment Theory in the Clinical Dialogue with Patients. *Psychodynamic Psychiatry*, 41(3) 397-418, 2013
    - Leeman E., The Costs of Compliance. *Journal of The American Academy of Psychoanalysis and Dynamic Psychiatry*, 35(2) 179-187, 2007
    - Rubin J., Be Careful What You Wish For: Going Beyond Compliance. *Journal of The American Academy of Psychoanalysis and Dynamic Psychiatry*, 35(2) 203-210, 2007
- Questions and clinical cases for further discussion
  - What are the common factors across psychotherapy modalities and psychopharmacology that affect positive treatment outcome?
  - How might attachment styles affect pharmacological treatment response?
  - A 17-year-old perfectionistic, depressed high school student is deeply attached

to her mother. She is offered SSRI for her depression. She asks her mother's advice. Her mother replies, "I don't want my daughter to become suicidal or drug addicted". The patient refuses pharmacology treatment. One year later, she moves to college and she seeks psychopharmacological consultation again for her depression. She decides to take an SSRI and also decides not to tell her mother that she has begun this treatment. What are the possible pharmacological and psychological effects of these decisions?

- A 16-year-old female presents with significant depressive symptoms after her parents divorced 2 years ago. Her father inconsistently visits or contacts her and is recently remarried. A male child psychiatry fellow evaluates this case and prescribes an anti-depressant. The patient misses the first follow up appointment. A child psychiatrist reaches out to reschedule the appointment but the patient comes to the second appointment late and tells the fellow that she often forgets to take the medication. She is not cooperative and replies only yes or no to questions. What is the possible transference and countertransference? How can we improve treatment adherence in this case?

### *Part III: Meaning of medication*

- PowerPoint Slides
  - Required reading
    - Li T., Psychodynamic Aspects of Psychopharmacology, Journal of the American Academy of Psychoanalysis and Dynamic Psychiatry, 384 (4) 655-674, 2010.
    - Mintz D., Recovering from Childhood Psychiatric Treatment: Addressing the Meaning of Medications. Journal of the American Academy of Psychoanalysis and Dynamic Psychiatry, 47 (3) 235-256, 2019.
  - Supplemental reading
    - Rappaport N, Chubinsky P. The meaning of psychotropic medications for children, adolescents and their families. Journal of the American Academic Child and Adolescent Psychiatry 2000; 39 (9):1198-200
    - Rosenfield P.J., Poison or Cure: Meaning of Medication in Schizophrenia. Journal of the American Academy of Psychoanalysis and Dynamic Psychiatry, 35 (2) 189-201, 2007.
- Questions for further discussion
  - How do you provide psychoeducation about depression and the rationale for using anti-depressants to children and families?
  - Who are most likely to develop side effects from medications (the nocebo response)?
  - An 8-year-old boy presents with significant ADHD symptoms, he is very impulsive. He is sometimes unintentionally aggressive toward his peers. The teacher notifies his parents regarding his aggressive behaviors and recommended to see a psychiatrist. A psychiatrist recommends stimulant medication for ADHD. However, his father who is a policeman would not give his

consent, even though he fully understood the rationale for prescribing a medicine for his son's ADHD. What are the possible reasons for his refusal to consent to treatment, and how do you further manage this patient?

- A 15-year-old male is referred for psychiatric consultation for medication management for Bipolar Disorder. He has a long history of psychiatric treatment which began at age 5 when he was diagnosed with ADHD. By age 11, after a consultation with a national expert on childhood bipolar disorder, his diagnosis was revised to Bipolar disorder. He tried several stimulant medications and SSRIs, which tended to help initially but then caused increased agitation. He is currently taking a combination of an anti-psychotic (Risperidone) and a mood stabilizer (Divalproex acid) but he is still prone to mood lability and anger. He requires a high dose of medications. The patient's father is a successful engineer who is hyper-competent and intolerant of imperfection in himself and others. His father seeks advice for a new medication for his son's bipolar disorder. What are the possible meanings of medications for this patient and his family? How do you further approach in this case?
- A 17-year-old female patient becomes very depressed after the death of her father. She does not want to go on summer vacation with her family and said to her family, "why go there anymore, my dad is not here to enjoy it with me". Her mother brings her to see a psychiatrist. Fluoxetine and Trazodone are remarkably helpful to her. After a few months, she decides to stop. What are some of the possible reasons she discontinued medications?

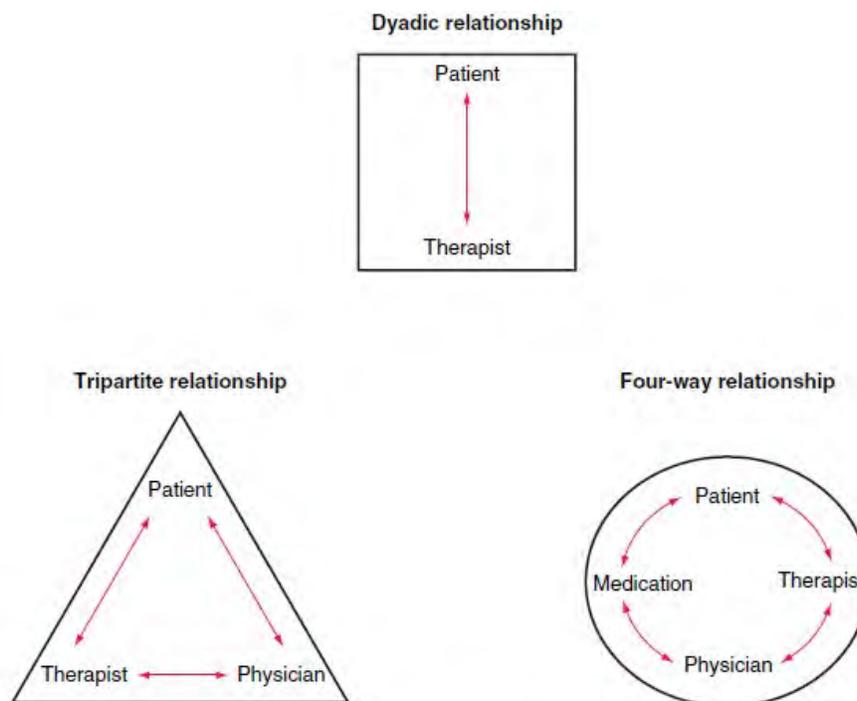
## MODULE 2

### COLLABORATION PROCESS AND INTERDISCIPLINARY TEAM CASE DISCUSSION:

An increasingly popular model of psychiatric care for children and adolescents requiring medication has increasingly been the split model whereby medication is prescribed by a psychopharmacologist while psychotherapies of different kinds are provided by a clinician, typically a psychologist or social worker. There are many positive aspects to split treatment, but effective split treatment depends upon excellent communication and collaboration between clinicians. This learning module helps learners be aware of the complexity of split treatment and develop effective communication and collaborative skills in the split treatment model.

#### *Teaching guideline:*

- Create the structure and framework of the referral and collaboration process between child psychiatry fellows and clinicians. This structure should provide the time and opportunities to review case materials, communicate and discuss cases.
- Emphasize the importance of changes in a relationship from dyadic to triadic alliance in split treatment. In addition, when medication is added, a four-way relationship is created. The distortions can arise among all four components, leading to unsuccessful treatment and care.



**Figure 87.1** Changes in relationships as therapy and medications are added or deleted. Reprinted with permission from Kay J [2001] *Integrated treatment: An overview*, in *Integrated Treatment for Psychiatric Disorders: Review of Psychiatry*, Vol. 20 (ed. Kay J). Copyright, American Psychiatric Press, Washington DC, pp. 1–29.

- Highlight the important factors and provide guidelines for effective collaboration. Facilitate the reflective process during interdisciplinary team discussion.

***Framework for collaboration:***

**Referral process:** Ask more questions that are pertinent to such medication consultations, such as the following:

1. Who is requesting the consultation: the therapist, the parents, the adolescent, or the school?
2. Why now? Is it a new patient? Is the treatment stuck? Are there new symptoms or history?
3. Is this a consultation for the overall treatment plan, psychotherapy, diagnosis, or symptom relief?

**Collaboration process:**

- Create a communication framework: the form of communication (email, phone call, face to face meeting) and the frequency of communication should be discussed.
- Confidentiality should be discussed at the beginning of treatment, including explicit signed consents allowing conversation to occur between providers.
- Diagnostic impressions should be independently arrived at, then discussed and agreed upon. If there is a difference of opinion, an understanding must be reached.
- Treatment plan: The psychiatrist must work collaboratively with all team providers and with the patients, families to determine the treatment plan. The treatment plan should be regularly reviewed and updated between providers and patients.
- Pay attention to transference and countertransference in this system of care.
- Adherence to medications and to psychotherapy should be addressed equally.
- There must be an agreement that either clinician can terminate the split therapy, but that the patient must be provided adequate and appropriate notice and referrals to other clinicians. The patient cannot be abandoned.

## MODULE 3

### **SUPERVISION:**

The primary supervisor will be onsite during most of fellow's time on the outpatient unit. The fellow and the primary supervisor will have formal individual and/or group supervision at least once per week. The secondary and tertiary supervisors (if applicable) will be available informally during group meetings and more formally as is needed to meet the education objectives of the fellow. The second-year child psychiatry fellow can start as a role of supervisor or group co-leader.

This group supervision model for psychodynamic psychopharmacology in this curriculum is modified from Balint Group models. The Balint group model has been demonstrated to prevent professional burnout.

### ***Brief guideline for the group leader in psychodynamic psychopharmacology supervision:***

- Create a safe, trusting and supportive atmosphere that will be beneficial to addressing the residents and fellows' most salient emotional concerns (e.g., feeling of helplessness or frustration, rescue fantasies, or experiences of emotional or role conflicts).
- Encourage residents and fellows to see their patients as human beings, beyond their psychopathology or psychiatric symptoms.
- Emphasize the importance of the doctor-patient relationship. The group leader may ask how the patient has made everyone feel.
- Facilitate the process of identifying what exactly is transpiring, on conscious and unconscious levels between doctors and patients.
- Use case-based learning in the group setting to explore conflicts and dilemmas of psychiatric practice, guide the fellows understanding and appreciate the complex psychological and interpersonal meanings that lie hidden within the pharmacotherapeutic encounter.

### **EVALUATION METHOD:**

1. Global rating
2. Case Logs
3. Portfolio
4. 360-degree rating
5. Record review
6. Direct observation

## BIBLIOGRAPHY

- Alfonso C.A. (2011) Understanding the psychodynamics of non-adherence, *Psychiatric Times, May 2011, Volume 28: 22-23*
- Auchincloss E. New Development of the Therapeutic Alliance (TA): Good News for Psychodynamic Psychiatry. *Psychodynamic Psychiatry, 44(1) 105-116, 2016*
- Balint M.(1957), *The Doctor, His Patient, and The Illness*. New York: International University Press.
- Beitman B.D., Riba M.B., Balon R., *The challenges of Split Treatment. Integrating Psychotherapy and Psychopharmacology*. New York: A Norton Professional Book
- Bowlby J (1988) *A secure base*. New York: Basic Books
- Chubinsky P., Hojman H., *Psychodynamic Perspectives on Psychotropic Medications for Children and Adolescents*. *Child and Adolescent Psychiatric Clinics of North American 2013; 22: 351–366*.
- Cortina M. The Use of Attachment Theory in the Clinical Dialogue with Patients. *Psychodynamic Psychiatry, 41(3) 397-418, 2013*
- Fonagy P., Allison E. The Role of Mentalization and Epistemic Trust in the Therapeutic Relationship. *Psychotherapy 2014, Vol. 51, No. 3, 372–380*
- Leeman E., *The Costs of Compliance*. *Journal of The American Academy of Psychoanalysis and Dynamic Psychiatry, 35(2) 179-187, 2007*
- Li T., *Psychodynamic Aspects of Psychopharmacology*, *Journal of the American Academy of Psychoanalysis and Dynamic Psychiatry, 384 (4) 655-674, 2010*.
- Metz J, Riba M. Understanding the symbolic value of medications: a brief review. *Primary Psychiatry 2000;10(7):45–8*.
- Mintz D., *Psychodynamic Trojan Horses: Using Psychopharmacology to Teach Psychodynamics*. *Journal of The American Academy of Psychoanalysis and Dynamic Psychiatry, 34(1) 151-161, 2006*

- Mintz D, Ryan D. How (not what) to prescribe: nonpharmacologic aspects of psychopharmacology. *Psychiatric Clinics of North America* 2012;35(1):143–53.
- Noam, G. G., & Malti, T. (2008). Responding to the crisis: RALLY’s developmental and relational approach. *New Directions for Youth Development*, 2008(120), 31–55.
- Plakun E, Sudak DM, Goldberg D (2009) The Y model: an integrated, evidence-based approach to teaching psychotherapy competencies. *Journal of Psychiatric Practice* 15(1):5-1
- Rappaport N, Chubinsky P. The meaning of psychotropic medications for children, adolescents and their families. *Journal of the American Academic Child and Adolescent Psychiatry* 2000; 39 (9):1198-200
- Rubin J., Be Careful What You Wish For: Going Beyond Compliance. *Journal of The American Academy of Psychoanalysis and Dynamic Psychiatry*, 35(2) 203-210, 2007
- Weinberg E., Mintz D., The Overall Diagnosis: Psychodynamic Psychiatry, Six-Minute Psychotherapy, and Patient-Centered Care. *Psychiatric Clinics of North America* 41 (2018) 263–275
- Zicha-Mano S, Roose SP, Brown PJ and Rutherford BR (2019). Not just Nonspecific Factors: The roles of Alliance and Expectancy in Treatment, and Their Neurobiological Underpinnings. *Frontier of Behavioral Neuroscience*, 12:293.