Training in Psychodynamic Psychotherapy

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KEYWORDS

• Residency training • Psychodynamic psychotherapy • Psychotherapy supervision
• Regulation focused psychotherapy • Mentalization-based therapy children

KEY POINTS

- Psychodynamic psychotherapy's position within general and child adolescent psychiatry training has declined and is commonly taught in an unsystematic fashion.
- Time constraints, personal interests, lack of supervisors, managed care system, and the rapid shift toward psychopharmacology contribute to the challenges of achieving psychotherapy competence.
- Manualized psychodynamic therapy treatments offer a simple, structured, and measurable approach to addressing these concerns and meeting training requirements.

INTRODUCTION

Psychodynamic psychotherapy remains an essential component of North American graduate medical education in general psychiatry[1,2] and child and adolescent psychiatry.[3,4] However, the shift toward hospital-based metrics, managed care,[5] resident time constraints, and psychopharmacologic emphasis in curricula challenge the preservation of dedicated time for training and supervision.[5,6] While behavioral and pharmacologic methods are effective in treating a variety of psychiatric disorders, unconscious process explorations inherent within psychodynamic psychotherapy remain critical in the formulation and insight of a youth's complete biopsychosocial profile. Trainees appreciate that psychopathology is multidimensional and complex and that the health and happiness of children and adolescence cannot always be explained by strict neurobiological and behavioral methods. Incorporating strong psychodynamic psychotherapy skills alongside psychopharmacology and behavioral

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Abbreviations	
MAP	managing and adapting practice
MBT-C	mentalization based therapy for children
PD	personality disorders
RFP-C	regulation focused psychotherapy for children
TFP-A	transference-focused psychotherapy for adolescents
UNM	University of New Mexico

methods equips the training physician to provide comprehensive and informed care for the child, adolescent, and adult.

Traditionally, psychodynamic psychotherapy models require significant time for training given the nature of its practice, which can conflict with current curricula requirements. Additionally, evidence-based approaches toward psychiatric patient care are now identified as gold standard practice, which leaves psychodynamic psychotherapy to be appreciated as subpar. Despite these challenges, both trainee and program director interest persist in psychodynamic psychotherapy training as a means to receive and to provide meaningful experiences to trainees.

Following a review of recent evidence concerning trainee and program director interest in psychodynamic psychotherapy, this article surveys the history and contemporary practices of training in psychodynamic psychotherapy and turns to position recent manualized psychodynamic psychotherapy developments as an opportunity for psychotherapy education in today's current landscape of psychiatric training. To mitigate the barriers pressing against psychodynamic psychotherapy in psychiatric training, structured, evidence-based, and time-limited manualized psychodynamic approaches for children and adolescents, including regulation focused psychotherapy for children,[7] mentalization based therapy for children,[8] and transference-focused psychotherapy for adolescents[9] have evolved and may be critical to preserving graduate medical education psychodynamic training in contemporary times.[10]

Trainee Interest in Psychodynamic Psychotherapy Training

Despite practice-based trends away from American psychiatrists providing psychotherapy,[11,12] resident interests in psychotherapy training remains strong. An American study of general psychiatry residents found that more than half (54%) intended to provide psychotherapy following residency, and the majority (82%) reported psychotherapy as central to their role as a psychiatrist.[13] In Canada, half (50%) of participating residents believed that performing psychotherapy was rewarding.[14] Another survey found two-thirds of respondents reporting psychotherapy training as a driving factor for choosing to become a psychiatrist, with 87% expressing psychotherapy as essential to their identity as a psychiatrist, and 86% of recent graduates aiming to incorporate psychotherapy into their current practice.[15]

How do we understand the discrepancy between residents' stated intentions and the realities of practice? In examining the longitudinal trend of psychotherapy attitudes and interests across junior to senior cohorts and postresidency trainees,[16] 229 psychiatry residents and 20 fellows in unspecified fields across 1 American programs showed a declined interest in studying psychotherapy over time compared with the intern year of residency. Postgraduate year (PGY)-1s reported a 3.5% decreased interest, PGY-2s a 13.3% decline, PGY-3s a 14.1% decline, and PGY-4s a 16.4% decline, attributing this to several individual and institutional factors.[16] Individual factors noted are the perceived separation of identity between psychiatrists and psychotherapists, where these therapeutic modalities stem from different

disciplines, and one's self-perceived competence in psychotherapy training.[16] As managed care has become the focus of psychiatric care in modern times, residents are pressured with both time constraints and limited opportunities to provide comprehensive psychotherapeutic skills, and their lack of adequate training raises concerns about their therapeutic abilities. With the collaboration of social workers and psychologists to provide psychotherapy services, residents focus on medication management, as they are one of the few mental health providers with a license to prescribe medications. Inadequate clinical experiences needed to strengthen psychotherapeutic skills are also noted, as a large portion of residency surrounds treating highly disturbed and lower functioning patients, in which psychotherapeutic techniques are at times felt to not be optimal for acute management. From an institutional perspective, dissatisfaction with the curriculum, lack of faculty members and supervision to train mentees, and limited time for dedicated training have contributed to residents' current attitudes.[16] Other residents note a perceived negative attitude toward psychotherapy from department leaders, which ultimately affects the perception and investment of practice on residents.[16] Additionally, some residents plan not to pursue further psychoanalytic training postresidency or plan to provide psychotherapy to patients for personal reasons including psychotherapy being less rewarding than other aspects of their care and psychotherapy being less central to their identity as a psychiatrist.[16]

One study from residents of American Midwest and Southern training programs placed equal importance between psychotherapy (79%) and biological treatment (80%), although majority reported a poor understanding of psychoanalysis, and only 44% expressed a high likelihood or certainty in using psychotherapy techniques.[17] Senior residents were analyzed separately from younger cohorts, and while there was slight improvement in the poor competency group, 37% still rated competence as poor, 44% and 16% as good/excellent. Despite the interest and slight improvement, 78% of residents were still highly unlikely to pursue further training after residency.[17]

From a regional perspective, psychoanalytic emphasis in residency programs directly correlates with areas that have psychoanalytic institutes.[18] Similarly, as with child and adolescent fellowship training, psychodynamic fellowship training is geographically concentrated in metropolitan areas, and smaller-scale programs may not have accessibility to psychiatrists with a background in psychodynamic therapy or access to trained supervisors.[19] Despite these challenges, the majority of residents in training programs outside of bi-coastal urban America still value psychotherapy and recognize its importance in patient care.[17]

Through this review of the literature, we see there is an overall consensus that residents remain interested in psychotherapy across North American programs; however, translating their interest into future pursuits in psychiatric practice falls short. While there is a robust amount of research on this topic, very few published papers within the last 10 years have examined further trends and attitudes in psychodynamic psychotherapy training. To our knowledge, based on a hand search from the National Library of Medicine database of literature using the search terms "child and adolescent psychiatry" and "psychotherapy training", few specifically examine trainees in child and adolescent psychiatry fellowships, though a recent study of the evidence-based psychotherapy program that did not incorporate psychodynamic approaches, termed Managing and Adapting Practice (MAP), found that a system of resources and decision models were well-received by trainees and satisfied feasibility, acceptability, applicability, and competence markers for use.[20] Given the sparse child and adolescent psychiatry (CAP) guidelines for psychotherapy within training, MAP serves as a useful curriculum to support Accreditation Council for Graduate Medical

Education (ACGME) competencies.[20] It draws from a diverse database of evidence-based youth treatment protocols and modules allowing for personalization of learning for instructor and trainees and accommodates the challenges faced in standardization of CAP training including assessment, treatment management, integrative reasoning, and quality improvement.[20]

The observed decline from internship to fellowship years underscores the strength of interventions to consolidate future psychiatrists' identity as psychotherapists early in their training. As mentioned, trainees express concerns with poor self-perceived competence in understanding psychodynamic psychotherapy, curriculum dissatisfaction, the perception that patients with more impairment are not appropriate for psychotherapy, and perceived negative attitudes from department leaders.[16] Given these barriers, positioning a child and adolescent psychodynamic psychotherapy curriculum that promotes early perceptions of competency through clear and tangible skills training, applicability to youth with more significant impairments, and acceptability to psychiatric departmental leadership is critical.

Program Director Interest in Psychotherapy Training

Despite weaknesses in psychodynamic curriculums in the majority of residency programs, most program directors still aim to provide meaningful experience in psychotherapy training in residencies.[21] A survey evaluating various psychotherapy metrics, including psychotherapy priority, competence goals, training strategies, supervision, and satisfaction was sent to American child and adolescent psychiatry program directors, and the majority (70%) regarded psychotherapy as a very important aspect of training.[21] While the majority felt that the time allotted to teaching was adequate, less than 5% was spent as dedicated time across a 2-year fellowship.[21] Additionally, half of program directors (50%) noted their concern in measuring competence through objective criteria.[21]

Other program directors highlight the pressure between time constraints and not having enough staff to teach.[18] While program directors support psychotherapy curriculum, several residents report that department leaders may not share a similar sentiment and undervalue the importance of psychotherapy practice.[22] Also discussed is the high productivity goal in today's medical system, where managed care focuses on reducing health care costs and, in doing so, limits the amount of time patients can spend with clinicians, an essential component to performing psychotherapy.[18]

In modeling a psychotherapy curriculum, training directors express a need for the appropriate patient population to perform psychotherapy and a larger budget to pay teachers and supervisors, as many psychoanalysts teach on a volunteer basis.[18] Others note that psychotherapy training requires a high level of personal processing within residents' and supervisors' own emotions to provide therapy to another individual who contains a multidimensional biopsychosocial profile and dynamic interpersonal relationships. This process becomes anxiety-provoking and can present as a challenge to trainees.[19]

Given that the majority of program directors perceive psychotherapy training as important, it is crucial to position psychodynamic psychotherapy in a manner that addresses program director needs, including objective competency measures, ensuring supervisor availability, and an approach that can fit into productivity models in addition to meeting the aforementioned trainees' needs.

History of Psychotherapy Training Models

Psychotherapy models have drastically changed over several decades. Traditional psychotherapy models are derived from psychoanalytic theory, where free

association is the central theme to interpreting various psychopathologies, and seem to conflict with present-day training, as psychoanalysis functions off of loose, unstructured, and free-flowing concepts.[23] In the twentieth century, psychoanalytic theory heavily influenced psychiatry, and it was common for residency graduates to enroll in psychoanalytic training.[24] In the 1950s, nearly all major American psychiatry programs were appointed by psychoanalysts, and more than half of psychiatrists were either pursuing training in psychoanalysis or psychoanalytically inclined during their training.[25,26] Approximately 3000 hours of psychoanalytic training were offered within a 3-year psychiatry residency in the 1940s-1950s post World War II; however, that number has significantly declined more than half a century later.[27]

Furthermore, there has been a drastic decrease in the number of psychiatrists applying to psychoanalytic institutes; since 2010, there has been a decrease in over 50% of annual applications, specifically psychiatrists.[17] Daniel Carlat recalls his personal experience in the years following the introduction of fluoxetine to psychiatry treatment and states, "Psychopharmacology was infinitely easier to master than therapy because it involved a teachable systematic method. But learning the formal techniques of therapy was like navigating without a compass. While I learned to form an alliance with my patients, becoming a skillful therapist requires much more practice than busy residencies allow."[28] Throughout the decades though, the expansion of neurobiological sciences and a need for treatment to be backed by evidence-based methods took shape which left the *soft science* to fall out of favor. Up until 50 years ago, psychiatrists were predominantly psychoanalysts[22]; however, psychoanalysis and biological medicine were at odds.

The lack of biologically-based pathologies separated psychiatry from medicine and it was difficult for medical specialists to take psychoanalysis seriously since its theory was not based on objective, replicable scientific data.[22] Additionally, psychoanalytic institutes initially repudiated nonmedical professionals, which ultimately led to the separation of analytical institutes from academic institutes.[22]

In the present day, paradigm shifts in the approach to treating acute psychiatric patients have affected treatment delivery. There is now more of an emphasis on managed care, efficiency, and cost-effectiveness. These factors have impacted length of treatment, focusing on a *quick fix* where psychopharmacology is prioritized over long-term psychotherapy. This may result in a lack of depth in the doctor-patient relationship as well as less opportunity to develop a deeper understanding of the patient's psychosocial profile.[29]

Current Practices: Structure

There is great variability in exposure and length of psychotherapy training across different residency and fellowship programs beyond the basics set forth by the ACGME[3,30] and the Royal College of Physicians and Surgeons of Canada.[2,4] One study of 328 PGY-3 and PGY-4 residents from 14 different training programs in the United States found that residents reported receiving less than 1 hour per month to more than 20 hours per month of psychotherapy training.[31] American residency programs showed a range of 2 to 200 hours of formal education in psychotherapy, 2 to 200 hours of supervised training in psychotherapy, and 8 to 500 hours of residents performing therapy in a frequency ranging from weekly to every 2 to 4 weeks.[18]

These results suggest a pattern of highly variable exposure and a lack of structure in the absence of a standardized training protocol. Notably, a task force of the American Association of Directors of Psychiatry Residency Training did not find agreement in recommending psychotherapy competence of independent practice as a core

entrustable professional activity, a responsibility expected to be performed by psychiatry residents by the end of their training.[32] This challenges the view that such a protocol would be universally perceived as important.

Current training models in Canada and the United States offer differing perspectives on pedagogy. The Royal Canadian College uses a model coined 'The Traditional Model', which places low emphasis on opportunities for supplementary training, medium emphasis on exposure to theory, and strong emphasis on experiential learning and supervision.[33] These competencies parallel the literature across Canadian psychiatry residencies, where 100% of programs teach and provide clinical experience with supervision in psychodynamic psychotherapy, and 29% provide direct observation of psychodynamic psychotherapy.[34] Canadian psychiatry residents are expected to meet the following standards: an introductory level of psychotherapy principles and brief psychodynamic psychotherapy, a working level of patient interviews, assessments, and treatment plans, and a proficiency level of integrating biopsychosocial treatment with application of evidence-based practice in a total of 8 months of their PGY2 to PGY5.[2,4] Even with these requirements, residents are still not equipped to achieve proficiency by graduation and are felt to need additional training to strengthen their skillset.[33]

The American-based model coined 'The Familiarity Model' places low emphasis on exposure to theory, experiential learning and supervision, and a medium emphasis on opportunities for supplementary training, with no strong emphasis on any specific points in training.[33] The ACGME's requirements for psychiatry also provide loose definitions on specifications for psychotherapy competence, as written "residents must demonstrate competence in managing and treating patients using both brief and long-term supportive, psychodynamic, and cognitive behavioral psychotherapies".[1] A 2018 task force consisting of the American Association of Directors of Psychiatric Residency training met to discuss residency graduation requirements. It concluded that while resident exposure to psychotherapy is essential, the need to achieve competence in independent practice is subject to debate, placing the essentialness of psychotherapy at a lower value.[32]

The ACGME for child and adolescent psychiatry requires that fellows be *competent in psychodynamic psychotherapy* without providing further guidance on how to achieve competency. In searching the child literature for recently used training models, results yielded no directly related training in psychodynamics but rather newer forms of therapy that are *psychodynamically rooted*.[35] These results further suggest the gray area in which psychodynamics is currently held.

In child and adolescent specialty programs, there are set milestones that fellows must meet to achieve *beginner level competency* in brief and long-term individual therapy, family therapy, group therapy, crisis intervention, supportive therapy, psychodynamic psychotherapy, cognitive behavioral therapy, and pharmacotherapy[36]; however, there is an undefined specification on what it means to be *beginner level competent*. Child and adolescent psychiatry milestones do, however, issue a 1 to 5 leveled system designed to track psychotherapeutic progress ranging from a level 1 *novice*, level 4 *target of graduation* to level 5 *expert in the subspecialty*, but still with vague elaboration.[21] PGY-3 and PGY-4 Columbia psychiatry residents responded to a course evaluation regarding their learning experience in psychodynamic therapy supervision, and 50% reported that they were unsure of the learning objectives of training, 56% did not discuss or clarify with supervisors on their objectives, and 37.5% felt that supervisor training did not translate to didactic courses.[37]

Today, there appears to be potential for an organized curriculum that addresses some of these noted concerns, including unclear learning objectives, suboptimal

supervisor familiarity with learning objectives, and limited integration with didactic courses. In the desire for better education on child and adolescent psychopathology, a curriculum modeled after a 6-step approach by the Curriculum Development of Medical Education was outlined by Santos and colleagues to help child and adolescent psychiatry residents grasp psychopathology through problem-based learning and seminars.[38] A similar curriculum was implemented in the University of Texas at Houston and received positive feedback from residents and faculty.[38] Fefergrad and Mulsant present another model to address this problem by incorporating aspects of Canadian and American models but focusing on teaching a variety of psychotherapy skills as opposed to learning a specific formal course.[33] An approach that makes use of manualized psychodynamic psychotherapies for children and adolescents is another avenue. Manualized approaches facilitate measures of adherence to defined protocols. This assists with creating defined curricular learning objectives and supervisors' assessments of practice competency.

Current Practices: Supervision

Given the complex nature of psychodynamic psychotherapy, residents may feel overwhelmed without sufficient guidance, not only in supervision, but also in the psychotherapeutic process as a whole. Training programs may not have available faculty to supervise and to teach. Supervision specific to psychodynamic psychotherapy in Canada poses a unique challenge given that there is a high degree of variability between supervisors regarding their training, experience, and personal style as well as poorly established criteria to gauge resident progress 34 Efforts are ongoing in the United States by the American Academy of Child and Adolescent Psychiatry's Psychodynamic Faculty Initiative to recruit and strengthen supervisory capabilities nationwide.[35]

Given the limited resources in supervisory training, the role of virtual learning has become a platform that has the ability to reach a widespread population and complement on-site supervision.[39] While an online approach to training yields a concern for the loss of human connection between provider and patient,[40] the benefit of making accessible talented supervisors is significant.

The E-learning model was tested on Canadian psychiatry residents and is structured to begin with online seminars, supplemental reading material, and clinical vignettes, followed by assessments and virtual simulations that attempt to assess therapeutic responses by the resident with feedback on decision-making skills.[39] Its resources have gained positive feedback, as this particular model is designed to understand the needs of learners and teachers within residency training to create a multitextural learning experience, incorporating presentations, online patient simulations, and notes from past residents.[39]

The University of New Mexico (UNM) introduced a psychodynamic psychotherapy tele-technology learning model to combat the geographically isolated issue surrounding psychoanalytic institutes and/or experts within New Mexico.[41] In previous times, psychotherapy was taught under the guidance of community psychiatrists and received poor ratings regarding utility and effectiveness. In 2007, UNM collaborated with 4 psychoanalysts across the country to serve as online consultants during virtual case conferences where residents presented cases supervised by an in-person faculty member with the guidance of the tele-psychoanalyst over the course of 8 weeks and were exposed to 4 different therapy styles, which were received with enthusiasm and highly positive ratings. Tele-technology was also used in didactic training of individual case supervision where a faculty member would record and conduct a therapy session and, with the guidance of a virtual trainer, receive constructive feedback on

psychotherapeutic techniques such as problem identification, development of an intrapsychic focus, patient capacity to experience affect, and therapist ability to identify psychological defenses.[41] This tele-technology training allows for the flexibility of virtual trainers to provide educational resources in the face of limited in-person supervisory teachers.

In-person visiting supervisors are another opportunity. Residents had positive responses to brief (2–3 days) psychodynamic teaching by a visiting psychoanalyst in underserved programs in efforts to enhance psychodynamic education and reported a self-perceived improvement and confidence within competencies of listening and intervening in psychodynamic therapy.[42] Manualized psychodynamic psychotherapy approaches offer the opportunity to more easily train future supervisors in a standardized approach and may increase the availability of local supervisors for trainees when such availability is limited in many geographic locales.

The Opportunity of Manualized Psychodynamic Psychotherapy for Children and Adolescents

Within current psychotherapy modalities, cognitive behavioral therapy is argued to be the gold standard therapy.[43] It has the most robust empirical backing and commonly provides a targeted approach to specific psychopathologies. It has been tested in conjunction with, and in comparison to, other strong empirically supported treatments,[44] outshining a more unstructured psychodynamic practice. Manualized psychodynamic approaches retain an investment in an understanding of unconscious meaning and developmental models and provide an opportunity to position the richness of the child psychoanalytic legacy within contemporary practice.

Evidence-based treatment manuals have emerged and offer a structured and straightforward way to train residents.[10] We highlight the capability of 3 manualized approaches: regulation focused psychotherapy for children (RFP-C), mentalization based therapy for children (MBT-C), and transference-focused psychotherapy for adolescents (TFP-A).

Regulation Focused Psychotherapy for Children

RFP-C is an effective short-term psychodynamic manualized treatment of school-aged children with externalizing behaviors.[8] A randomized controlled trial has demonstrated efficacy,[45] and further studies are underway. With 16 sessions of play therapy coupled with 4 parent sessions, RFP-C is designed to enable a child to explore troubled emotions and show a decreased necessity to externalize problematic behaviors. RFP-C has the benefit of a foundation in neuroscience through a proposed link between defense mechanisms and the implicit emotion regulation system.[46] Children's maladaptive defenses are understood as impairments in the functioning of this system and its defined neural correlates, and the psychoanalytic mainstay of defense interpretation, which is the core technique of the approach, is positioned as a teachable psychosocial intervention tailored to these underlying neural deficits. By focusing on the transdiagnostic concept of emotion dysregulation, RFP-C has applicability to a range of externalizing childhood disorders, including oppositional defiant disorder, attention-deficit/hyperactivity disorder, disruptive mood dysregulation disorder, and others. Future studies with different youth populations may facilitate its extension to a further range of disorders, such as autism spectrum disorders, as well as to youth at a different range of developmental ages and environmental trauma and disparity.

The process of associating external behavior with inner conflict is rooted in psychoanalytic theory, and RFP-C incorporates this practice into treatment. The initial phase focuses on the clinician's identification of the child's avoidance mechanisms through

play sessions and understanding the countertransference responses that occur between the child and the provider. Parent check-ins give insight into their reactions when the child displays dysregulated behavior and also functions to increase parent mindfulness of how their responses may affect the child. Throughout the sessions, the child has more exposure to the events that trigger maladaptive behavior, which increases tolerance to painful emotions.

The benefits of this therapy include its cost-effectiveness, short duration, transferability from provider to parent, and minimal prior experience needed. This answers the challenges faced with dropout rates, retention, and financial burdens on families. Additionally, parents may be hesitant to medicate their child given the unwanted side effects, and would rather consider psychotherapeutic approaches as a more favorable method of treatment.

The following clinical vignettes[47,48] offer a vision for the applicability of the RFP-C approach to the various settings in which child and adolescent psychiatry fellows train.

JOHNNY

Johnny was an 8-year-old foster child. He was admitted to a child and adolescent inpatient psychiatry unit after an argument with his foster mother over dinner led to her calling 911 when he had run into his room and tightened a phone charging cord around his neck, yelling that he wanted to die. Johnny was a bright and friendly young boy in interactions with his peers and with staff, though staff noted him to be very needy. He had difficulties with staff changes of shift and at bedtime commonly requested a melatonin as-needed order for sleep. He held onto a stuffed animal that his biological mother had given him when he had entered foster care.

In sessions with his physician, he frequently engaged through play around sports figures and triumphs in the big game. In one session, when his physician provided a gentle reminder that the session would soon come to a close, he unexpectedly drew a menacing face and threw stuffed football directly at the clinician's head. His physician commented aloud that he noticed that the reminder of the coming session's end led to this wild throw, and that he the physician wondered what Johnny thought of that.[47]

In this small intervention, the physician helps through a simple defense interpretation to shift the child's aggressive act into a space in which feelings and matters close to the child can be reflected upon and spoken about. The physician acts on the child's implicit emotion regulation through engagement where an unconscious pattern involving the emergence of aggression as a defense against separation and loss occurs. Through mobilization of the positive feelings toward the physician and his invitation to accept the aggression and explore it together with Johnny, the physician helps to bring awareness of the pushing-away action of this maladaptive defense and helps Johnny to come 1 step closer to accepting the pain based on his history of saying goodbye and the uncertainty from frequent transitions in caregivers to the future.

JULIE

Twelve-year-old Julie had presented to the emergency department of a teaching hospital when she was found at school to have had a bruise on her elbow.[48] When the triage nurse noted on a screening that Julie endorsed suicidal thoughts, a child and adolescent fellow was called into the assessment.

Julie in sharing the history told her physician that her mother wouldn't let her have her phone. Her mother was concerned about her interest in boys at her age and the photos she had shared of herself wearing her two-piece swimsuit. Her mother had

wrestled the phone away from her and in the process hit her elbow hard against the frame of the car door.

Julie had only laughed when her mother was clenching her wrist after the bump. Her mother became even more angry and told her not to laugh in her face, to which Julie laughed only harder. Her mother hit the accelerator even harder, drove her home, and told her to go to bed without dinner or further conversation about the event.

In the emergency department, Julie's physician asked her what she thought about that she had laughed at that moment. Julie just said that it was funny. Her physician commented that it must have been easier for Julie to laugh in that moment than to feel a mix of feelings, and her physician wondered aloud what they were that made it so challenging to feel such that laughter came out at that moment.

Here, the physician as with Johnny modeled and encouraged for Julie to break patterns of avoidance of challenging affects and even within the most recent of closeness with a new caregiver stand to look at them. Julie and her mother went on to accept a referral for outpatient psychotherapy where a psychodynamic process unfolded based on the approach introduced in the emergency department.

Mentalization Based Therapy for Children

MBT-C is a time-limited, transdiagnostic, psychotherapeutic approach to working with children 5 to 12 years of age and their caregivers.[8] Mentalization, the ability to observe oneself from the outside and imagine the other from the inside, is considered a protective factor against psychopathology.[49] This treatment seeks to improve and maintain the child and parents' openness toward social learning to promote reflective functioning and increase healthy interpersonal relationships. MBT-C's techniques are guided by developmental psychology, neuroscience, and relational psychodynamic principles and focus on identifying moments of change in affective states, shifts in attention control, and breakdowns of mentalizing capacity. Identifying these moments allows the therapist to invite the child to engage in coregulation and reciprocity, which promotes the development of mentalization. Psychotherapeutic interventions such as empathy, exploration, validation, and clarification serve as ways of developing a new relational language around emotional regulation and increases the effectiveness of interpersonal functioning for both child and caregivers. MBT-C highlights the importance of activating parents' reflective functioning capacities before they invite them to mentalize their children, as it leads to a reduction in negative parental attributions, improvement in adapting to various parental approaches, and enhancement of their capacity to offer a secure base for their children.

MBT-C consists of 6 assessment sessions followed by a block of 12 sessions for the child, and parallel sessions for the parents. Treatment progress is reviewed by the therapist, child, and parents during the eighth session of each treatment block, with up to 3 blocks of 12 sessions that can be offered. The initial assessments with the child, primary caregivers, and family provide the necessary information to coconstruct an MBT-C tool termed *focus formulation* to promote a sense of agency and active participation regarding treatment objectives. Psychoeducation about mentalization enables the development of a common language. After focus formulation is established, a calendar is used by therapist and child to chart major treatment themes and help guide the process and content of therapy. There are several publications exploring the application of MBT-C to diverse clinical populations.[50–54] Most recently, Halfon and colleagues (2024) showed the effectiveness of MBT-C in improving mother-child emotional regulations, mother-child dysfunctional interactions, and children's subjective emotional and behavioral problems with a sample of children in Turkey compared to a parenting and child social skills group.[55]

A vignette shows an mentalization based therapy for children approach

Luis. Luis was a 6 year old Latino boy who moved from his native country 2 years ago to a new city. He was referred by his school's guidance counselor due to aggressive behavior in the playground with peers (punching, kicking), which was described as oppositional behavior toward his teachers. Luis was the youngest of 3 male siblings. His parents worked long hours, leaving him and his sibling under the care of their grandmother from a young age. Both parents spoke of Luis as a high-strong boy who always struggled with managing his emotions. His father said he often took Luis running in the evenings to calm him down, which seemed to help with regulating his emotions. Psychological testing showed average cognitive functioning with no major learning issues. Developmental milestones were met with the exception of sleeping. Both parents spoke of concerns with Luis over his sleep routine. Luis would go to bed at 11 o'clock in the evening and often wake up at 5 o'clock in the morning regardless of physical activity the day prior.

The therapist met with Luis and his family and asked Luis to pick an animal that made him think of his father and one that made him think of his mother. Luis' mother thought Luis would not understand the request; however, to everyone's surprise, Luis chose a bear for his father stating "he is big!" and a koala for his mother stating "she gives nice hugs and has nails!". The therapist assessed the parents' reaction and wondered if they imagined Luis to choose these animals to represent them. The therapist, with a playful voice, made a curious face to catch Luis' gaze and keep his attention. Luis looked at his parents with a half-smile and the therapist asked his mother what she thought his expression implied. She stated she thought Luis was proud. The therapist then asked the mother to ask Luis, to which he replied with a big smile and said: "I am a smart cookie!". The therapist and parents shared a laugh that caused Luis to be excited, his body movements becoming more active. The therapist stated, "I think Luis' body is talking and telling us he likes when we admire him. What do you think dad?". Luis' father replied, "I think so!", matching the therapist's musical tone. During the following meeting with both parents, the therapist reviewed the family session video and introduced the idea of mutual enjoyment, connecting it with mentalization and how we feel safe and validated when learning to safely think of others and ourselves. The following sessions with Luis focused on creating a profile of his functioning by observing his capacity to cope with a new situation with a stranger. The therapist focused on assessing Luis's capacity for connection and reciprocity and observed that, while Luis was an active boy, he enjoyed activities where he could practice his frustration tolerance with explicit naming and noticing from a predictable adult.

Following the assessment, Luis and his therapist created a story about a small lion who couldn't find the words to express his sadness and worry. The therapist presented the story to Luis and his parents to establish a framework for their objective: to help Luis, the little Lion, find better ways to ask for help when he felt afraid, worried, or confused. The therapist explained that they would work together on this goal and encouraged his parents to practice at home as well.

Luis and his therapist worked together and in their eighth session, met with his parents and decided that little Luis Lion was ready to try his new skills and would be saying goodbye after 4 more sessions. The main theme observed in Luis' sessions was a sense of loneliness and feeling lost, which was portrayed with lost and found games and elaborate stories in the sandbox where sessions often began and were used as a place to coregulate and explore thoughts and difficult feelings. Both parents requested monthly meetings to continue finding ways to remain curious and value the small moments of mutual enjoyment, as these moment helped Luis practice internal

regulation. Strategies to continue supporting Luis' emerging sense of agency in his new city were also shared with his school who now felt that Luis was a strong-willed and highly sensitive boy. Finally, improvement in his sleep routine and incorporation of natural remedies resulted in a vitalized first-grader who could notice, name, and regulate his emotions in an age-appropriate manner.

The MBT-C approach in this case focuses on Luis' attention control capacities through joint attention games that required coregulation and reciprocity. By staying firmly in this level, Luis' effortful control capacities, the capacity to control one's impulses in the service of the relationship, improved significantly. Luis' symbolic representational capacities emerged and with them, his capacity to verbalize his emotions and ask for help when needed in the context of emotional regulation. This ultimately led to Luis' capacity to express his anger and sadness of being away from *abuelita*, his beloved grandmother, with which his therapist and parents validated and empathized.

Transference-Focused Psychotherapy for Adolescents

TFP-A is another manualized psychodynamic treatment approach tailored for individuals with severe personality disorders (PD).[9] It aims to guide patients toward a more realistic and stable view of self. Adolescence is a defining developmental period that serves as a springboard to identity formation as adolescents learn to navigate complex social, interpersonal, and emotional challenges. These moments are often vulnerable and can lead to maladaptive behaviors, contributing to the development of PD.

TFP-A is optimal in intervening in these moments. Rooted in psychoanalytic theory, TFP-A uses transference of patient onto provider to explore relationship patterns and address unhealthy reactions to improve behavioral control. The following vignette demonstrates TFP-A with an adolescent.

David

David,[56] a 16-year-old young man with a prior psychiatric diagnosis of narcissistic personality disorder, came into his outpatient psychotherapy intake with concerns from his parents over his procrastination challenges. David avoided social engagements, and his parents were concerned about anxiety as a motivator, and soon he was avoiding school days completely, further compounding his academic problems.

Quiet and polite, in his session with his physician he shared his expectations of being rejected and disowned from the high-profile institutions his parents aspired for him to attend beyond his high school years. He felt his teachers were in on the game, and that there was a trend amongst those he respected to belittle him and prevent him from succeeding. He gave up on his work to maintain some sense of control with this game. Fantasies about suicide provided some comfort in his reserved capability to maintain a sense of control over the horrible situation in which he found himself.

David's stance was recognized as a product of a narcissistic personality disorder for which David received psychoeducation on its manifestations and characteristics. David with his physician explored the cost of this stance. A contract was raised with David to protect him from the consequences of self-destructive behaviors including suicide, and secondary measures to encourage his full attendance at school and in treatment were made. His parents were involved to support the treatment, and into the opening phase they went.

There, violations of the frame began from the start. David arrived late and began to cancel sessions completely, entering his conflicts into the transference situation. He felt his physician was negative toward him, and he wanted nothing more than to shut him out.

David's physician commented on these behaviors that flew in the face of his commitment, and the physician supported him to maintain an observing stance on the impact of his *autonomic relationship patterns* that touched on his polarized relationship dyads. David's physician was the tormenting figure of his helpless victimized state, and the role-reversal that he employed to translate his own aggression against the treatment into experiencing himself as the recipient of such subtle hostile abuse from the physician.

With time, the positive side of the split between David and his physician emerged. David's physician became the understanding, unencumbered figure that he felt he needed to rescue him through his immense patience and tolerance of his negativity.[57] With time, David began to attend school more regularly and work out his issues within the treatment, abandoning *preemptive strikes* on himself in favor of opening himself to new if initially threatening experiences, knowing and incorporating the therapeutic space set by David's therapist into himself.

Applications

There are several benefits of manualized child psychodynamic psychotherapies to promote training in psychodynamic psychotherapy in both general residency and child and adolescent psychiatry fellowships alike. First, the structured protocol and adherence measures to these encapsulated approaches address concerns that psychodynamic psychotherapy is not teachable or capable of definition and competency measurement.[20] Their language is written for clinicians with no prior exposure to psychodynamic psychotherapy, making them accessible. Their accessibility enhances the feasibility to engage trainees in their early years of training and potentially maintain and even extend interest in psychodynamic psychotherapy against the trend of declining rates of resident interest across the timespan of training.[16] Their accessibility also promotes supervisor familiarity and potentially availability. Their establishment as evidence-based practices addresses the common concern that psychodynamic psychotherapy is not evidence-based, and their integration with neurobiological models, including emotion regulation[45] and mentalization,[58] eases integration with other elements within a psychiatric curriculum. As these approaches are structured to be applicable with children with more severe impairments, they are appropriate for use within the clinical populations commonly encountered in training.

Whereas the time-limited structure of these approaches promotes their capability for application within the limited time of trainees in outpatient setting rotations, even further benefit may derive from their modularization and application of their active interventions within the diverse clinical settings of training. Inpatient, emergency department, and consultation-liaison settings may receive operationalized interventions.[59] Their interventions may also be extended into the adolescent range. The presented vignettes provide impressions of how such applications may perform for the trainee and for their patients.

SUMMARY

As psychodynamic psychotherapy's emphasis in psychiatry residency training becomes a question of relevance, clinicians must vouch for its preservation by demonstrating its positive value to improved treatment outcomes. With the pressures of contemporary psychiatry to offer fast and efficient treatment in efforts to care for larger quantities of patients, the health care system functions to deliver quick fix treatments specific to acute symptom improvement but lacks the holistic approach that psychotherapy offers for overall mental health outcomes. E-learning, tele-technology, and visiting supervisors offer alternatives to fill the gap in the challenges of limited resources within departments

and general competence of psychodynamic concepts. From the vantage points of time constraints and the need for evidence-based approaches for measurable outcomes, the problems most heavily criticized in current psychiatry programs, manualized short-term psychodynamic approaches have evolved and demonstrate great utility in treating various internalizing and externalizing disorders amongst others. The therapeutic benefit allows the patient to explore their unconscious and do the mental and physical work necessary to reframe and reshape their prior behaviors in a structured approach. Within psychiatry, we must not lose sight of the role of biological interventions to relieve symptoms, but we also must attend to the mind itself and appreciate the power of psychotherapy to assist the patient in understanding his or her underlying psychopathology in order to improve overall social, emotional, and interpersonal functioning.

Psychodynamic therapy honors the multidimensional, mysterious, and ever-changing intricacies of the mind. It is crucial that residents remain equipped with this tool to better navigate the complexities of the human psyche.

CLINICS CARE POINTS

- Psychiatry trainees and program directors remain interested in learning and teaching psychodynamic psychotherapy in post-graduate medical education.
- Regulatory bodies continue to require attainment of comptency in practicing psychodynamic psychotherapy during postgraduate education.
- Manualized child and adolescent psychodynamic psychotherapy approaches including RFP-C, MBT-C, and TFP-A provide an avenue for education and attainment of competency.

DISCLOSURE

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