APA Resource Document

Resource Document on Introduction to Psychotherapy and the Treatment Relationship from an Integrative Perspective

A Psychotherapy Curriculum Combining Neuroscience and Traditional Psychotherapeutic Understanding for Residents and Other Beginners

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INTRODUCTION

This curriculum has been developed to provide early-stage psychiatry residents with a foundation of basic knowledge and skills to appreciate and utilize the therapeutic relationship in all clinical care settings, across all types of patient interactions, and to offer a nondenominational introduction to the practice of psychotherapy. A core tenet of this curriculum is that an encounter with an understanding, empathetic and helpful other is itself therapeutic. The relationship is itself a kind of medicine, and psychotherapy is in fact a biological treatment. Taking an integrative perspective, this curriculum emphasizes what we consider to be the most essential aspects of human development and psychopathology, which apply dimensionally across all categorical diagnoses and forms of treatment and play a role at every step of patient care.

Teaching psychotherapy to early-stage psychiatry residents is a challenge in today's environment. In eras past, when less was known about the pathophysiology and somatic treatment of psychiatric disorders, there was greater emphasis on a psychological–at first, psychoanalytic–approach. With the dramatic growth of medical knowledge, more didactic time has been devoted to biological understanding and treatment and less to psychology and psychotherapy.

Today, programs train residents in a variety of clinical contexts, and faculty typically have an eclectic mix of psychotherapy experiences to bring to teaching. The Accreditation Council for Graduate Medical Education (ACGME) requirements in psychotherapy are becoming ever leaner, though it is our strong belief that a strong foundation in psychotherapy training is essential to becoming a well-rounded and nuanced psychiatrist.

The limited time given to psychotherapy often follows an older, traditional model of teaching various specific psychotherapy modalities, each with its unique foundational theories and methods. The time dedicated to this teaching is insufficient, and as a result, it is our impression that residents generally do not emerge from training with competence in the conduct of psychotherapy or with a serviceable psychological understanding of human development and psychopathology. One important concern is that teaching specific models of therapy does not necessarily translate to the diverse clinical roles of psychiatric practice for graduates. Further, teaching several different models, in which the resident will not have time to develop a sense of competence, can discourage residents from doing any psychotherapy and erode a sense of efficacy in using basic psychotherapy skills. [ref: Judy Kantrowitz]

By adopting an integrative approach, this curriculum addresses these gaps in training. It updates psychotherapy teaching to the latest status of the field, where there is a developing convergence of proposed change mechanisms between CBT and psychodynamic psychotherapy [Barlow, Unified Protocol; Psychotherapy Q-Sort research]. This curriculum not only describes a model of eclectic technique use, but it also integrates theories of change through research in neuroscience and psychotherapy change processes. It supports the requirements of the recently revised Psychiatry Milestones, reflects the criteria of the AADPRT A-MAP assessment model, and borrows from–yet extends beyond–the well-known Y-model (Plakun et al., 2009) of teaching psychotherapy. In these ways, it provides programs with a framework for resident competency.

This integrative approach to psychotherapy and the doctor-patient relationship emphasizes research findings that all bona fide psychotherapies work relatively as well as others (the "dodo bird effect")

and that nonspecific or "common" factors play a critical role in the outcome of psychotherapy. It takes into account the findings of placebo studies and studies on clinician stance, which suggest that the therapeutic relationship is a vital factor in determining patient outcomes. These lead us to emphasize, first, the nature, function and value of the therapeutic relationship, and second, the critical roles of attachment, trauma and systems theory in understanding human psychology.

The curriculum covers the following core topics:

1. Interpersonal skills and the therapeutic relationship
2. Individualized diagnostic formulation
3. Emerging neuroscientific understandings that explain the value and utility of the therapeutic relationship and of psychotherapy
4. Attachment
5. Trauma
6. Systems theory

While the concept of psychotherapy integration is used in a variety of ways in the literature (common factors, technical eclecticism, theoretical integration, assimilative integration, integral metatheory, to name a few), we focus on the following aspects in defining our approach:

1. Common factors research is central to understanding treatment. It demonstrates important elements of the change process across all forms of psychotherapy, which are readily applicable to the doctor-patient relationship in all clinical settings. These include therapist factors such as attunement, empathy, warmth and transparency; patient factors such as motivation, positive expectance and internal locus of control; and relationship factors such as the alliance and management of alliance ruptures through relational repair. Common factors research leads us to the value of the therapeutic relationship regardless of the setting or psychotherapy modality employed.
2. Treatments are informed by the emerging neuroscientific understanding of how the mind combines information and updates itself to change or respond to the environment, especially the relational environment.
3. Emphasis is placed on the shared foundations and complementary aspects of psychotherapy, rather than on differing schools, modalities and ideas across psychotherapies. (This is the stem of the Y in the Y model, Plakun et al., 2009).
4. Treatment is individualized through consideration of the whole person in a transdiagnostic and dimensional formulation. Techniques and interventions can be drawn from multiple models and schools to suit the individual patient.
5. A flexible, integrative model allows for attunement and adaptation to the particular values and preferences of the individual or family, as well as to the cultural, economic and community contexts of symptoms and treatment. In this way, the integrative approach appreciates that people exist in and operate as part of systems that they play roles in, and they are impacted by the functioning and structure of those systems.

The most recent revision of the ACGME Psychiatry Milestones requires competence in three core modalities of psychotherapy: cognitive-behavioral, psychodynamic and supportive. It also requires other applicable skills, captured in the domains of Psychotherapy (Patient Care 4, Medical

Knowledge 4) and Patient- and Family-Centered Communication (Interpersonal and Communication Skills 1).

The Patient Care 4 domain lists competencies such as establishing and managing the therapeutic alliance, utilizing the common factors of psychotherapy, individualized tailoring of psychotherapy based on specific patient factors, and accurately understanding the patient's core issues and feelings (empathy) while managing the emotional content and feelings elicited (interpersonal affect regulation).

Medical Knowledge 4 lists competencies such as describing common elements across specific psychotherapy modalities (common factors); identifying the central theoretical principles across the three core psychotherapeutic modalities: supportive, psychodynamic and cognitive-behavioral; and explaining the theoretical mechanism of therapeutic change in each core modality (neuroscience).

Interpersonal and Communication Skills 1 lists competencies such as establishing therapeutic relationships in a variety of circumstances, identifying communication barriers, demonstrating self-awareness (self-mentalizing) and communicating effectively.

While didactic teaching of psychotherapy is delivered in very different ways within different programs, this integrative psychotherapy curriculum provides a standard framework for teaching early-stage residents fundamental core competencies that help them meet the ACGME requirements and become skilled psychiatrists.

The six modules in this curriculum cover topics that are considered the most relevant and foundational in the competent use of interpersonal and psychotherapeutic skills necessary to diagnose and treat psychiatric conditions. It opens with an **introduction** to familiarize residents with the concept of integration in psychotherapy and to help them understand why psychotherapy is relevant to them, no matter what their career goals or theoretical orientation may be. The modules are then presented in a sequence that starts with foundational scientific concepts and builds toward interpersonal skills development.

The **neuroscience module** teaches residents how the mind is the expression of the complex activity of the brain and how psychotherapy has a material basis alongside its psychological effects.

The **attachment module** teaches about the essential role of caregiver attunement during infancy and early childhood in the development of our capacity for self-regulation and for understanding the minds of others. It outlines the trajectory of the relational mind from early development into adulthood and its relevance for the psychotherapeutic relationship.

The **systems theory** module shows how the individual interacts with and functions within systems such as families, couples and larger groups.

The **trauma module** demonstrates how the normal development of the mind and relationships can be interrupted or impaired by life experiences.

The **formulation module** shows residents how clinicians can systematically describe and understand how psychological problems develop and how they can be addressed in therapy.

Finally, the **interpersonal stance module** takes a deeper look at how a therapeutic relationship is formed and maintained and how this is instrumental in treatment and healing.

While it is recommended that the course be taught as a whole as the modules build on each other, it is appropriate to use each module as a stand-alone set of sessions on a particular topic if that most suits the needs of the specific training program.

LEARNING OBJECTIVES

By completing this curriculum, learners will:

1. Feel prepared to engage in psychotherapeutic interaction in a variety of settings.
2. Develop confidence and enthusiasm in their ability to implement basic psychotherapeutic skills in all clinical encounters.
3. Appreciate the value of psychotherapeutic skills in all clinical encounters.
4. Become familiar with basic psychological concepts relevant to supporting a sense of safety and trust in clinical care.
5. Understand what is meant by an integrative approach to psychotherapy.
6. Appreciate the importance of the therapeutic alliance as the foundation for effective treatment. Learn approaches to optimize relational interactions in clinical care settings.
7. Understand the possible mechanisms by which change occurs in psychotherapy.
8. Learn essential parts of neuroscience, developmental theory and cultural background that are relevant to psychotherapy.
9. Learn how to think in a transdiagnostic/dimensional way.
10. Learn to think about clinical encounters from a systems perspective.

Specific session learning objectives are covered in detail within each module.

FACULTY GUIDE

Intended Learners

This curriculum is intended for general psychiatry residents in their PGY1 and PGY2 training years. The content is relevant to all treatments and should be learned prior to the start of formal clinical psychotherapy practice in residency. Delivering the material too late may mean that residents are unprepared for their longitudinal psychotherapy experiences.

The curriculum is also appropriate for learners in other disciplines who intend to learn about the basics of psychotherapy and building therapeutic relationships.

Faculty Guidance

Teachers and supervisors are recommended to complete the following prior to teaching sessions:

1. Read learning objectives and outlines for the session.
2. Obtain and read all "Key References" for the session.
3. If available, consider the learning resources provided for the session.
4. "Additional References" may be obtained and reviewed by instructors who would like more in-depth background on a particular topic.

During each teaching session, the following are recommended:

1. Discuss the learning objectives of each module.
2. Explain the purpose and relevance of the module.
3. Use the outline to structure each student learning session while adapting the format and specific details of each session to the interests and level of the audience.
4. Provide specific examples and discuss relevant clinical experiences to facilitate learning and engagement.

Resources Required

Materials: Recommended resources for session teachers include textbooks, articles and other resources, listed at the end of each session outline. These are intended for teachers to read in preparation for teaching and should not be assumed to be suitable as assigned reading for learners.

"Key References" are intended to provide the teacher of the session with publications that are considered central to the topics of each teaching session. Some are "Appendix Materials," which are key references that have been written by the authors of this curriculum.

"Additional References" in each module are supplemental materials that may be helpful but are not strictly necessary.

Clinical Vignettes for each module are provided in Appendix Resources to link the concepts to a variety of real-world clinical settings. These can be used as a basis for discussion, along with other clinical examples provided by teachers and learners themselves.

The authors of this curriculum are not authorized to provide the majority of the textbooks or articles for this curriculum due to copyright limitations.

Faculty: This curriculum can be taught by faculty clinicians with experience, interest and training in psychotherapy (psychiatrists, psychologists or other psychotherapists). Expertise in any particular psychotherapy modality is not necessary, given the integrative approach of the curriculum.

If these faculty are not available, the sessions can be supervised by clinical faculty members or clinicians with an interest in the field of psychotherapy. In-person sessions are strongly recommended, though remote supervision and teaching may be more practical for some programs.

Clinical Experiences: This curriculum is meant to introduce students to the basics of psychotherapy. Because we emphasize common factors and general principles that can be used in general medical and psychiatric clinical settings, we hope that knowledge and skills developed in this curriculum will be relevant to patient interactions in most first-and second-year clinical rotations.

Innovation

To our knowledge, this curriculum is the first integrative psychotherapy curriculum designed for general psychiatry residents. The teaching is not limited to specific psychotherapy schools or theories. It encompasses both a neuroscientific and a psychological understanding of treatment and psychotherapy, and it is designed to apply to all treatments, not just psychotherapy. It incorporates up-to-date research in the field and addresses (cutting-edge) topics, including cultural trauma and social and family systems.

Adaptability

The goal of this curriculum is to provide a framework that will be usable by any program. The curriculum can be taught as a whole or can be integrated in pieces into a program's existing psychotherapy curriculum to suit the needs of residents in whatever year of training is most appropriate.

OUTCOMES ASSESSMENT

Pre-/Post--Test Questions to Assess Knowledge Base

To assess your learners' knowledge base before and after taking the sessions in this course, we have provided multiple-choice pre-/post-test questions in the Appendix Resources for each session.

Self-Assessment Test Questions

Additional Methods for Psychotherapy Learning Assessment

We also encourage programs to evaluate resident progress toward completing the ACGME psychotherapy milestones using a mixture of methods, including, but not limited to:

- Direct observation of patient interviews and interactions
- Psychotherapy supervisor ratings of residents
- Feedback/reflection from the residents about their own performance

AADPRT Milestone Assessment for Psychotherapy

Learner-patient psychotherapy interactions can be assessed using the A-MAP form, created by the American Association of Directors of Psychiatric Residency Training.

This form provides a structured way to assess a learner's psychotherapy skills in the areas of alliance, empathy and boundaries, using a 15-minute video clip of a recorded psychotherapy session. It provides an opportunity for evaluation and a structured discussion between supervisor and learner to help provide feedback about a learner's psychotherapy skills.

The A-MAP form and a guide to using it can be obtained at the following website:
https://www.aadprt.org/training-directors/virtual-training-office

ACGME Psychotherapy Milestones

For further reference, the ACGME psychotherapy milestones can be found at the following website:
https://www.acgme.org/globalassets/pdfs/milestones/psychiatrymilestones.pdf

MODULE 1: INTRODUCTION TO INTEGRATIVE PSYCHOTHERAPY

How does talking with an empathic, nonjudgmental listener lead to a decrease in suffering and an improvement in functioning for someone in distress? How is the psychologically attuned listener attending and responding differently from a caring friend or family member in a social conversation? Or from a wise coach giving good advice? These two introductory sessions will offer experiential, theoretical and technical approaches to understanding and practicing psychotherapeutic listening, inquiry and response.

Session 1 begins with an exploration of students' ideas about how psychotherapy works. Students will be encouraged to consider reasons for learning an integrated curriculum on the fundamental processes that underlie all psychotherapeutic interactions. Students will be introduced to the format and expectations of this seminar and to accessing the written and recorded resources that will be made available.

Guidelines for maintaining curiosity and communicating understanding will be given for role-playing of therapeutic listening. Debriefing of these interactions will encourage the students to make observations of the listener's characteristics and techniques that facilitate self-acceptance and self-reflection for the "patient."

Session 2 will explore how these techniques and qualities of interaction contribute to the therapeutic stages of:

1. developing an empathic connection with the patient;
2. facilitating co-regulation of emotion; and
3. re-experiencing emotions in a new, therapeutic context, which lead to
4. healing.

The role of these interactions in any therapeutic encounter will be highlighted to reflect the importance of psychotherapeutic intent in all aspects of care.

Session 1: An Integrative Approach to the Therapeutic Encounter

Learning Objectives

1. The resident will be able to explain what an integrative approach to psychotherapy is and how this is relevant to clinical practice.
2. The resident will be able to describe the characteristics and techniques of therapeutic listening and responding.
3. The resident will be able to describe how the therapeutic interaction sets the stage for change in psychotherapy.

Outline

1. Review a brief history of the development of psychotherapy and how it has been taught in residency programs and other training programs. (Additional Reference #4)
    a. Sigmund Freud's talking cure: uncovering unconscious causes of emotional and behavioral disorders through free associations, slips of the tongue and dream interpretation
    b. B. F. Skinner's description of operant conditioning, antecedents and consequences of behavior; treating the mind as a black box
    c. Aaron Beck's recognition that therapy can be effective by identifying the maladaptive thought patterns that are on the surface of the mind, rather than needing to uncover unconscious causes
    d. "The Third Wave" of mindfulness-based interventions (DBT, ACT, mindfulness-based cognitive therapy for depression)
    e. A proliferation of different empirically validated treatments: too many for one provider to learn
    f. A response of unifying different approaches:
        i. The Unified Protocol for Transdiagnostic Treatment of Emotional Disorders (David Barlow and colleagues) offers a unified therapeutic approach based on exposure to avoided affect in anxiety and depression
        ii. The Modular Approach to Therapy for Children with Anxiety, Depression, Trauma or Conduct Problems (Chorpita & Weisz, 2009) offers a modular approach, with CBT treatment guidelines, worksheets and handouts, with decision trees to guide therapists in providing the appropriate intervention
2. In this curriculum, we focus on the factors that are common to all effective therapeutic approaches. We offer ways to teach the beginning therapist the critical skills of developing a therapeutic alliance. We explain how the therapeutic relationship itself is the agent of change, and we address these mechanisms of change in the neuroscience module.
3. Discuss how teaching specific treatment approaches (e.g., DBT or mentalization-based treatment for borderline patients) or teaching specific treatment elements (exposure for anxiety, interpretation of conflict in psychoanalysis) differs from teaching an integrative psychotherapy or common factors approach.
    a. Use of language and thinking not tied to a specific theory
    b. Orientation toward treatment interventions that are geared toward understanding a person's unique responses rather than diagnosing specific disorders

c. Understanding areas of convergence among psychotherapies over time
    i. Exposure to intolerable or difficult experiences, including but not limited to thoughts, emotions, memories and situations

        Examples: "Affect phobia" treatments and exposure to obsession-inducing triggers, as well as use of the Unified Protocol to target avoidance of aversive experiences
    ii. Clinical attention to learned patterns of relationships and self-understanding, especially when these can be observed in the therapeutic encounter
        a. Schemas or core beliefs in CBT
        b. Transference in psychodynamic psychotherapy
d. Theory and understanding derived from multiple areas of study

    I.e., Integral metatheory (looking at problems from different perspectives)
e. Willingness to consider and learn from a variety of theories and schools

4. Discuss how psychotherapy skills and theory are relevant to general clinical practice
    a. Study of psychotherapy allows for a broader understanding of the functioning of the mind and brain
    b. What are the core psychotherapy competencies that matter regardless of your treatment setting and theoretical orientation?
        i. Empathy/empathetic style.
        ii. Warmth.
        iii. Authenticity.
        iv. Emotional fluency.
        v. Reflective capacity–detecting the patient's and the therapist's internal states/thinking and changes in these states/thinking.
        vi. Acceptance of all parts of the patient and all aspects of the patient's life, including awareness of cultural, racial, community and family systems factors.
        vii. Capacity to establish and manage (repair) alliance. Alliance is the presence of shared goals and tasks between the patient and therapist, along with the emotional bond.
        viii. Recognizing maladaptive patterns and bringing awareness of these to the patient.
5. Explore and discuss residents' ideas and experiences about what makes a clinical encounter "psychotherapeutic"
6. Discuss how a clinician's interventions can lead to positive changes for patients
7. Lead residents through a listening exercise, and assign homework for discussion in session 2

Key References

1. Bender, S., & Messner, E. (2003). *Becoming a Therapist*. New York: The Guilford Press. (Chapter 3, Initiating an Alliance and Assessing Safety, pp. 26-39). https://www.academia.edu/88679527/Becoming_a_Therapist_What_Do_I_Say_and_Why*An excellent chapter on the initial consultation, with general and specific instructions on how to make a good connection with a new patient through responsive listening. This is a very helpful chapter (and book) for students to read as well as for teachers to review.*

2. Smith, J. (2017). *Psychotherapy: A Practical Guide.* Cham, Switzerland: Springer International Publishing. (Chapter 9, Conducting an Initial Assessment, pp. 95-109). https://link.springer.com/book/10.1007/978-3-319-49460-9
Offers specific guidelines for initial consultation in the context of an integrative approach to psychotherapy.

3. Norcross, J. C. (2016). Integrative psychotherapy. *Encyclopedia of Mental Health* (pp. 390-394). https://doi.org/10.1016/b978-0-12-397045-9.00027-6https://www.sciencedirect.com/topics/nursing-and-health-professions/integrative-psychotherapy
For teachers: overview of a chapter explaining what integrative psychotherapy is.

Additional References

1. Duncan, B. L. (2002). The legacy of Saul Rosenzweig: The profundity of the dodo bird. *Journal of Psychotherapy Integration*, 12(1), 32-57. https://doi.org/10.1037/1053-0479.12.1.32

2. Norcross, J. C., & Wampold, B. E. (2018). A new therapy for each patient: Evidence-based relationships and responsiveness. *Journal of Clinical Psychology*, 74(11), 1889-1906. https://doi.org/10.1002/jclp.22678

3. See Appendix Resources, Session 1.

4. Williams, J. M. G. (2012). The Mindful Way Through Depression: Freeing Yourself From Chronic Unhappiness. http://enlight.lib.ntu.edu.tw/FULLTEXT/JR-AN/an166746.pdf

5. Barlow, D. H., Farchione, T. J., Fairholme, C. P., Ellard, K. K., Boisseau, C. L., Allen, L. B., & Ehrenreich-May, J. (2010). *Unified Protocol for Transdiagnostic Treatment of Emotional Disorders: Therapist Guide.* https://openlibrary.org/books/OL30596288M/Unified_Protocol_for_Transdiagnostic_Treatment_of_Emotional_Disorders

6. Chorpita, B. F., & Weisz, J. R. (2009). *Modular approach to therapy for children with anxiety, depression, trauma, or conduct problems (MATCH-ADTC).* PracticeWise.

Session 2: Practice Through Clinical Case Illustrations and Discussion

This session will review, clarify and consolidate the concepts introduced in session 1, as well as review the exercise and homework. Since this module is introductory, session 2 focuses more on review and a deeper understanding of material from session 1 through case studies. This is of particular importance for new learners, who can feel lost or stuck in the abstract for these very important concepts.

Learning Objectives

1. The resident will describe a variety of ways that a psychotherapeutic encounter can lead to change.
2. The resident will describe the role of emotional connection, affect regulation and self-reflection in therapeutic change.
3. The resident will describe listening and rapport-building skills that facilitate change.

Outline

1. Discussion of the intentional use of listening skills in the past week, identifying listening skills that corresponded with possible changes in the patient:
    a. Feeling understood, experiencing validation of emotional state
    b. Becoming more emotionally regulated in the presence of a calm listener
    c. Becoming more able to describe feelings and narrate events when in a calmer state of mind
    d. Beginning to recognize patterns of cause and effect in intrapsychic experience and interpersonal interactions
    e. Providing examples of situations in which these skills did not work, and exploring why

2. Case example to illustrate how change can occur through psychotherapeutic encounters:
    a. From the teacher's own experience
    b. Or a brief presentation of the case of Jack from Chapter 2 in Smith J., *Psychotherapy: A Practical Guide*, highlighting:
        i. Presentation with panic attack
        ii. Understanding precipitating factors
        iii. Developing understanding of personality built around sense of self-sufficiency
        iv. Recognizing self-sufficiency as an adaptation to a childhood lacking emotional support: an adaptation that is now leading to maladaptive responses to normative increased need for support
        v. Tailoring initial intervention to be acceptable (supporting self-sufficiency by learning skills to manage emotional distress)
        vi. Long-term goal of creating a safe space in which the patient can feel vulnerable and acknowledge and tolerate feelings of hurt and anger toward parents who were unable to offer emotional support

vii Learning, in the therapy relationship, that expressing vulnerability and need for another can be met with empathy and increased sense of emotional connection

Key References

1. Davidson, L., & Chan, K. K. S. (2014). Common Factors: Evidence-Based Practice and Recovery. *Psychiatric Services*, 65(5), 675-677. https://doi.org/10.1176/appi.ps.201300274
Brief, readable article on emphasizing evidence-based common factors of alliance building in training.

2. Smith, J. (2017). Layers of Pathology, Chapter 2. In *Psychotherapy: A Practical Guide*. Springer. http://dx.doi.org/10.1007/978-3-319-49460-9_2
For a case example of how emotional connection with a therapist brings about change.

MODULE 2: NEUROSCIENCE

This module sets the stage for the curriculum as a whole by grounding our psychological knowledge and skills in the latest neuroscientific theories and knowledge. This module will help you think about the neural basis of relationships and behavior. All experience and all learning are accompanied by physical changes in the brain. As with any activity or behavior that is repeated frequently, the patterns of our responses to social interactions and emotional experiences become strengthened and are more easily activated with repetition. The therapeutic relationship provides an opportunity to recognize maladaptive patterns of responses and to discover and practice new patterns of relating to the self and others.

The stages of learning and change in the therapeutic experience can be understood/considered as consisting of an emotional bond or connection, the interactive expression and regulation of emotion, the reorganization of experience through the process of therapeutic change, and the opportunity for healing. After an introduction to key theories in sessions 1 through 4, each subsequent session of this module will cover these aspects of the therapeutic relationship from the perspective of some of the most relevant and interesting discoveries in neuroscience.

Sessions 1 through 4 cover prominent, contemporary neuroscientific models that are relevant to psychotherapy and the doctor-patient relationship. Sessions 5 through 8 then teach about the process of therapy and therapeutic change through the lens of neurobiology and some of the neuroscientific theories described in the first four sessions.

For those who prefer to teach the neuroscience theories in summary format, HERE is a single session.

Session 1: Models of the Mind in Brain–Predictive Processing and Schema

Learning Objectives

1. Residents will understand some basics of predictive processing and the neuroscience of schema relevant to psychotherapy.
2. Residents will be introduced to some implications of predictive processing, including interoception and hemispheric specialization.

Outline

Schemas can be understood as mental models or frameworks through which perceptions are filtered for selection, interpretation, storage and decision-making. Schemas predict patterns of cognitive, affective and physiological experiences typically associated with self, others and the world.

Many forms of psychotherapy consider and target maladaptive schemas, though different terms may be used. Examples include "dysfunctional core beliefs" in cognitive behavioral therapy or "internal working models" in attachment-based psychotherapy. These terms, drawn from different psychotherapies, are roughly equivalent to "predictions."

Predictions should be defined within a neuroscience context earlier in the introduction.

1. Predictive processing theory and the neuroscience of schema and affect (expectation vs. outcome)
2. Neuroscience of self-schema/other persons' schema:
    a. Narrative self
        i. Narrative self and memory
    b. Interoceptive self (emotions/visceral experience, "here and now")
3. Experiential avoidance/affect phobia and predictive processing

Key References

1. Ecker, B. (2020). Erasing Problematic Emotional Learnings: Psychotherapeutic Use of Memory Reconsolidation Research In R. D. Lane & L. Nadel (Eds.), *Neuroscience of Enduring Change: Implications for Psychotherapy*. New York: Oxford University Press. Kindle Edition. http://dx.doi.org/10.1093/oso/9780190881511.003.0016

2. Lane, R. D., & Smith, R. (2020). Neuroscience of Enduring Change and Psychotherapy: Chapter 16 Summary, Conclusions, and Future Directions. In R. D. Lane & L. Nadel (Eds.), *Neuroscience of Enduring Change*. Oxford University Press. Kindle Edition. http://dx.doi.org/10.1093/oso/9780190881511.003.0016

3. Farb, N., et al. (2015). Interoception, contemplative practice, and health. *Frontiers in Psychology*, 6, 763. https://doi.org/10.3389/fpsyg.2015.00763

4. Gilboa, A., et al. (2017). Neurobiology of schemas and schema-mediated memory. *Trends in Cognitive Sciences*, 21(8), 618-631. https://doi.org/10.1016/j.tics.2017.04.013

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1. Pezzulo, G. (2014). Why do you fear the bogeyman? An embodied predictive coding model of perceptual inference. *Cognitive, Affective, & Behavioral Neuroscience*, 14(3), 902-911. https://doi.org/10.3758/s13415-013-0227-x

2. "Surprise" and the Bayesian Brain: Implications for Psychotherapy Theory and Practice. (March 2019). *Frontiers in Psychology*. https://doi.org/10.3389/fpsyg.2019.00592

3. Brown, V. M., Zhu, L., Solway, A., Wang, J. M., McCurry, K. L., King-Casas, B., & Chiu, P. H. (2021). Reinforcement Learning Disruptions in Individuals With Depression and Sensitivity to Symptom Change Following Cognitive Behavioral Therapy. *JAMA Psychiatry*, 78(10), 1113-1122. https://doi.org/10.1001/jamapsychiatry.2021.1844

4. McNally, G. P., Johansen, J. P., & Blair, H. T. (2011). Placing prediction into the fear circuit. *Trends in Neurosciences*, 34(6), 283-292. https://doi.org/10.1016/j.tins.2011.03.005

Session 2: Models of the Mind in Brain–Extinction and Memory Reconsolidation

Learning Objectives

Residents will learn about the role of memory reconsolidation and extinction in the model of change in therapy.

Outline

1. Brain changes from psychotherapy are believed to be primarily from memory reconsolidation and extinction.
2. Both extinction and reconsolidation involve changes in the synaptic strength triggering a response from a stimulus.
3. How are extinction and reconsolidation different processes, and how do they interact in new learning and revision of old memory?

Key References

1. Kida, S. (2013). Memory Reconsolidation Versus Extinction. In C. M. Alberini (Ed.), *Memory Reconsolidation* (pp. 119-137). Academic Press. ISBN 9780123868923. http://dx.doi.org/10.1016/B978-0-12-386892-3.00005-6

2. Bouton, M. E., Maren, S., & McNally, G. P. (2021). Behavioral and Neurobiological Mechanisms of Pavlovian and Instrumental Extinction Learning. *Physiological Reviews*, 101(2), 611-681. https://doi.org/10.1152/physrev.00016.2020

3. Ecker, B., & Bridges, S. K. (2020). How the science of memory reconsolidation advances the effectiveness and unification of psychotherapy. *Clinical Social Work Journal*, 48(3), 287-300. https://link.springer.com/article/10.1007/s10615-020-00754-z

4. Guskjolen, A., & Cembrowski, M. S. (2023). Engram neurons: Encoding, consolidation, retrieval, and forgetting of memory. *Molecular Psychiatry, 28*(8), 3207–3219. https://doi.org/10.1038/s41380-023-02137-5

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1. Lane, R. D. (2008). Neural Substrates of Implicit and Explicit Emotional Processes: A Unifying Framework for Psychosomatic Medicine. *Psychosomatic Medicine, 70*(2), 214-231. https://doi.org/10.1097/psy.0b013e3181647e44

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Session 3: Models of the Mind in Brain–Complexity Theory

Learning Objectives

Residents will be introduced to complexity theory/chaos theory as applied to the mind in the brain as a complex adaptive system.

Outline

1. Features of complex adaptive systems:
    a. Emergent properties
    b. Top-down and bottom-up effects
    c. Self -organization
        i. Attractor states
        ii. Nodes and networks
    d. Nonlinear dynamics
        i. Positive and negative feedback loops
        ii. A small change in conditions may precipitate a major change in the system
    e. Feedback loops
    f. Multiple meta-stable states
2. The brain as a complex adaptive system:
    a. The brain is a complex neural network, composed of a hierarchy of interacting systems and subsystems of neural circuits. Information processing is both "bottom-up"–reflecting sensory input from receptors–and "top-down." Input is interpreted and processed reflecting top-down predictions/expectations from prior experience of the input in similar contexts.
    b. Evidence suggests that such attractor networks are important for psychologically important functions, such as memory, attention and decision-making.
    c. The brain is not fixed in a single attractor state, but rather changes dynamically over time to enter other attractor states.
3. Speculations about psychotherapy:
    a. Rigidity vs. flexibility
    b. Intersubjectivity as an increase in complexity
    c. Mental representations are attractor networks
    d. A hypothesis of therapeutic change
4. Interpersonal neurobiology:
    a. Brains do not operate in isolation, but rather are embedded in systems. Consider interpersonal systems: family, society, culture.
    b. Isomorphism ("same forms") can reproduce itself in psyches and in societies: Scapegoating in societies is a form of splitting that can parallel splitting within psyches, in which unwanted aspects of self-schema are projected onto the other.

Key References

1. Cozolino, L. J., & Siegel, D. J. (2017). Chapter 3: Contributions of the psychological sciences, Section 3.1: Sensation, perception, and cognition. Subsection: Self-Organizational Processes. In B. J. S. Sadock, V. A. Sadock, & P. Ruiz (Eds.), *Kaplan and Sadock's Comprehensive Textbook of Psychiatry* (10th ed.). Wolters Kluwer Health. https://www.wolterskluwer.com/en/solutions/ovid/kaplan--sadocks-comprehensive-textbook-of-psychiatry-761

2. Hayes, A. M., & Andrews, L. A. (2020). A complex systems approach to the study of change in psychotherapy. *BMC Medicine*, 18, 197. https://doi.org/10.1186/s12916-020-01662-2

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1. Holland, J. H. (2014). *Complexity: A Very Short Introduction* (1st ed.). Oxford, United Kingdom: Oxford University Press. https://global.oup.com/academic/product/complexity-a-very-short-introduction-9780199662548

2. Eliasmith, C. (2007). Attractor Network. *Scholarpedia*, 2(10), 1380. http://www.scholarpedia.org/article/Attractor_network

3. Chan, S. (2001). Complex Adaptive Systems. Massachusetts Institute of Technology ESD.83 Research Seminar in Engineering Systems. https://docs.google.com/viewer?url=https%3A%2F%2Fweb.mit.edu%2Fesd.83%2Fwww%2Fnotebook%2FComplex%2520Adaptive%2520Systems.pdf

Session 4: Models of Mind in Brain–Evolutionary Psychology

Learning Objectives

1. Residents will be able to describe how evolutionary psychology can help explain psychopathology.
2. Residents will demonstrate more empathy toward their patients by appreciating how symptoms like depression and anxiety are not simply features of illness; they may be adaptations to stressful circumstances understood through the lens of evolutionary psychology.
3. Residents will be able to describe how, from an evolutionary psychology framework, psychopathological sequelae of insecure attachment may be adaptations to early life stress.

Outline

1. Evolutionary psychology challenges the common idea of psychopathology as brain pathology. In contrast, psychopathology is seen as reflecting evolutionary adaptation. The function of the brain is understood to promote fitness, rather than happiness.
2. Evolutionary forces promote passing on genes to the next generation
    a. Reproductive fitness over happiness
3. Psychopathology as evolutionary adaptation
    a. Depression/low mood as "involuntary defeat strategy" may facilitate accepting defeat (Durisko et al., 2015)
    b. Impulsive behavior can be adaptive (with respect to passing on genes) if lifespan is quite limited and social status is low ("die young, live fast" strategy).

Key References

1. Del Giudice, M. & Haltigan, J. D. (2023). An integrative evolutionary framework for psychopathology. *Development and Psychopathology*, 35(1), 1-11. https://doi.org/10.1017/S0954579421000870

2. Macleod, M. (2010). Die young, live fast. *New Scientist* (1971), 207(2769), 40-43. https://doi.org/10.1016/S0262-4079(10)61750-2

3. Durisko, Z., Mulsant, B. H., & Andrews, P.W. (2015). An adaptationist perspective on the etiology of depression. *J Affect Disord,* 172, 315-323. https://doi.org/10.1016/j.jad.2014.09.032

4. Szepsenwol, O., Simpson, J.A. (2019). Attachment within life history theory: an evolutionary perspective on individual differences in attachment. *Current Opinion in Psychology*. DOI. https://doi.org/10.1016/j.copsyc.2018.03.005

5. Nesse, R. M. M. (2017). Evolutionary Foundations for Psychiatric Research and Practice. In B. J. S. Sadock, V.A. Sadock; P. Ruiz (Eds.), *Kaplan and Sadock's Comprehensive Textbook of Psychiatry (10th ed.)*: Wolters Kluwer Health. Kindle Edition. https://www.wolterskluwer.com/en/solutions/ovid/kaplan--sadocks-comprehensive-textbook-of-psychiatry-761

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1. Griskevicius, V., Delton, A. W., Robertson, T. E., & Tybur, J. M. (2011). Environmental contingency in life history strategies: the influence of mortality and socioeconomic status on reproductive timing. *J Pers Soc Psychol, 100*(2), 241-254. https://doi.org/10.1037/a0021082

2. Gilbert, P. (2001). Evolution and Social Anxiety: The Role of Attraction, Social Competition, and Social Hierarchies. *Psychiatric Clinics of North America*, 24(4), 723-751. http://dx.doi.org/10.1016/s0193-953x(05)70260-4.

Session 5: Creating a Connection/Bonding

Learning Objectives

1. The resident will understand the role of neurotransmitters and neuropeptides in social behavior, including romantic love, play and nurturing.
2. The resident will consider the implications of this for the doctor-patient relationship.

Outline

1. Neurotransmitters and neuropeptides in behavior
    a. Attachment and bonding (oxytocin and epigenetics) (Vrticka article)
    b. Love and lust
    c. Nurturing

Key References

1. Wu, K. (2017). "Love Actually: The Science Behind Lust, Attraction, and Companionship." *Harvard Medical School–Science in the News*. https://sites.harvard.edu/sitn/2017/02/14/love-actually-science-behind-lust-attraction-companionship/

2. Vrticka, P. (2012). Neuroscience of human social interactions and adult attachment style. *Frontiers in Human Neuroscience*, 6, 212. https://doi.org/10.3389/fnhum.2012.00212

Session 6: Establishing Safety and Regulation/Approaches to Underregulated States

Learning Objectives

1. The resident will become familiar with the neural correlates of underregulated states.
2. The resident will be introduced to neurobiological models that correspond to regulatory interventions in psychotherapy.

Outline

1. Stress responses:
    a. Autonomic nervous system
    b. Hypothalamic-pituitary-adrenal axis (cortisol)
    c. Inflammation
    d. Neurotoxicity of chronic stress
    e. Fragmentation of neural networks (prefrontal cortex offline from sympathetic surge)
2. Responding to an acute stress state (underregulated states):
    a. Affect labeling to reduce amygdalar activation (integrative)
    b. Cognitive and affective reappraisal to emphasize safety
    c. Cognitive reappraisal to heighten prediction error through attentional shift
    d. Use of nonverbals and empathy, both explicitly and implicitly, to enhance safety and create a new, healing experience
    e. Opioid release from attachment dampens sympathetic arousal

Key References

1. Kozlowska, K., Walker, P., McLean, L., & Carrive, P. (2015). Fear and the Defense Cascade–Clinical Implications and Management. (2014). *Harvard Review of Psychiatry*. https://doi.org/10.1097%2FHRP.0000000000000065

2. Tabibnia, G. (2020). An affective neuroscience model of boosting resilience in adults. *Neuroscience & Biobehavioral Reviews*, 115, 321-350. https://doi.org/10.1016/j.neubiorev.2020.05.005

3. Kircanski, K., Lieberman, M. D., & Craske, M. G. (2012). Feelings into words–contributions of language to exposure therapy. *Psychological Science* (see especially Introduction and Discussion). https://doi.org/10.1177/0956797612443830

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1. Tracey, K., (2002). The Inflammatory Reflex. *Nature*. https://www.nature.com/articles/nature01321

2. O'Toole, M. S., et al. (2018). Effects of psychological interventions on systemic levels of inflammatory biomarkers in humans: A systematic review and meta-analysis. *Brain, Behavior, and Immunity*, 74, 68-78. https://doi.org/10.1016/j.bbi.2018.04.005

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Session 7: Working at Therapeutic Change/Neuroplasticity

Learning Objective

The resident will describe the two main processes of change–memory reconsolidation and fear extinction–from the perspective of neuroplasticity.

Outline

1. Neurobiological processes:
    a. Fear extinction, contextual cues, fear memory and memory reconsolidation
    b. Memory and schema: advantages and disadvantages of schema
    c. Sense of agency
    d. Integration (information theory)
2. All effective therapy models utilize combinations of the above processes (show a few examples but not an exhaustive list as below):
    a. CBT
    b. Psychodynamic
    c. Experiential
    d. Mindfulness
    e. Family therapy
    f. Group therapies

Key References

1. VanElzakker, M. B., Dahlgren, M. K., Davis, F. C., Dubois, S., & Shin, L. M. (2014). From Pavlov to PTSD: The extinction of conditioned fear in rodents, humans, and anxiety disorders. *Neurobiology of Learning and Memory,* 113, 3-18. https://doi.org/10.1016/j.nlm.2013.11.014

2. Lane, R. D., Ryan, L., Nadel, L., & Greenberg, L. (2015). Memory reconsolidation, emotional arousal, and the process of change in psychotherapy: New insights from brain science. *Behavioral and Brain Sciences, 38*, e1. https://doi.org/10.1017/s0140525x14000041

3. Gilboa, A., et al. (2017). Neurobiology of schemas and schema-mediated memory. *Trends in Cognitive Sciences*, 21(8), 618-631. https://doi.org/10.1016/j.tics.2017.04.013

Session 8: Healing

Learning Objective

The resident will become acquainted with speculated clinical correlates of therapeutic change.

Outline

1. Speculated clinical correlates of therapeutic change: improvement in transdiagnostic vulnerability and protective factors:
    a. Emotional fluency (less alexithymia)
    b. Affect tolerance instead of experiential avoidance
        i. Interoceptive awareness and tolerance
    c. Attachment security
    d. Metacognition
    e. Improved self-regulation
    f. Revised narrative/schemas (see session 2, predictive processing, and session 7, memory reconsolidation)
        i. No longer phobic/traumatized
        ii. Reality-based
            1. More self-compassion
            2. Less perfectionism/shame
        iii. Integration instead of fragmentation/dissociation (information and systems theory–see module 4)
        iv. Expanded and nuanced
2. All of the above yield improvements in relationships and problem-solving (show simple clinical examples for relatable broad categories, relate them to a therapy encounter and changes in both participants)

Key References

1. Lane, R. D., & Nadel, L. (Eds.). (2020). *Neuroscience of Enduring Change: Implications for Psychotherapy* (1st Edition). Oxford University Press. https://global.oup.com/academic/product/neuroscience-of-enduring-change-9780190881511?cc=us&lang=en&

2. Gilboa, A., et al. (2017). Neurobiology of schemas and schema-mediated memory. *Trends in Cognitive Sciences*, 21(8), 618-631. https://doi.org/10.1016/j.tics.2017.04.013

MODULE 3: ATTACHMENT

Our earliest experiences of being cared for will influence the way we feel about ourselves, the way we relate to others, and the way we respond to our own thoughts and emotions. Attachment theory and research point to the importance of attuned, responsive caregiving in the first years of life for the development of a "secure base" from which children can begin to explore the wider world. At birth, the infant's nervous system is ready to recognize and respond differentially to the familiar sounds and smells of caregivers and others, and to start developing strong bonds with caregivers. Through the mutual experience and co-regulation of emotional states, children learn to respond to feelings of pleasure and distress. Attachment theory and research span observations of early attachment styles in infants and their caregivers to investigations of how these patterns may be expressed in romantic relationships, parenting styles and interpersonal interactions throughout the life cycle. Early experiences of neglect and abuse, if not corrected by caring attachments, have been shown to lead to challenges in emotional and behavioral self-regulation and to less secure styles of attachment that can impact relationships throughout life. In this module, we explore the importance of attuned caregiving, the impact of chronic neglect and abuse, and the way attachment styles may be expressed and addressed in the psychotherapy relationship.

Through this module, residents will understand the different types of attachment experiences that develop in early childhood and how they may influence relationships throughout the lifespan, including the psychotherapy relationship.

Session 1: Our Earliest Relationships

Learning Objectives

1. Residents will be able to explain how an attachment relationship is different from other relationships.
2. Residents will be able to describe early attachment behaviors observed in parents and infants.
3. Residents will identify characteristics of early parenting that are associated with healthy attachment styles in young children.
4. Residents will be able to list the different attachment styles that have been observed in young children in the Strange Situation experiment.
5. Residents will learn how emotional experiencing is co-regulated by caregiver and child, leading to schemas for emotional and behavioral self-regulation.

Outline

1. Observation of co-regulation of emotional experience in infants. Assign for watching before class or show videos of attachment behaviors. Examples:
    a. Beatrice Beebe, Ph.D.: Decoding Mother-Infant Interaction
    b. Beatrice Beebe, Ph.D.: Joining Your Baby's Distress Moments: on how to recognize healthy attachment as critical in the development of emotional experiencing
    c. Edward Tronick, Ph.D.: Still-Face Experiment
    d. Secure, Insecure, Avoidant Ambivalent Attachment in Mothers Babies in The Strange Situation Experiment
2. Define, discuss attachment relationships
    a. Relationships with caregivers who provide regular care
    b. The attachment relationship provides a "secure base," which offers a sense of safety and comfort that is sought when the child experiences stressful situations (e.g., separation from the attachment figure)
3. Mary Ainsworth's "Strange Situation" observations of toddlers 12-18 months old. Toddler played in a room with mother present. Mother left and an unfamiliar adult stayed with the child for a few minutes, until the mother's return. The toddlers' responses to their mother's leaving and returning were observed and characterized by Ainsworth as:
    a. Secure: when the safety and reassurance of the relationship are sought and the relationship provides relief of distress. The child explored the playroom freely before the mother left, was distressed at separation and comforted by the mother's return. The child returned to exploring the playroom freely and playing with the toys in the mother's presence.
    b. Insecure: when there is avoidance, anxiety or disorganized behavior in relation to the attachment figure (e.g., https://www.youtube.com/watch?v=DRejV6f-Y3c). Insecure attachments have been characterized as:
        i. Anxious: In mother's presence, exploration was reduced, and the child cried easily. On separation, the child was distressed. At reunion, the child was not comforted by the caretaker and had prolonged distress. Mothers of anxiously attached children were observed to be inconsistent, not attuned.

   ii. Avoidant: Child did not behave as if distressed when mother left. On reunion, there was no contact with mother (child focused on toys). Mothers were observed to avoid closeness with the child.
   iii. Disorganized: Child had no consistent strategy for managing distress. Behaviors were contradictory, such as "strong attachment followed by avoidance, freezing or dazed behaviors." (Main and Solomon, 1990)
4. These patterns of behavior led to investigation of caregiver characteristics and interactional styles associated with secure attachment and the ability of the caregiver to regulate the toddler's fearful response (e.g., being attentive, attuned and responsive to child's needs, both physical and emotional).
5. This early relational regulation of emotional response has important implications for development. It also informs the work we do in the psychotherapy relationship.
6. Attachment theory has evolved in response to changes in family structure, the increased participation of children in early care and early education, research in developmental neuroscience (Thompson, Simptom & Berlin, 2022), and recognition of the variety of secure attachment models across different cultures.

Key References

1. Wallin, D. J. (2007). Chapter 2, The foundations of attachment theory. In *Attachment in Psychotherapy* (pp. 11-24). The Guilford Press. https://www.guilford.com/books/Attachment-in-Psychotherapy/David-Wallin/9781462522712/reviews
   Chapters 2 and 3 provide a good structure for residents to learn about attachment, without being too cumbersome.

2. Thompson, R. A., Simpson, J. A., & Berlin, L. J. (2022). Taking perspective on attachment theory and research: nine fundamental questions. In *Attachment & Human Development*, 24(5), 543-560. https://doi.org/10.1080/14616734.2022.2030132

3. 5 Steps for Brain-Building Serve and Return. (2020, October 29). Center on the Developing Child at Harvard University. https://developingchild.harvard.edu/resources/5-steps-for-brain-building-serve-and-return
   Educational videos and a flyer for parents; this website includes a focus on the developing brain of the child.

4. Winnicott, D.W. (1965). *The theory of the parent-infant relationship*. In D.W. Winnicott (Ed.), https://www.taylorfrancis.com/books/mono/10.4324/9780429482410/maturational-processes-facilitating-environment-donald-winnicott

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2. Main, M., & Solomon, J. (1990). Procedures for identifying infants as disorganized/disoriented during the Ainsworth Strange Situation. In M.T. Greenberg, D. Cicchetti, & E.M. Cummings (Eds.), *Attachment in the Preschool Years: Theory, Research, and Intervention* (pp. 121-160). Chicago: University of Chicago Press. https://press.uchicago.edu/ucp/books/book/chicago/A/bo3774473.html

3. Main, M., Kaplan, N., & Cassidy, J. (1985). Security in Infancy, Childhood, and Adulthood: A Move to the Level of Representation. *Monographs of the Society for Research in Child Development*, *50*(1/2), 66. https://doi.org/10.2307/3333827

Session 2: Failures in Attachment and Opportunities for Repair

Learning Objectives

1. Residents will understand how stressed attachment differs from attuned attachment and potential consequences in early childhood.
2. Residents will understand how clinicians can work with parents to support parent-child attachment and child emotional development.
3. Residents will learn to define internal working models in attachment theory and their importance in understanding the long-term impact of early attachment.
4. Residents will understand how maltreatment and neglect impact brain development, function and behavior.
5. Residents will understand how benevolent childhood experiences can modulate the impact of adverse childhood experiences.
6. Residents will learn that there are many different ways of assessing attachment throughout the lifespan.

Outline

1. How does stressed attachment differ from healthy attachment and its consequences in early childhood? Clinical insights:
    a. "Ghosts in the Nursery" (Key Reference 1) provides excellent clinical examples of how infants respond to a parent's post-traumatic stress, depression and neglect, as well as how infants can thrive when parents respond to sensitive trauma-informed psychotherapy and parenting support
    b. Teaching tip: Assignment of "Ghosts in the Nursery" with specific discussion questions on the relationship of early attachment history and adult presentations, parenting style and the critical elements of trauma-informed therapy for parents of at-risk children
    c. Role of the therapist in facilitating attachment: parallel process when working with parents:
        i. Therapist helps parent feel safe in experiencing emotions, so parent can help child feel safe in experiencing anger or other "dangerous" feelings
        ii. Working with parents: combining insight with personal history and practical parenting support
2. How does stressed attachment differ from healthy attachment? Theoretical model:
    a. Bowlby developed the concept of the internal working model as the mental representation formed through the young child's experience of their relationship with a caregiver
    b. This model (or possibly, multiple models) is understood as forming the basis for the child's subsequent expectations, experiences of and responses to subsequent relationships
    c. Differences in brain development in children with maltreatment and neglect:
        i. Early abuse and neglect, especially if chronic, have a negative impact on cognitive, social-emotional and physical development, and later, general and mental health.

ii. Adverse childhood experiences (ACEs, see Key Reference 2): the kinds of adversity children face in the home environment (e.g., physical and emotional abuse, neglect, parental substance abuse, mental illness).
iii. The more ACEs experienced in childhood, the greater the chance of poor outcomes later in life, including dramatically increased risk of heart disease, diabetes, obesity, depression, substance abuse, smoking, poor academic achievement, time out of work and early death.
iv. Chronic or repeated trauma leads to the activation of neurochemical and hormonal systems involved in the stress response and in emotion regulation. Chronic activation of the glucocorticoid, noradrenergic and vasopressin-oxytocin systems leads to changes in brain structure and function, often leading to extreme reactions to what appear to be minor stressors (Hagele, *NC Med Journal*, 2005). This helps us understand the long-standing impact of early trauma.
v. The epigenetic effects of trauma shed light on the intergenerational impact of war, famine, racism and other community-wide experiences of trauma.

3. How can positive attachment experiences be protective, even in the face of overwhelming trauma?
    a. "Angels in the Nursery" (Key Reference 3): Alicia Lieberman and her colleagues identified clinical examples of how early benevolent childhood experiences (BCEs) can protect against overwhelming trauma
    b. Just as Fraiberg identified ways to work with the re-emergence of feelings associated with traumatic experience, Lieberman and colleagues identified ways to encourage the re-emergence of feelings associated with benevolent figures– "feeling nearly perfectly understood, accepted and loved," as "growth-promoting forces in the lives of traumatized patients" (Key Reference 3)
4. Early trauma, abuse and neglect put the developing child at risk for difficulties with self-regulation and subsequent relationships.
5. Popular books on self-assessment of attachment style (e.g., *Attached*) provide interesting and fun ways to reflect on our own styles of attachment. However, there is no expert consensus on which types of early relationships will lead to which personality styles. Nor is there consensus on how enduring and pervasive a particular attachment style is over the lifespan (Thompson, Simpson, Berline, 2022).

Key References

1. Fraiberg, S., Adelson, E., & Shapiro, V. (1975). Ghosts in the Nursery. *Journal of the American Academy of Child Psychiatry*, 14(3), 387-421. https://doi.org/10.1016/s0002-7138(09)61442-4 *Classic article on the development of a model of parent-infant psychotherapy for infants at risk.*

2. Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., Koss, M. P., & Marks, J. S. (1998). Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults. *American Journal of Preventive Medicine*, 14(4), 245-258. https://doi.org/10.1016/s0749-3797(98)00017-8

3. Lieberman, A. F., Padrón, E., van Horn, P., & Harris, W. W. (2005). Angels in the nursery: The intergenerational transmission of benevolent parental influences. *Infant Mental Health Journal*, 26(6), 504-520. https://doi.org/10.1002/imhj.20071
Case examples of positive attachment figures promoting healthy development.

4. Thompson, R. A., Simpson, J. A., & Berlin, L. J. (2022). Taking perspective on attachment theory and research: nine fundamental questions. *Attachment & Human Development*, 24(5), 543-560. https://doi.org/10.1080/14616734.2022.2030132

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2. Levine, A., & Heller, R. (2012). *Attached.: The New Science of Adult Attachment and How It Can Help You Find–and Keep–Love.* Penguin.
https://www.penguinrandomhouse.com/books/303069/attached-by-amir-levine-md-and-rachel-sf-heller-ma/
Fun and readable book in self-help style, with good overview of attachment research and attachment styles (see introduction). Concepts are clearly explained but oversimplified, as the Shaver & Mikulincer article, below, reveals.

3. Rothbaum, F., Weisz, J., Pott, M., Miyake, K., & Morelli, G. (2000). Attachment and Culture: Security in the United States and Japan. *American Psychologist*, 55(10), 1093-1104. https://doi.org/10.1037/0003-066X.55.10.1093
For a multicultural perspective on how attachments are characterized differently in different cultures (Japanese and Western cultures).

4. Rothbaum, F., Rosen, K., Ujiie, T., & Uchida, N. (2002). Family Systems Theory, Attachment Theory, and Culture. *Family Process*, 41(3), 328-350. https://doi.org/10.1111/j.1545-5300.2002.41305.x

5. Keller, H., & Kärtner, J. (2013). Development: The cultural solution of universal developmental tasks. In M. J. Gelfand, C. Y. Chiu, & -Y.-Y. Hong (Eds.), *Advances in Culture and Psychology* (Vol. 3, pp. 63-116). Oxford University Press.
https://web.archive.org/web/20151224094525id_/http://www.gelfand.umd.edu:80/pages/papers/C2_%209780199930449_Gelfand_Advances%20in%20Culture%20and%20Psychology.pdf

Session 3: Attachment Over the Lifespan

Learning Objectives

1. Residents will learn a theory of how early attachment experience can be related to flexible regulation, underregulation or overregulation of emotional states.
2. Residents will learn how attachment styles in adults have been researched and characterized by investigators using different types of assessments.
3. Residents will learn how secure early attachment relationships help individuals develop "working models" for relationships that allow for open expression of emotions, cognitive flexibility and a broad range of emotional experiencing.
4. Residents will learn how insecure attachment experiences in childhood can make it difficult to develop a capacity for self-reflection, regulation of emotional responses and the flexibility that facilitates trusting relationships in adulthood (with loved ones or in therapy).

Outline

1. From temper tantrums to distress tolerance: Attachment patterns change in developmentally appropriate ways over the course of childhood:
    a. Infants and toddlers are able to explore the environment and be playful when they are in proximity to an attachment figure who supports their self-regulation.
    b. As toddlers enter preschool and grade school, they develop a greater capacity for self-regulation even when their attachment figure is not in proximity.
    c. Attachment theory suggests that infants develop automatic behavior strategies to deal with stress in response to the type of caregiving they receive (Maine, 1990).
    d. Securely attached infants have received responsive care and develop an expectation that other close relationships will offer responsiveness (Bowlby, 1973). Theoretically, this facilitates the ability to use flexible emotion regulation strategies, signaling distress with the expectation of being understood, calming easily in the presence of a caregiver, and returning to playing and exploring freely when soothed.
    e. In contrast, insecurely attached infants have received less responsive caregiving and have more negative expectations in relationships, which lead to different emotion regulation strategies (Bowlby, 1973; Grime et al., 2021).
        i. Avoidant infants have automatic patterns of hiding their distress in order to avoid rejection by a caretaker who is intolerant of negative emotions. Theoretically, these responses could lead to overregulation of emotions in adult relationships.
        ii. Anxiously attached infants are thought to heighten their emotional expression in order to elicit care from inconsistently responsive caregivers. Theoretically, these patterns could lead to heightened bids for attention and extreme sensitivity to any hint of rejection in adult relationships.
    f. Childhood and adolescence:
        i. Infants rated as more insecure tend to have more difficulty with emotion regulation/coping strategies during early childhood and adolescence (Zimmer-Gembeck et al., 2017)

   ii. Adolescence brings the challenge of developing and making use of trusted relationships outside the family
- g. Attachment in young adulthood, partnering and parenting:
   i. Adults who are securely attached are observed to use romantic partners as a "secure base": seeking proximity when stressed, responding more constructively to challenging situations and exhibiting greater resilience when distressed (Karreman & Vingerhoets, 2021; Simpson, Rholes & Neligan, 1992)
   ii. Avoidant adults tend to suppress their emotional reaction
   iii. Anxiously attached adults tend to heighten their emotional response in an attempt to increase their partner's care and concern
   iv. Both the avoidant and the anxiously attached adults are less able to communicate their thoughts and feelings or express their emotions in a constructive way (Low et al., 2018)
- h. With aging, illness or other life stressors, adults may once again need to depend on others for help, activating patterns of trust or mistrust, security or insecurity, in their close attachments
- i. Throughout the lifespan, not only personal stressors but also stressors experienced because of war, environmental disaster, racism, economic oppression, displacement and other social factors have an important impact on the capacity of adults to offer a secure base for developing the child

2. What can we learn from a variety of approaches to assessment of attachment styles throughout development:
   - a. Observations by developmental psychologists of infants and toddlers in the Strange Situation procedure (Ainsworth, Blehar, Waters, & Wall, 1978).
   - b. Clinical interviews of adults that ask them to reflect on their early relationships (The Adult Attachment Interview (AAI)) so as to understand how they make sense of what happened to them in their childhood. Here, the focus is less on what actually happened and more on whether adults can tell a coherent, genuine-sounding story of what happened and how it impacted their development (Main, Kaplan, & Cassidy, 1985; Shaver, P. R., & Mikulincer, M., 2002, for a review).
   - c. The AAI (George, Kaplan, & Main, 1985; Main, 1995, p. 437) explores the internal working models for relationships (unconscious rules for how relationships work) that derive from early attachment experience.
   - d. The AAI sorted adults into four categories, theoretically corresponding to patterns observed in infants and toddlers: the first being securely attached, and the following three being insecurely attached, showing three different patterns:
      i. Secure-autonomous individuals can reflect on their early relational experiences without becoming overwhelmed and without distancing themselves from the emotions, thus integrating positive and negative feelings, even when past experience has been abusive.
      ii. Dismissing (avoidant) narratives are characterized by contradictions between vague generalization (e.g., "Things were fine growing up") and specific episodes that reflect serious parental failures. The importance of relationships may be minimized, while self-reliance is emphasized.
      iii. Preoccupied (anxiously and insecurely attached) individuals have long, detailed but often incoherent narratives that reflect a preoccupation with attachment

relationships, often with ongoing anger or fear that extend to current interactions.

iv. Unresolved/disorganized attachment is a category based on the individual's extreme difficulty discussing traumatic events involving loss or physical or sexual abuse. Dissociative states and other serious disruptions of the trauma narrative characterize this category.

e. Social psychologists have observed adult behavior in experimentally manipulated conditions to reveal a positive association between self-reports of attachment security and actual support-seeking behavior in stressful naturalistic and laboratory situations (see Shaver, P. R., & Mikulincer, M., 2002, reference below for review).

3. Reflective functioning and mentalization: Mentalization, the ability to imagine what another person may be thinking or feeling, is an essential capacity for negotiating social interactions, and may develop through the repeated interactions of feeling seen and understood in early secure attachment relationships (Fonagy, 2003). Children of attuned parents come to understand their own minds and emotions, and the minds of others, through these interactions.
4. Intergenerational transmission of trauma:
    a. The effect of maternal stress on the prenatal environment, as well as on the post-natal interactional environment, has a biological influence on brain development.
    b. Thus, we need to consider not only the particular parent-child relationship but also the historical and social influences of war, starvation, racism and other social forces on the developing child.
    c. Both clinical experience and emerging research encourage us, as clinicians, to offer parents the supportive therapy relationships (attachment experiences) that can help them be attuned and responsive parents for the next generation.

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Fun and readable book in self-help style, with a good overview of attachment research and attachment styles (see introduction). Concepts are clearly explained but over-simplified, as the Shaver & Mikulincer article, below, reveals.

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Session 4: Attachment in the Psychotherapy Relationship

Learning Objectives

1. Residents will understand how therapy offers a new attachment relationship, in which old patterns of early attachment experience may be repeated.
2. Residents will learn to recognize how different early attachment experiences impact the therapy relationship.
3. Residents will learn how disturbances in attachment can present in therapy.
4. Residents will discuss when and how attachment styles need to be addressed in therapy.
5. Residents will understand how this new attachment relationship can provide an opportunity for developing new working models for relationships and new capacities for emotional experiencing.

Outline

1. When psychotherapy offers a safe and attuned relationship:
    a. The relationship can provide a holding environment for the patient, in which difficult feelings can be known and tolerated, just as in early attachment. Relationships provide this emotionally containing experience for the young child.
    b. Experiencing difficult feelings in a safe relationship can lead to more adaptive coping skills and greater freedom to experience the full range of feelings associated with challenging life circumstances.
2. The secure base of the therapy relationship can offer support with emotion regulation in both directive and nondirective ways:
    a. When a therapy is nondirective, the therapist offers a relationship in which the patient learns "implicit emotion regulation" (or automatic, rather than skills-based, regulation; see Hoffman, Rice & Prout, 2015). When the therapist recognizes a pattern of avoidance of difficult feelings (e.g., changing the subject, inappropriate affect for content, picking a fight), the therapist can point this out and create space for the patient to experience the undesirable emotion in the context of a safe and regulating relationship. Over time, patients learn to trust themselves to experience difficult feelings without being overwhelmed.
    b. When therapy is more directive, the therapist can offer skills and strategies for improving the capacity for emotion regulation. Mindfulness, emotion regulation, distress tolerance and interpersonal effectiveness skills (Linehan, 1993) can help patients learn to stay present with difficult experiences.
3. This close attachment can also be experienced as a repetition and painful reminder of past disappointment, frustration, abuse or neglect in early attachment relationships:
    a. The therapist may be caught off guard when the offer of a close and compassionate relationship gives rise to a range of maladaptive responses that threaten the therapy relationship, e.g., missing sessions, feeling abandoned by the therapist over the first inevitable disappointment, transient paranoid feelings about the therapist's intentions, self-injury and suicidal ideation in the context of a therapist's vacation, and more.

b. In the process of psychotherapy, the patient usually repeats, in the therapy relationship, patterns of behavior that developed in childhood and have been repeated in other relationships.
c. This repetition is called an enactment. Enactment has been "defined as a pattern of nonverbal interactional behavior between the two parties in a therapeutic situation, with unconscious meaning for both" (Plakun, 1998).
d. The therapist may recognize an enactment through reflection on the therapist's own feelings and reactions (which can be surprisingly strong).
e. This type of interaction, described as "transference-countertransference" in the psychoanalytic literature, can often be understood in terms of the patient's attachment style and the therapist's response.

Examples of different presentations:

f. Avoidant behaviors:
    i. Patients with an avoidant attachment style may not come for treatment willingly. If they are still dependent on their parents, they may come when their parents insist they need treatment. Others may come simply to appease a distressed partner.
    ii. Avoidant behaviors can be overtly distancing (refusal to make a second appointment, missed sessions, premature ending of treatment).
    iii. Or avoidance can be expressed through the sustained reciting of a narrative that is detailed and avoids discussing feelings or vulnerabilities.
    iv. Or avoidance can be expressed in devaluing comments toward the therapist and toward therapy.
    v. If there are "50 ways to leave your lover," there are even more ways to avoid engagement in therapy. (Elicit examples from class.)
g. Anxiously attached behaviors
    i. Patients with anxious attachment styles may initially form a strong connection or even an idealizing relationship with the therapist.
    ii. Unexpectedly, they may react intensely to having a phone call returned later than expected or other disappointments that fail to meet the patient's hope for constant reassurance about the availability of the therapist.
    iii. Reactions can range from extreme anxiety and repeated attempts to get in touch with the therapist to angry attacks on the therapist or threats of self-injury or suicide.
    iv. Patients interpret these disappointments as signs that the therapist is abandoning them. Such patients may be unable to maintain a coherent sense of themselves without feeling "held" securely by another. Such patients are often described as having borderline personality disorder. Their vulnerability to panic, despair and suicidal behavior when not feeling held, and their treatment, are well described by Gunderson (2015).

4. Responding to different attachment patterns in psychotherapy:
    a. Bringing attachment behavior patterns into awareness:
        i. Whether a patient reacts with anxious or avoidant responses to the therapy relationship, it is the goal of therapy to bring this pattern of response to awareness and to create a space for the patient to reflect on the feelings and thoughts that arise in the context of disappointment or threatened loss

   ii. Once the patient becomes aware of rather than lost in the reactivity, the patient may begin to recognize the feelings that drive the repetition
   iii. If the patient is able to recognize these feelings as appropriate to past circumstances but not fitting with present experience, then the patient may be free to respond to the present relationship *as it actually is*, in the present moment
   iv. In order to engage the patient in this process of self-reflection, therapists must themselves engage in reflection on their own feelings and on their interactional patterns in the therapy.
- b. Interventions to encourage new responses and develop new working models:
   i. If a patient seems withdrawn in a session, after the therapist has done something disappointing (declined to write a script, declined a request for a different hour, appeared preoccupied or misunderstood the patient's feelings), it is important that the therapist bring this up, nondefensively, and encourage the patient to explore their own feelings.
   ii. Example: Anthony Batemen, in a video recording of a session, said, "I just said something that hurt your feelings."
   iii. The therapist is not presuming to understand why, but creates a holding environment for the safe expression of feelings.
- c. The therapist is modeling the type of self-reflection and reflection on the interaction that will help the therapy move forward, revealing old patterns of reactivity that interfere with freedom to respond in the present moment
- d. Through repeated interaction patterns in the therapy relationship, insecurely attached patients may be able to recognize their patterns of response:
   i. Anxiously attached (preoccupied) patients may recognize their tendency to interpret disappointments as signs of devastating abandonment
   ii. Avoidant (dismissing) patients may recognize their tendency to be defensively avoidant of relationships that might become disappointing
- e. Reflection on these interactions creates opportunities for the patient to develop new ways of interpreting and responding to relationship challenges

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Chapters 2 and 3 provide a good structure for residents to learn about attachment, without being too cumbersome.

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MODULE 4: SYSTEMS THEORY

The goal of the systems theory module is to introduce concepts around family systems, family consultation, and the basics of couples work and group psychotherapy. While individual psychotherapy emphasizes patient autonomy, it is also important to take a wider view of the individual in the context of families, couples, groups and social/cultural environments.

A family systems orientation is distinguished by its view of the family as a transactional system. Stressful events and problems of an individual member affect the whole family as a functional unit, with ripple effects for all members and their relationships. In turn, the family response (how the family handles problems) contributes significantly to positive adaptation or to individual or relational dysfunction. There is extensive research (Heru, 2006) that shows that family support, education and psychoeducation improve both patient and family functioning in medical and psychiatric illness.

Family systems theory and practice also encompass the challenges many families face in their social environment, including economic, racial, gender and sexual orientation. Particular attention is given to those who confront economic and racial barriers and larger systemic/structural disparities (Boyd-Franklin, in press; Hardy, 2019). An ecological view considers the family's interface with larger systems, such as schools, workplaces, and community and healthcare systems, including sociocultural influences.

We have included group psychotherapy in this module because understanding how groups (and individuals in groups) function provides another important perspective on the individual in a systems context. Couples, family and group psychotherapies allow for direct observation and treatment of the individual within multi-person systems. Families and groups differ in that family members are bound by attachment and loyalty and have a past and a future together; groups are connected only as long as the group persists and members begin as strangers. Participating in this training helps residents develop a deeper understanding of systems theory and specific tools for family and group work in the context of psychiatric care.

Module Learning Objectives

1. Develop skills to ally with family members to help the patient comply with goals of care, such as medication adherence, keeping appointments and managing emotions.
2. Help patients understand the influences of their families in their lives, including understanding of intergenerational transmission of trauma and resilience. This includes both issues from childhood (parental loss, adverse childhood experiences (ACEs)), and the influence of nuclear and extended family members on the current issues.
3. Practice family assessment and case conceptualization, developing a treatment plan by identifying the problems in a family and individuals within the family AND evaluating how the systemic issues affect the identified problem.
4. Understand the impact of illness, both psychiatric and physical, or major life events on the family unit and the impact of the family unit on illness.
5. Learn techniques to manage families or couples in a treatment session.
6. Learn basic concepts related to psychotherapy groups and organizational psychology.

Session 1: Understanding Family Systems

Learning Objectives

1. Residents will be able to define open systems and discuss how the nested subsystems of culture, community, family, self and neurobiology interact within a family system.
2. Residents will learn how to map a family system with a genogram.
3. Residents will understand how family systems can be organized and how changes in one part of the system affect other parts.

Outline

1. Understanding systems:
    a. The family as a three- or four-generation attachment-based system
    b. The family as it moves through time and increasing complexity
    c. The genogram as a way of mapping family systems
2. Exercise: mapping family systems:
    a. Do your own and a fellow resident's genogram.
    b. Within the genogram, focus on the location of the individual within their family system and demonstrate all external influences on the patient's personal life.
    c. For children, use the sand tray or other physical objects to construct a genogram. Include the family in the production or discussion of the genogram when appropriate.
    d. Watch Monica McGoldrick's new video on genograms and video on complex adaptive systems.

Key References

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Session 2: Characteristics of Family Systems

Learning Objectives

1. Residents will be able to define terms used to describe family systems, including power, closeness, boundaries, feedback loops, open vs. closed systems, and nested subsystems.
2. Residents will understand ways to assess family structure and functioning.
3. Residents will review the attachment module in the context of family systems theory and be able to discuss how attachment makes families different from other systems.

Outline

1. Characteristics of family systems:
    a. Power
        i. The ability of one individual to change the behavior of other family members or to carry out their own will in the face of resistance
        ii. Comes in many forms: direct authority, influence, even weakness
    b. Closeness-Distance
        i. The amount of emotional intensity, warmth and engagement of family members
        ii. This may vary between different pairs of family members
        iii. The family system as a whole may demonstrate consistent patterns of engagement or disengagement
    c. Boundaries
        i. The set of rules by which the family keeps information and activities to itself or allows outside information and contact with extended family, and nonfamily members
        ii. Within the family, boundaries maintain generational subsystems (for example, parents do not tell children about their sexual activities)
    d. Circular causality
        i. Behavior is maintained by circular feedback loops within the family system
2. The couple as a subsystem
3. Varieties of family forms:
    a. Same-sex couples
    b. Single parent
    c. Divorced but connected household
    d. Grandparents raising children
    e. Polyamory and other forms of nonmonogamy, etc.
4. Family assessment
5. Exercise:
    a. Role-play groups and families; use movies and ask residents to assess. Examine the boundaries of family, community and culture.

Key References

1. Glick, I. D., Rait, D. S., Heru, A. M., & Ascher, M. S. (2016). *Couples and Family Therapy in Clinical Practice*. Wiley Blackwell.
   Chapter 5: Problems and Dysfunction From an Integrated Family Systems Perspective.
   Chapter 6: The Process of Evaluation.
   https://www.wiley.com/en-be/Couples+and+Family+Therapy+in+Clinical+Practice%2C+5th+Edition-p-9781118897218

2. Family Systems Theory: Basic Concepts/Propositions, Marriage and Family Encyclopedia (website). https://family.jrank.org/pages/597/Family-Systems-Theory-Basic-Concepts-Propositions.html

Session 3: Family Consultation

Learning Objectives

1. Residents will understand the basic techniques and goals of a family consultation. This may involve providing psychoeducation or brief family interventions.
2. Residents will understand how to manage a family meeting and challenges that may come up in family meetings.
3. Residents will develop their ability to maintain multidirectional partiality, accept multiple family realities and learn to manage their own responses to intense family reactions.
4. Residents will develop a list of internet and community resources to provide to families who want to learn more about family education.

Outline

1. Family consultation:
    a. Families meet the therapist with or without the patient to share information, discuss the diagnosis and treatment plan, and address family needs
    b. These are one- or two-session meetings
2. Basic family consultation:
    a. Introduction of participants
    b. Agenda
    c. Controlled discussion
    d. End with plan
3. Psychoeducation with SMI (severely mentally ill):
    a. Family psychoeducation is a multisession model that provides families information about the illness, how they can help and practice in communication techniques

Key References

1. Sherman, M.D. (2003). SAFE Program: 18-Session Family Education Program for People Who Care About Someone Living With Mental Illness or PTSD. https://www.researchgate.net/publication/232492066_The_SAFE_Program_A_family_psychoeducational_curriculum_developed_in_a_Veterans_Affairs_Medical_Center

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1. NAMI resources. https://nami.org/Home

Session 4: Basics of Working With Couples

Learning Objectives

1. Residents will understand basic concepts relevant to working with couples.
2. Residents will understand how the broader cultural context affects the functioning of couples.
3. Residents will be able to provide couples with referrals or resources to learn more about common couples' issues.

Outline

1. Love and attachment in adulthood
2. Variety of couple forms (including committed couples, polyamory, same-sex couples, marriage)
3. Common issues in couple communication and couple dysfunction
4. Basics of working with couples and sexual functioning in couples' relationships
    a. Imago therapy and emotionally focused therapy are good models to start with
5. Sexuality in committed couples and its common issues

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Session 5: Basics of Group Psychotherapy and Organizational/Cultural Groups

Learning Objectives

1. Residents will learn basic terms and concepts to describe treatment groups and groups in an organizational context.
2. Residents will learn about the stages of group formation.
3. Residents will be introduced to the concept of a group contract.

Outline

1. Define basic group psychotherapy concepts:
    a. Systems view of groups–interplay between person, role, group, context
    b. Therapeutic factors:
        i. Social learning
        ii. Secure emotional expression
        iii. Instillation of hope
        iv. Awareness of relational impact
2. Discuss stages of group formation:
    a. Tuckman's group stages: Forming, Storming, Norming, Performing (and Adjourning)
3. Define concepts that are helpful for understanding group dynamics:
    a. Boundary, authority, role and task
4. Consider how group concepts may apply to medical and psychiatric settings, the residency program, the university, and wider cultural and organizational contexts
5. Review the elements of a group contract, which provides boundaries and contributes to psychological safety in group treatment (optional)

Key References

1. Green, L. R. (2020). Ch. 3: Group Structure and Levels of Analysis. In F. J. Kaklauskas & L. R. Greene (Eds.), *Core Principles of Group Psychotherapy: An Integrated Theory, Research, and Practice Training Manual*. Routledge. https://www.routledge.com/Core-Principles-of-Group-Psychotherapy-An-Integrated-Theory-Research/Kaklauskas-Greene/p/book/9780367203092

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MODULE 5: TRAUMA

The first lecture will discuss the effect of trauma on the individual. Subsequent lectures will deal with evaluating and treating the patient with trauma, cultural understanding of trauma, and the integration of treatments for trauma.

Session 1: What Is Trauma?

Learning Objectives

1. Residents will be able to define multiple types of trauma.
2. Residents will discuss the etiologies of trauma.
3. Residents will understand how people can present after experiencing trauma.

Outline

1. Types of trauma:
    a. Injury can be physical and/or psychological
    b. Trauma stimuli, which can be varied
    c. Acute (incident) trauma vs. developmental trauma:
        i. Timing, age and duration of traumas can have different effects
2. Theories of trauma formation:
    a. Trauma overwhelms a person's coping strategies
    b. Adverse childhood experiences (the ACEs study)
        i. Please refer to this curriculum's Attachment Module: Session 2: Failures in Attachment and Opportunities for Repair, for additional information on ACEs
    c. Cumulative trauma
    d. Neurobiology of trauma
3. Presentations of trauma:
    a. Trauma can result in repetition:
        i. PTSD: flashbacks, nightmares
        ii. Enactments
    b. Trauma can lead to avoidance
    c. Trauma can lead to dissociation
    d. Trauma can lead to chronic negative mood and cognition, negative schema and maladaptive coping
    e. Trauma can lead to changes in physiology and how people relate to and interact with others:
        i. Describe common physiological and relational changes in trauma:
            1. Addictions, anxiety, mood disorders and emotional instability are linked
    f. Trauma can lead to personality disorders or traits:
        i. These conditions may originate from traumas and neglect during development
        ii. Developmental trauma and borderline personality disorder can overlap
    g. Intergenerational trauma:

i. Epigenetics
ii. Systems

Key References

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Session 2: Social/Cultural Trauma

Learning Objectives

1. Resident will become better versed at incorporating culture in formulation.
2. Resident will obtain a better appreciation of historical trauma.
3. Resident will gain a better understanding of refugee trauma.
4. Resident will understand the impact of trauma in LGBTQ+ communities.

Outline

1. DSM-5 and the Cultural Formulation Information Interview (CFI)
    a. Describe the CFI
2. Historical trauma:
    a. Historical trauma is not just an outcome of historical acts of genocide but also of ongoing forms of structural violence
    b. Trauma as "soul wound"–wounding to the level of being
    c. Acknowledgment of historical loss (e.g., loss of land and culture in Native American community)
    d. Acknowledgment of colonial violence
    e. Epigenetic studies on transgenerational trauma (e.g., epigenetic markers in children of Holocaust survivors)
    f. Trauma is relational–treatment needs to incorporate concepts of interrelatedness and interconnectedness (versus only cognitive approach)
3. Structural violence and trauma:
    a. Acknowledgment of racial trauma, ableism, ethnocentrism, classism, gender-based violence and other forms of structural violence
    b. Recognize the impact of past and ongoing racial trauma and ethnic discrimination (e.g., African American community, Japanese internment camps, Latinx immigrants, Pacific Islanders)
    c. Emphasize the importance of intersectionality in trauma-informed care
    d. Awareness of implicit biases and managing microaggressions
4. Refugee trauma:
    a. Trauma of displacement
    b. Mass violence creates a "historical space" with new attitudes, feelings and behaviors, where justice forms the core of the survivor-healer relationship
    c. Each trauma story has four elements:
        i. Factual accounting of the events
        ii. Cultural meaning of trauma
        iii. Revelations
        iv. Storyteller-listener relationship
    d. Four questions to maximize the therapeutic power of the trauma story:
        i. What traumatic events have happened?
        ii. How are your body and mind repairing the injuries sustained from those events?
        iii. What have you done in your daily life to help yourself recover?

iv. What justice do you require from society to support your personal healing?

5. Trauma and LGBTQ+ community:
    a. LGBTQ+ community is more at risk for interpersonal trauma
    b. Health disparities
    c. Institutional discrimination
    d. Microaggressions and microtraumas:
        i. Discuss heteronormative and cisnormative biases
    e. Creating a safe space and a healing environment:
        i. Using gender-affirming pronouns
        ii. Using chosen name
        iii. Signage
    f. Review LGBTQ+ terminology
    g. Discuss minority stress theory
6. Learn about resources available
    a. Online resources
    b. Community groups

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14. Ka'm-t'em, Indigenous Knowledge. https://kamtem-indigenousknowledge.com/training-information/

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Session 3: Psychotherapy of Trauma Part One: Principles of Treating Traumatized Individuals

Learning Objectives

1. Residents will learn about safety and trust as prerequisites for the treatment of trauma.
2. Residents will understand the concept of stages in trauma treatments.
3. Residents will learn about specific skills in treating trauma patients.
4. Residents will understand that a focus on the body and personality is an important feature of trauma-focused treatment.

Outline

1. Acute management of trauma
    a. Psychological first aid
        i. Safety
        ii. Calm and comfort
        iii. Connection
        iv. Efficacy
        v. Resources
        vi. Hope
    b. Immediate debriefing and re-exposure to traumatic memories (within one month) has not been demonstrated as effective and could be harmful
        i. Trust and readiness of the patient are key to engagement with trauma psychotherapy
        ii. Some studies suggested there was a higher rate of PTSD development at one year after a debriefing intervention (Wessely et al., 2002)
2. Psychotherapy for trauma
    a. Janet's three-stage model
    b. Horowitz's model
3. Creating a treatment frame for trauma
    a. Provide for adequate time for treatment and recovery
    b. Assess and build adequate self-regulation, self-compassion and self-esteem
    c. Establish a safe and trusting relationship and alliance
        i. Psychological safety within the treatment relationship
        ii. Consider patient's preference (shared decision process in treatment), although therapist training and interest and system resources have a lot to do with which treatments are available to be integrated
    d. Assess the stability of the patient and the patient's environment
        i. Assess other comorbidities (e.g., substance use, suicidality, medical illnesses)
        ii. Address environmental and behavioral concerns (e.g., housing, safety and stability, domestic violence, social supports, finances)
4. Traumatic experiences are unique, and the "person behind the story of trauma" should inform treatment
5. Attention to the body

   a. Education about physiological effects of trauma
   b. Somatically oriented techniques are often helpful
6. Attend to interpersonal functioning and personality
   a. Trauma patients may benefit from learning new ways to interact with others, such as setting boundaries in relationships
   b. Family members and others closely related to patients should be interviewed and included in treatment when appropriate
      i. Family members may have their own difficulties, including mental health problems or personal traumas, which may complicate treatment and warrant clinical attention
7. Engagement in exposure and desensitization
   a. Facilitating the return to socialization and prior activities, engaging in new behaviors and activities
8. General skills for conducting interviews and treatment with traumatized individuals
   a. Open discussion of the frame and boundaries of the treatment
   b. Tracking and addressing dissociation and emotional dysregulation in the encounter
      i. Grounding techniques
   c. Seeking consultation and support as the therapist when encountering difficult emotions and reactions when treating patients

Key References

1. Psychological First Aid Field Operations Guide, 2nd Edition. https://www.ptsd.va.gov/professional/treat/type/PFA/PFA_2ndEditionwithappendices.pdf

2. See Appendix Resources for Session 3.

3. Substance Abuse and Mental Health Services Administration. (2014). SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach. HHS Publication No. (SMA) 14-4884. Rockville, MD. Retrieved from: https://store.samhsa.gov/sites/default/files/d7/priv/sma14-4884.pdf

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6. NCTSN: National Child Traumatic Stress Network. (n.d.). Retrieved from https://www.nctsn.org/ *Includes lots of resources as well as a core curriculum on childhood trauma.*

7. National Neuroscience Curriculum Initiative. (n.d.). Retrieved from https://nncionline.org/ *Includes lots of free resources, such as "Create or Supplement Your Own Curriculum."*

8. Center on the Developing Child at Harvard University. (n.d.). Retrieved from https://developingchild.harvard.edu/
Lots of resources about all aspects of development.

9. Van der Hart, O., Brown, P., & Van der Kolk, B. A. (1989). Pierre Janet's treatment of post-traumatic stress. *Journal of Traumatic Stress,* 2(4), 379-395. https://doi.org/10.1002/jts.2490020404

Session 4: Psychotherapy of Trauma Part Two: Specific Approaches and Special Considerations

Learning Objectives

1. Residents will understand common features among trauma psychotherapies.
2. Residents will be aware of common challenges in the treatment of traumatized people.
3. Residents will be familiar with common types of trauma psychotherapies and how they can be categorized.

Outline

1. Commonalities among approaches
    a. Learning procedures: extinction and memory reconsolidation
    b. Preparatory psychoeducation and framing of treatment (i.e., expectations, difficulties)
    c. Emotion regulation capacities
    d. Attention to somatic experience
    e. Revising narratives/updating schema
2. Difficulties in the treatment of trauma patients
    a. Shame
    b. Interpersonal dysregulation, including aggression and acting out or passivity and automatic obedience
    c. Substance use and addictions
    d. Gaps of culture or identity, including but not limited to politics, nationality, ethnicity, gender and sexuality, or other lifestyle differences
    e. Practical safety
    Practitioners trained in higher socioeconomic areas can unknowingly recommend activities and exposures to patients in high crime/dangerous areas that put them at risk of re-traumatization/injury. The practitioner needs to consider the practical safety of their recommendations in the context of the patient's real life.
    f. James Chu's article "Ten Traps for Therapists in the Treatment of Trauma" notes attention is needed in the treatment of trauma survivors with respect to:
        i. Trust
        ii. Distance
        iii. Boundaries
        iv. Limits
        v. Responsibility
        vi. Control
        vii. Denial
        viii. Projection
        ix. Idealization
        x. Motivation
3. Survey of specific approaches
    a. Treatments can occur individually or, if unavailable, in groups
    b. Primarily somatic: eye movement desensitization and reprocessing (EMDR), sensorimotor, biofeedback, polyvagal theory, somatic experiencing, tai chi, yoga, etc.

c. Primarily psychological: CBT for trauma, prolonged exposure, cognitive processing therapy, narrative exposure therapy, brief eclectic psychotherapy (BEP)
d. Non-trauma-focused treatments are also possible, including stress inoculation training, present-centered therapy, interpersonal psychotherapy (IPT), DBT, ACT, accelerated experiential dynamic psychotherapy, skills training in affect and interpersonal regulation, seeking safety, and supportive psychotherapy

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MODULE 6: FORMULATION

Formulation is a guide to knowing where you are in therapy: how to begin, what to attend to, when to intervene, and when and how to bring therapy to a close. “Personalized formulation fills a gap between diagnosis and planning treatment. We don’t treat a diagnosis, we treat a patient” (Session 1, Reference 1, Horowitz, 2019).

While evidence-based treatments are often related to specific diagnoses, psychotherapy needs to be individualized. Techniques may advance through stages as more is learned about the patient. Formulating guides the choice of techniques and, usually, combinations of techniques as treatment progresses.

This module will teach transdiagnostic formulating methods to guide interviewing and treatment. Over the course of psychotherapy, the therapist will be continually reformulating the patient’s current level of functioning. These reformulations will guide a personalized integration of techniques.

Session 1: Basic Components of Formulation

Learning Objectives

1. Residents will learn what a formulation is and how it can guide psychotherapy.
2. Residents will learn how to write or present a helpful and well-organized formulation at the start of psychotherapy.

Outline

1. Understanding what a formulation is
    a. How it differs from a differential diagnosis: going beyond syndromic diagnoses to understanding phenomena of psychopathology and complex interactions of predisposing, precipitating, perpetuating and protective factors, including culture/adversities and personal relationships in development.
    b. Understanding how formulation is critical for guiding the course of psychotherapy: Formulating is explaining how matters got to the point of distress and problems. It starts with evidence from facts, such as observations and complaints, as well as tests, and considers complex, personalized, interactive factors. Formulating guides actions such as treatment techniques in psychotherapy. It starts ambiguously and advances through trial and error, including observing sessions for how emotions are expressed and regulated, as well as how that changes.
2. Describe-review-link: a model for organizing formulation (Cabaniss et al., 2013)
3. Sharing formulation with the patient (Gordon & Reiss, 2005)

Key References

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For people interested in child and adolescent assessment.

Session 2: Focusing Observations to Use in Formulation

Learning Objectives

1. The resident will learn how to evaluate a patient so that a meaningful formulation can guide psychotherapy–eliciting history while observing mental status changes.
2. The resident will learn how to write or present a helpful and well-organized formulation at the start of psychotherapy.
3. The resident will learn how to revise the formulation as psychotherapy progresses.

Outline

1. How assessment leads to formulation
    a. Observe how the patient responds to the interview situation
    b. Observe your own reactions to the patient and any others present
    c. Invite the patient to describe their goals and obstacles
    d. Listen for conflicts and avoidances, as well as intentions and expectations
2. How to describe important mental status observations
    a. Observe control of emotion: well-modulated, undermodulated and overmodulated states
    b. Consider what precedes and precipitates shifts between states that may occur in the interview
    c. Techniques for dealing with under-control of feelings or impulses and their warning signs, which may appear during the interview
        i. When to encourage staying present with feelings that threaten to be overwhelming
        ii. When to support a retreat from feelings that are overwhelming the patient's ability to sustain the interview process
    d. Techniques for dealing with excessive avoidances
    e. Observing states of mind and changes in response to interactions in session
3. Focus on what can change in psychotherapy
    a. A helpful grid: Bio-psycho-social determinants and the four (or five or six P's) (Key Reference 3)
        i. Predisposing (Why me?)
        ii. Precipitating (Why now?)
        iii. Perpetuating (Why does it continue?)
        iv. Protective (What can I rely on?)
        v. Prognosis (What might we expect?)
        vi. Psychotherapy (What aspects of the causes of maladaptive functioning might change?)

Key References

1. Horowitz, M. J. (2018). *Formulation as a Basis for Planning Psychotherapy Treatment* (2nd ed., Chapter 2, States of Mind. American Psychiatric Association Publishing. https://www.appi.org/Products/Psychotherapy/Formulation-as-a-Basis-for-Planning-Psychotherapy

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Session 3: Formulating What Can Change Next

Learning Objective

The student will understand how adaptive changes may occur by modifying core attitudes and capacities to regulate expression of feelings. (These are examples of models of how change happens in psychotherapy.)

Outline

1. Using case examples from the teacher, the focus in this session is to show how to observe changes in psychotherapy: in the patient, the therapist and the relationship. This can usefully include ways for observing control of emotion by defining the characteristics of well-modulated, undermodulated and overmodulated states. Such categories can lead to a better understanding of how and why shifts between states may occur in interviews. Then learners can be taught techniques for dealing with under-control of emergent feelings/impulses and for dealing with excessive avoidances.
2. Consider and select techniques related to the current **Phases of Therapy**, as shown below.

Phases of Therapy

Phase	Client Role	Clinician Role	Therapeutic Alliance
Initial Evaluation	Shares personal background, symptoms, concerns, and treatment preferences.	Gathers background information and develops preliminary understanding. Offers psychoeducation and reviews possible interventions.	Collaborative Formulation: Establishes a shared understanding of the problem, how therapy can help, the therapy structure and expectations.
Stabilization	Openly expresses difficulties and focuses on managing immediate stressors.	Provides guidance to support emotional regulation and begins identifying key areas for deeper work.	Clarifies responsibilities and collaboration within the therapeutic partnership.
Meaning Exploration	Reflects on how current issues relate to sense of self and life patterns.	Helps connect thoughts and emotions to presenting problems and deepens insight.	Reaches agreement on focal areas for continued exploration.

Cognitive/Attitudinal Shift	Engages with previously avoided themes and reconsiders established patterns.	Assists in restructuring maladaptive beliefs and perspectives.	Facilitates new experience of previously avoided or overwhelming emotions being safely expressed and valued in the relationship. Collaboratively reviews and adjusts expectations for future relationships and functioning.
Termination Phase	Reviews progress and considers future goals and maintenance strategies.	Reinforces key insights and highlights adaptive changes achieved.	Focuses on a healthy and planned conclusion of the therapeutic relationship.

3. As stages progress, advance the formulation of the patient's emotional and ideational expressions using configurational analysis.

Component	Purpose	Key Aims for Therapist
1. Phenomena	Select symptoms and problems.	Educate patient about symptom formation.
2. States of mind	Describe states in which the symptoms do and do not occur. Include states of avoidance and numbing of feelings.	Help patient reduce both being overwhelmed by feelings and pushing away useful emotional experiences.
3. Topics of concern	Describe topics that evoke problematic states. Describe how expression is habitually avoided.	Clarify and challenge irrational beliefs and help patient plan effective action.
4. Self and relationships	Infer roles of self and others interacting for each recurrent state.*	Help patient learn adaptive attitudes for attachments and self-regard.

5. Therapy planning	Plan how to increase safety in sessions.	Heighten the patient's emotional control and interpersonal skills.

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*For example: The patient (self) may be in a role of feeling unfairly criticized by the therapist (other), who is perceived as scornful, leading the patient to manifest an angry state of mind.

4. Formulation of entrenched maladaptive patterns and how they can change
    a. Exploration of meanings, memories and patterns of relating to others and reflecting on self
    b. Motivations: understanding configurations of conflict: wish, fear, defense
    c. Clinical examples given and elicited from students

Key Reference

1. Horowitz, M. J. (2018). *Formulation as a Basis for Planning Psychotherapy Treatment* (2nd ed., Chapters 1 and 2). American Psychiatric Association Publishing. https://www.appi.org/Products/Psychotherapy/Formulation-as-a-Basis-for-Planning-Psychotherapy

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1. Eells, T. D. (2022). *Handbook of Psychotherapy Case Formulation, Third Edition*. The Guilford Press. https://www.guilford.com/books/Handbook-of-Psychotherapy-Case-Formulation/Tracy-Eells/9781462548996

Session 4: Formulation of Identity and Relationship Patterns and How They Might Change in Psychotherapy

Learning Objectives

1. The resident will learn how to use the direct experience of the relationship with the patient to recognize entrenched maladaptive problems.
2. The resident will learn how to draw the patient's attention to these patterns as they occur in the psychotherapy session to facilitate change.
3. The resident will learn how to recognize when the patient or therapist is ready to terminate the treatment and how to set the stage for a therapeutic termination process.

Outline

1. Relationship patterns: within therapy and with others
    a. How to observe the patient's style of interaction and trust or distrust in the therapeutic alliance
    b. How to use the framework of the therapeutic alliance as a vehicle for developing new ways of behaving
    c. Psychotherapy techniques to promote and sustain new ways of seeing self and others in relationships
    d. How to clarify and possibly interpret roles of self, role of a significant other, and the pattern of expected emotional interactions for schemas of success (desires gratified, getting what I want) and failure (rejection, rupture, anger, sadness, shame)
    e. Recognition of impact of privilege and cultural, economic, ethnic, racial, gender and educational influences on the development of roles and relationship patterns
    f. Understanding how these factors can shape, limit, or expand possibilities of role development and change
    g. Understanding how these factors impact roles in the therapeutic relationship
    h. Supportive techniques as needed for suggesting new patterns of interaction in relationships (as in grief reactions and withdrawal from social interaction)
2. Formulation as a guide to knowing "where you are" in therapy, when and how to terminate
3. What are indications that the patient is ready to terminate (review goals and obstacles from initial assessment and formulation)
4. How to set the stage for "good goodbyes"

Key references

1. Horowitz, M. J. (2018b). *Formulation as a Basis for Planning Psychotherapy Treatment* (2nd ed.). American Psychiatric Association Publishing. https://www.appi.org/Products/Psychotherapy/Formulation-as-a-Basis-for-Planning-Psychotherapy

2. Horowitz, M. J. (2005). *Understanding Psychotherapy Change: A Practical Guide to Configurational Analysis*. American Psychological Association (APA). https://www.researchgate.net/publication/232539936_Understanding_Psychotherapy_Change_A_

Practical_Guide_to_Configurational_Analysis

3. Horowitz, M. J. (1987). *States of Mind: Configurational Analysis of Individual Psychology* (2nd ed.). Plenum Medical Book Co/Plenum Press. https://psycnet.apa.org/record/1987-97958-000

MODULE 7: INTERPERSONAL STANCE AND THE THERAPEUTIC RELATIONSHIP

Four Classes, Four Questions: What? Why? How? What If?

The interpersonal stance (our way of being with a patient) is the fundamental basis of any treatment process. Research on the common factors of different psychotherapies reveals shared elements of all effective psychotherapy treatments that reflect the quality of interpersonal connection between therapist and patient. These elements better predict positive treatment outcomes than any specific therapeutic model or technique. For this reason, it is critical to train psychiatric residents not only to provide evidence-based treatment but also to form strong working alliances, repair the inevitable ruptures, express empathy, collaborate on treatment goals and learn from patient feedback about how the patient is feeling about their interpersonal relationship (Laska, 2015). This module will help learners understand how to create a therapeutic relationship, why this facilitates change for patients, how to appreciate the emotional experiences of both the patient and the therapist, and how to handle challenges that arise in treatment.

Session 1: What Is the Therapeutic Relationship?

Learning Objectives

1. The resident will understand the skills that make therapists effective.
2. The resident will understand evidence that common factors predict outcome as much, if not more than, the particular type of therapy one implements.
3. The resident will be able to describe how their interpersonal stance creates the basis for a therapeutic relationship.
4. The resident will understand and be able to define the components of the therapeutic alliance.
5. The resident will be able to describe at least three ways a therapist can act in a therapeutic or nontherapeutic manner.

Outline

1. Summarize literature on the association between factors in the therapeutic relationship and positive outcomes in psychotherapy (Key Reference 4)
2. Discuss why the therapeutic interaction with the particular patient is more important than the choice of a specific psychotherapy for a particular disorder (Key Reference 4)
3. Discuss and define the interpersonal stance:
    a. The interpersonal stance is the way we communicate–our attitude, engagement, interest, feelings and reactions to another person–through verbal and nonverbal expressions.
    b. In therapy, the interpersonal stance is the clinician's whole way of being with a patient or a group. It includes, but is not limited to, the deliberate and habitual ways of attending to, addressing, listening to and responding to the patient.
    c. The interpersonal stance grows out of the clinician's understanding of their role (in both duties and limitations), their intentions and motivations, and their internal feelings about the patient and themselves.
4. Discuss the common factors in treatment and how these factors are described and measured in the literature
5. Describe the three common elements of the therapeutic alliance and the collaborative nature of the relationship (See Key Reference 2, which refers to other sources.)
    a. The affective bond between therapist and patient
    b. Mutual agreement about the goals of therapy/treatment
    c. Mutual agreement about the tasks of therapy/treatment
6. Discuss how the development of the therapeutic alliance is a collaborative and ongoing process that brings the therapist and patient toward a shared understanding of the treatment
7. Engage in open discussion and assign exercises before the next session
    a. Discuss concrete examples of a working therapeutic alliance across treatment settings and types beyond psychotherapy
    b. See Appendix Resources for further discussion questions and exercises

Key References

1. See Appendix Resources for session 1.

2. Stubbe, D. (2006). The Therapeutic Alliance: The Fundamental Element of Psychotherapy. *Focus*, 16(4), 402-403. https://doi.org/10.1176/appi.focus.20180022

3. Peterson, B. S. (2019). Editorial: Common Factors in the Art of Healing. *Journal of Child Psychology and Psychiatry*, 60(9), 927-929. https://doi.org/10.1111/jcpp.13108

4. Laska, K. M., Gurman, A. S., & Wampold, B. E. (2014). Expanding the lens of evidence-based practice in psychotherapy: A common factors perspective. *Psychotherapy*, 51(4), 467-481. https://doi.org/10.1037/a0034332

5. Cuijpers, P., Reijnders, M., & Huibers, M. (2019). The Role of Common Factors in Psychotherapy Outcomes. *Annual Review of Clinical Psychology*, 15, 207-231. https://doi.org/10.1146/annurev-clinpsy-050718-095424

Additional References

1. Center for Alliance Focused Training Website: www.therapeutic-alliance.org

2. Psychological Films. (1965). Three approaches to psychotherapy. Santa Ana, CA.
   With captions: https://youtu.be/MIsPg4YDgHY
   Gloria and Carl Rogers: https://youtu.be/ee1bU4XuUyg
   Gloria and Fritz Perls: https://www.youtube.com/watch?v=cpUVR43jZHk
   Gloria and Albert Ellis: https://www.youtube.com/watch?v=Jg5o0479uUQ

Session 2: Why Is the Therapeutic Relationship Important?

Learning Objectives

1. The resident will be able to describe the characteristics of a therapeutic relationship, or holding environment.
2. The resident will understand why the therapeutic relationship is important to treatment and change.
3. The resident will understand how the therapeutic relationship facilitates the patient's ability to tolerate difficult emotional experiences and how this process leads to therapeutic change.

Outline

1. Define and discuss the therapeutic relationship and related concepts and techniques
    a. Holding environment (Winnicott)
    b. Container and containment (Bion)
    c. "Playing catch" with patients throughout the interaction
        i. Attending to the internal experiences of patients and actively responding
        ii. These are "serve and return" interactions in a clinical context
        iii. Person-centered counseling (Carl Rogers), motivational interviewing
2. What does a therapeutic relationship make possible?
    a. Trust
    b. Learning new skills, psychoeducation
        i. The balance of advice giving, teaching, insight-building and nonverbal containment varies among different traditions of therapy
    c. Emotional expression and experience
    d. Distress and memory tolerance
    e. Learning about maladaptive patterns
3. Discuss how a therapeutic relationship is the foundation for change. The therapeutic process provides the opportunity for healing. It:
    a. Progresses from an emotional bond or connection between the therapist and patient
    b. Progresses through the interactive expression and regulation of emotions
        i. Often referred to as co-regulation
    c. Facilitates the reorganization of perception, experiences and behaviors
        i. New ways of responding (emotionally and relationally) are discovered and practiced in the context of the therapeutic relationship
        ii. When a patient is seen and heard by the therapist in a new way, the patient begins to see self and others in a new way
        iii. Through these experiences, patients can build insight into their habits and patterns and engage in new behaviors in other relationships
4. Engage in open discussion and assign exercises before the next session
    a. See Appendix Resources for discussion questions and exercises

Key References

1. See Appendix Resources for session 2

2. Substance Abuse and Mental Health Services Administration (US). (2019). Chapter 3– Motivational Interviewing as a Counseling Style. In Enhancing Motivation for Change in Substance Use Disorder Treatment. https://www.ncbi.nlm.nih.gov/books/NBK571068/

3. Wallin, D. J. (2015). *Attachment and Change*, Chapter 1, Attachment in Psychotherapy (Reprint ed.). The Guilford Press, 1-8. https://www.guilford.com/books/Attachment-in-Psychotherapy/David-Wallin/9781462522712/reviews

4. Lanman, M. (1998). The Human Container: Containment as an Active Process. *Psychodynamic Counselling*, 4(4), 463-472. https://doi.org/10.1080/13533339808402523

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1. Brown, L. J. (2012). Bion's Discovery of Alpha Function: Thinking Under Fire on the Battlefield and in the Consulting Room. *The International Journal of Psychoanalysis,* 93(5), 1191-1214. https://doi.org/10.1111/j.1745-8315.2012.00644.x

2. Center on the Developing Child at Harvard University (2016). From *Best Practices to Breakthrough Impacts: A Science-Based Approach to Building a More Promising Future for Young Children and Families*. https://developingchild.harvard.edu/resources/from-best-practices-to-breakthrough-impacts/

3. Lanyado, M. (1996). Winnicott's Children: The Holding Environment and Therapeutic Communication in Brief and Non-Intensive Work. *Journal of Child Psychotherapy*, 22(3), 423-443. https://doi.org/10.1080/00754179608254517

4. Housby, H., Thackeray, L., & Midgley, N. (2021). What contributes to good outcomes? The perspective of young people on short-term psychoanalytic psychotherapy for depressed adolescents. *PLOS ONE*, 16(9). https://doi.org/10.1371/journal.pone.0257334

Session 3: How to Create a Therapeutic Relationship

Learning Objectives

1. The resident will understand what skills to develop in order to build the therapeutic alliance and facilitate a therapeutic relationship.
2. The resident will be able to describe how mindfulness and mentalization are important skills in facilitating a therapeutic relationship.
3. The resident will understand specific techniques for developing greater awareness of their own inner experiences and greater attunement (emotional responsiveness) to the patient's emotional experiences.
4. The resident will learn what kinds of comments "shut down" the patient's communication, and what kinds of comments help the patient to open up new and relevant areas that can be explored.
5. The resident will understand what is appropriate empathic validation and what is not.

Outline

If preceded by a session where homework is assigned, first review the homework.

1. Review the definition of "therapeutic alliance"
    a. See session 1
    b. The process of building the therapeutic relationship forms and strengthens the alliance, which allows for effective treatment and facilitates change
2. Define and discuss the concept of the treatment frame
    a. The treatment frame includes the purpose and limitations of the treatment and what activities are appropriate and necessary to the treatment (responsibilities of the patient and the therapist)
    b. The treatment frame must be a shared and maintained understanding between the therapist and the patient, and should be revisited as needed
    c. Consistency of the therapist's availability and responsiveness allows for a sense of safety and trust and allows both the patient and the therapist to reorient themselves to the core therapeutic activities whenever needed
3. Discuss how effective therapists can maintain a nonjudgmental awareness and understanding of the inner experiences of both their patients and themselves
    a. Mindfulness allows for attention and awareness of moment-to-moment emotional experiences in the therapist and the patient
    b. Mentalization allows the therapist to consider and provide potential explanations for the patient's thoughts, feelings, beliefs and behaviors
        i. Mentalization is the ability to understand, imagine and consider the thoughts, feelings and motivations in oneself and others. This involves forming a variety of predictions and inferences about internal mental states.
            1. Forming a "broad differential" about why people do what they do
            2. Example: If your co-worker passes by and doesn't say hello, do you:
                a. Conclude that they dislike you and are ignoring you

b. Consider other possibilities, such as that they were too preoccupied to notice you or too stressed to take the time to say hello

ii. Secure attachment relationships support an individual's development of the ability to mentalize

iii. Related concepts include teleological reasoning and fundamental attribution error

4. Review and discuss the techniques and practices that can develop the therapist's ability to create a therapeutic relationship and build emotional regulation skills
    a. Facilitating a narrative
        i. Establishing trust and expressing interest
    b. Emotionally validating interventions
        i. Empathic statements and mirroring
        ii. Containment
    c. Asking questions that build the therapeutic alliance
        i. Responding to and exploring the emotional nuances observed in the session allows patients to feel support, encouragement and gratification
        ii. The focus of the therapy interventions (which questions are asked and what statements are made) shows the patient what topics are most important to the treatment
    d. Mindfulness skills and practice
    e. Emotional awareness (both patient's and therapist's) and mentalization
    f. Nonjudgmental attitude and acceptance of the patient
        i. Therapeutic neutrality
        ii. Appropriate emotional validation expresses understanding and acceptance of the patient for who and where they are, but does not mean expressing approval of maladaptive, inappropriate or dangerous actions
5. Discuss how the approach to alliance-building becomes more complex in therapies involving more than one therapist and one patient
    a. Group psychotherapy
    b. Family psychotherapy
    c. Multidisciplinary treatment teams
6. Review and discuss errors or attitudes from the therapist or patient that can impair the therapeutic relationship
    a. Arguing with the patient
    b. Negative judgments
        i. Responses that create shame or guilt in the patient
    c. Inappropriate advice-giving
        i. For example, giving advice in a way that implies disapproval of the patient
        ii. Advice-giving that is outside the scope of the professional
    d. Making assumptions about understanding the patient too early or with too much confidence
        i. For example, making specific empathic statements or interpretations too early or inaccurately

e. Ruptures in the therapeutic alliance and relationship are inevitable over time and should be addressed. (See session 4.)

Key References

1. See Appendix Resources for session 3.

2. Bender, S., Messner, E., & Trinh, N. (2022). Initiating an Alliance and Assessing Safety; Enhancing the Therapeutic Alliance and Eliciting History. *Becoming a Therapist, Second Edition: What Do I Say, and Why?* The Guilford Press, 33-80. https://www.guilford.com/books/Becoming-a-Therapist/Bender-Messner/9781462549467

3. Wallin, D. J. (2007). Chapter 2, The Foundations of Attachment Theory. *In Attachment in Psychotherapy*. The Guilford Press, 11-24. https://www.guilford.com/books/Attachment-in-Psychotherapy/David-Wallin/9781462522712/reviews
Chapters 2 and 3 provide a good structure for residents to learn about the roles of attachment and mindfulness in therapy.

4. Rait, D. S. (2000). The Therapeutic Alliance in Couples and Family Therapy. *Journal of Clinical Psychology*, 56(2), 211-224. https://pubmed.ncbi.nlm.nih.gov/10718604/

5. Moorey, J. (2006). The Treatment Frame and the Treatment Alliance. In M. Sampson, R. McCubbin, & P. Tyrer (Eds.), *Personality Disorder and Community Mental Health Teams: A Practitioner's Guide*. John Wiley & Sons Ltd., 241-259. https://doi.org/10.1002/9780470713594.ch12

Additional References

1. Wallin, D. J. (2007). Chapter 17, Mentalizing and Mindfulness: The Double Helix of Psychological Liberation. In Attachment in Psychotherapy. The Guilford Press, 307-338. https://www.guilford.com/books/Attachment-in-Psychotherapy/David-Wallin/9781462522712/reviews

2. Resources for Mindfulness Practice, Meditation, and Loving-Kindness Meditation: Mindfulness Exercises: https://mindfulnessexercises.com/free-guided-meditations-mindfulness-talks/
Other online and in-person resources: Dharma Seed Catalog, Everyday Zen, Spirit Rock, Insight Meditation Society

Session 4: What If? Understanding Challenges and Ruptures in the Relationship as Opportunities

Learning Objectives

1. The resident will be able to describe the concept of an interpersonal style.
2. The resident will understand how a patient's individual characteristics and history contribute to their interpersonal style.
3. The resident will understand how to manage and discuss emotions and challenges that arise during therapy.
4. The resident will understand the concept of co-regulation of emotional experience in the treatment of trauma and other states of dysregulation.
5. The resident will be able to describe at least two methods of helping the patient regulate their emotions.
6. The resident will understand how to recognize and address ruptures in the therapeutic relationship.

Outline

If preceded by a session where homework is assigned, first review the homework.

1. Review the definition of "interpersonal style" and what factors influence the interpersonal style
    a. Attachment style
    b. Developmental challenges and traumas
    c. Family and societal systems
2. Discuss how interpersonal style produces transference or habitual behaviors in relationships
3. Discuss how emotions are generally regulated
    a. Emotions are regulated within relationships (co-regulation)
        i. Empathic mirroring, emotional validation, containment, support
    b. Emotions are regulated by individuals and their actions (self-regulation)
        i. Psychological defenses, skills, avoidance, self-soothing, outward-facing actions
4. Discuss methods that can be used to help patients regulate their emotions
    a. Practicing mindfulness skills
    b. Practicing new and adaptive behaviors
    c. Practicing emotional awareness and communication
5. Discuss how the therapist can regulate their own emotions when providing treatment
    a. Maintaining the treatment frame, boundaries and professional behavior
        i. Doing so makes it easier for therapists to regulate their own emotions, avoid acting on impulses, and prevent boundary crossings and violations
    b. Mindfulness and curiosity about the therapist's emotions
    c. Understanding the patient's background, deficits and capacities
    d. Utilizing supervision, particularly to discuss the therapist's own emotional reactions and challenges in the treatment
6. Discuss the management of ruptures in the therapeutic relationship

   a. How to recognize when a rupture has occurred
   b. Ruptures can occur due to contributions from the patient, the therapist or both
   c. Methods of communicating and addressing ruptures and the associated emotional reactions
   d. Ruptures as an opportunity for treatment, understanding and growth
7. Discuss common difficulties experienced by the therapist
   a. Liking or disliking the patient too much
   b. Romantic or sexual feelings for patients
   c. Identifying too much or too little with the patient
   d. Cultural or racial gaps and biases
8. Assign practice: Reflect on your response to a challenging interaction in a clinical encounter and how it could provide an opportunity for growth
9. Use video https://www.youtube.com/watch?v=vRBXYm3KuJU from the Center for Alliance Focused Training website, on Confrontation: "This Is a Waste of Time," a demonstration of nonjudgmental, relationship-focused skills to overcome an impasse

Key References

1. See Appendix Resources for session 4.

2. Bender, S., Messner, E., & Trinh, N. (2022). Chapters 15-16, Managing Impasses; Empathic Lapses. In *Becoming a Therapist, Second Edition: What Do I Say, and Why?* The Guilford Press, 325-342. https://www.guilford.com/books/Becoming-a-Therapist/Bender-Messner/9781462549467

3. Loades, M. E., Midgley, N., Herring, G. T., O'Keeffe, S., IMPACT Consortium, Reynolds, S., & Goodyer, I. M. (2023). In Context: Lessons About Adolescent Unipolar Depression From the Improving Mood With Psychoanalytic and Cognitive Therapies Trial. *Journal of the American Academy of Child and Adolescent Psychiatry,* S0890-8567(23)00231-9. Advance online publication. https://doi.org/10.1016/j.jaac.2023.03.017

4. O'Keeffe, S., Martin, P., & Midgley, N. (2020). When Adolescents Stop Psychological Therapy: Rupture-Repair in the Therapeutic Alliance and Association With Therapy Ending. *Psychotherapy,* 57(4), 471-490. https://doi.org/10.1037/pst0000279

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1. Center for Alliance-Focused Training: https://www.therapeutic-alliance.org/

2. Benish, S. G., Quintana, S. M., & Wampold, B. E. (2011). Culturally Adapted Psychotherapy and the Legitimacy of Myth: A Direct-Comparison Meta-Analysis. *Journal of Counseling Psychology*, 58(3), 279-289. https://doi.org/10.1037/a002362
   Note: Effectiveness [of psychotherapy] is critically altered by the degree of fit between the psychotherapeutic explanation of illness offered by the therapist and the client's understanding of illness and suffering.

3. Yeo, E., & Torres-Harding, S. (2021). Rupture Resolution Strategies and the Impact of Rupture on the Working Alliance After Racial Microaggressions in Therapy. *Psychotherapy*, 58(4), 460-471. https://doi.org/10.1037/pst0000372

4. Asnaani, A., & Hofmann, S. (2012). Collaboration in Multicultural Therapy: Establishing a Strong Therapeutic Alliance Across Cultural Lines. *Journal of Clinical Psychology*, 68(2), 187-197. https://doi.org/10.1002/jclp.21829

5. Vasquez, M. J. T. (2007). Cultural Difference and the Therapeutic Alliance: An Evidence-Based Analysis. *American Psychologist*, 62(8), 878-885. https://doi.org/10.1037/0003-066x.62.8.878

APPENDIX RESOURCES

Appendix: Module 1 (Introduction), Session 1: An Integrative Approach to the Therapeutic Encounter

1. Rationale for teaching an integrated psychotherapy course: Understanding the shared foundation of psychotherapeutic approaches in decreasing suffering and improving functioning.
2. Explanation of format; expectations for practice outside of sessions and role-playing within sessions (and reading, if this is required or recommended); how to access written and recorded materials.
3. Listening exercises:
    a. Divide the group into pairs of listener and speaker, with the option to add a third who observes and gives feedback.
    b. Give guidelines for listening with
        i. **Genuine curiosity** (so that the listener tries to be aware of assumptions while refraining from imposing those on the discussion)
        ii. **Attention to emotional state**/state of mind of self and other
        iii. **Empathic comments** that support a regulated emotional state and offer validation
        iv. **Attention to inconsistencies** and gaps, which could be fruitful opportunities for the speaker to pause, reflect and discover something new about what they are feeling or thinking
        v. **The goal of simply understanding what happened, what was difficult about it for the speaker. The listener is not there to make suggestions, advise or try to make the person feel better or worse**. Without asking why it was difficult, the listener may hear clues that allow them to guide the speaker in understanding the reasons.
    c. Give prompt for "real play":
        i. "One of the difficult clinical experiences I have had this week is …"
        ii. "A patient I keep thinking about is …"
        iii. "A patient who reminded me of …"
    d. Debrief: Ask speakers to identify what characteristics and interventions of the listener led to comfort in self-disclosure, greater opportunity to reflect and understand an experience, decreased distress, or improved ability to learn from the experience.
    e. Use these observations to generate a list of techniques to return to in the next session.
4. Weekly practice: Make note of one therapeutic interaction in which you intentionally used an approach to listening and responding that we discussed today. Describe the impact of this on your interaction with the patient.

Appendix: Module 2 (Neuroscience), Executive Summary of Sessions 1-4

The explosion of neuroscientific knowledge over the past two decades has offered new ways of looking at long-held beliefs about psychological health, dysfunction and healing. Here, we summarize four recent theories of neuroscience that enrich our understanding of human behavior and of the causes of psychological symptoms, and the possible mechanisms of healing through the process of psychotherapy. Some of these recent findings align with theories formulated over the past century through close observation of healthy and dysfunctional patterns of human development and interaction in the nursery, the lab and the clinic. Some neuroscience findings offer alternative interpretations. Symptoms that we consider signs of psychiatric illness might also be understood as adaptations to particular family or historical conditions. Some findings suggest neurocognitive mechanisms for the process of change in psychotherapy.

The following four areas of research each contribute new insights into accepted practices of psychiatric diagnosis and treatment.

1. Predictive Processing Theory
   Predictive processing theory is grounded in research in neurocognitive science that describes how the brain develops predictions based on prior experience and how these predictions then influence our perception of reality. Findings from experiments in human perception are consistent with the observation made by psychotherapists and philosophers that, as humans, we do not see what is really there. Rather, we tend to see what our brain automatically predicts will be there. As a simple example, this is one reason we are not very good at proofreading our own writing for errors: We tend to see what we think we wrote rather than what is actually written. While this type of misreading error may have trivial consequences, predictions about interpersonal interactions can set off chains of emotional response and behavioral impulses that have great consequences, especially when these patterns of response are maladaptive and become entrenched. This area of research helps us understand the power of the self-fulfilling prophecy and the way this plays out in human interactions.

   We could describe the job of the therapist as observing, reflecting on and responding to these false predictions in a way that leads to “prediction error”: the feared outcome does not materialize. In the therapeutic relationship, the patient reveals, responds to and acts on their predictions. The therapist can observe and nonjudgmentally reflect together with the patient on the sequence of events leading to the patient’s perceptions and response. These maladaptive patterns of prediction and response are repeated in therapy, often in the form of strain or even threat of rupture of the therapeutic alliance. The patient who has been repeatedly criticized by parents or devalued at work may perceive judgment and disapproval if the therapist maintains a neutral expression. Each time this process can be observed and reflected on in therapy, there is an opportunity for therapeutic change: The patient can begin to recognize repeated patterns of perceiving what they think will happen and how this interferes with being receptive to what is

actually happening.

Parallel teachings from ancient meditation traditions and modern mindfulness practices point the practitioner to the same discovery. Once we sit quietly and observe what goes on in our mind, we find ourselves in a torrential downpour of thoughts, assumptions, predictions of the future and preoccupations with the past that cloud the lens through which we see our current circumstances. This is one way in which meditation or mindfulness practice can help the therapist understand and have compassion for the patient, and all humans, who are at the mercy of the very active, predictive and stubborn cognitive habits of the mind.

Early life experience considerably influences long-standing predictions, or schema, predicting typical perceptions, attitudes and behaviors of ourselves and others. How children attach to their parents has an outsized impact on the schema of self, others and relationships well into adulthood. Child maltreatment can promote early maladaptive schema, resulting in relational patterns that are inadvertently persistent and self-defeating.

How can these persistent patterns of misperception, and their emotional and behavioral sequelae, be modified in the course of psychotherapy? Neurocognitive research on the **mechanisms of extinction and memory reconsolidation** offers explanations of how psychological change takes place in the context of psychotherapy.

2. Extinction and Memory Reconsolidation

The nervous system, like the musculoskeletal system, is continually changed by experience: Neuronal connections that fire repeatedly become more efficient and will respond more rapidly under the repeated conditions. Neuroplasticity is the capacity of the nervous system to proliferate and to prune different synaptic connections, depending on what stimuli the individual is exposed to and what activities the individual engages in. The metaphor of “Building a Baby’s Brain: From a Dirt Road to a Superhighway” highlights how efficiency in synaptic connections is built through repeated stimulation of certain pathways during development (First Five Nebraska, 2016) Familiar examples of changes in the brain that reflect life experiences are the prominence of the motor cortex that controls hand and finger movements in musicians who play string instruments and keyboards, and the larger hippocampus of London taxi drivers who have navigated and memorized thousands of routes through a large city.

A popular way of explaining neuroplasticity is “neurons that fire together wire together,” a phrase used by Carla Shatz (Shatz, 1992) to describe a phenomenon proposed by Donald Hebb (Hebb, 1949). Hebb proposed a neurophysiologic model for learning: When cell A repeatedly fires and excites cell B that is nearby, long-term potentiation strengthens the synaptic connection so that cell A can more quickly and efficiently cause the firing of cell B. When this model is applied to psychological development, we see how an individual’s pattern of responding to environmental and interpersonal stimuli has been shaped by experience.

Schemas are believed to be created by extracting commonalities, or repeated patterns, from memories of similar experiences. As such, their role is to predict that such patterns will recur when such experiences arise again. Schemas are encoded in auto-associative neural networks through interactions of the ventromedial prefrontal cortex and hippocampus.

Memories and schemas are not fixed but change with experience, mediated by the hippocampus. Many forms of psychotherapy, such as CBT and psychodynamic approaches, target maladaptive schemas for change. To do so, these approaches often promote patient attention to mismatches between expectations generated by maladaptive schemas and actual experiences. A mismatch, or "prediction error," is believed to prompt revision/update of the schema by the hippocampus.

The "corrective emotional experience," in which patients experience their therapist as acting in unexpected ways that create a mismatch with predictions from maladaptive schema, is considered a key factor facilitating therapeutic change. For example, a patient with a maladaptive schema predicting rejection or scorn consequent to self-disclosure can be surprised by their therapist's unexpected acceptance. The mismatch, or prediction error, is believed to prompt updating of the maladaptive schema by the hippocampus.

The mechanisms of how predictions are updated are not fully understood (Bein et al., 2023; Huppert et al., 2020). Several neural processes have been suggested as mediating the update of schemas in psychotherapy. These are memory reconsolidation, extinction and pattern separation. Memory reconsolidation involves erasing old associations from the neural network encoding the old prediction and adding new neural connections. The result is a new auto-associative network encoding a new prediction, which replaces the old one. Extinction involves a new prediction, encoded by new neural associations, that co-exists and competes with the old prediction. Pattern separation involves associating a new prediction with a new context, separated from old predictions associated with a previous context. For example, pattern separation allows a veteran to remain calm during fireworks by separating associations of sharp, loud noises in a civilian context from similar sounds associated with a previous context involving combat.

3. Complex Systems

   In order to understand the power of therapeutic interaction, as well as the impact of our earliest relationships on the course of human development, we need to appreciate how **complex systems** evolve and change. When we understand how complex systems evolve and function, we can better understand how family function or dysfunction emerges from a variety of factors, rather than through the "fault" of one or another family member. We can understand how siblings with similar genetic vulnerabilities to a psychiatric disorder may or may not develop symptoms, based on the different environmental factors that impact each sibling's

development. We can also understand how the therapeutic relationship is one of many factors in a patient's family, community, cultural and socio-historical network that will help or hinder the emergence of healthier behaviors.

Understanding the properties of complex adaptive systems is critical in learning how the human nervous system develops its amazing capacity for self-awareness, awareness of others and integration of a myriad of sensory inputs into coherent, well-regulated, interpersonal responses (Seigel, 2020). As the brain develops, certain areas of the brain differentiate from others, expressing properties that are specialized for performing certain functions. Because all the parts of the brain are connected, the functioning of one area influences the development and functioning of other areas. These differentiated parts are linked, mutually influencing each other. At the same time, sensory input from the environment, and especially input from interpersonal interactions, impacts the functioning and development of the different parts of the nervous system (Seigel, 2020). As we know from our studies of parent-infant attachment, the infant and parent are particularly attuned to each other's emotional communication, expressed through movement of the body, tone of voice and facial expression. Thus, the development of a self-regulating nervous system that can respond to stimuli and re-regulate as needed depends on the innumerable interactions of all the different parts of the nervous system as well as the interpersonal environment. Similarly, parents and children each have the potential capacity to regulate or dysregulate each other's nervous system through interpersonal interactions.

The brain is a complex system, developing within the complex system of the human body of a child whose development is embedded in the context of a complex system of interpersonal relationships and environmental, cultural and historical influences. Thus, we see that linear cause-and-effect models cannot do justice to the process of emerging properties that arise from these self-organizing systems. The impact of parents on their children's behavior, and the impact of children on their parents' behavior, needs to be understood in the context of the complex systems of family, community, culture, medical systems of care, and the social and physical environment. The presence of green space in a community is one of the many environmental properties of this complex system that has been shown (in data from the National Institutes of Health (NIH) Environmental Influences on Child Health Outcomes cohort) to impact psychological functioning. (Towe-Goodman et al., 2024)

We also learn from these models that in medical and therapeutic encounters, we, as psychiatrists, become part of this complex system of interpersonal relationships and therapeutic interactions. As psychiatrists, we both influence the patient and are influenced by these interactions. If we can appreciate the complexity of the systems that we enter into and participate in with our patients, we can be more open to recognizing what new and unanticipated experiences can emerge from our therapeutic endeavors.

4. Evolutionary Theory

   Becoming a psychiatrist and/or psychotherapist requires flexibility in thinking and openness to new interpretations, both in the consulting room and in reading the literature, and a commitment to lifelong learning. For this reason, this discussion of neuroscientific findings offers not only support of but also a challenge to traditional explanations of "psychopathology." Western traditions of medical care identify and treat disease. Blood tests and other diagnostic procedures have standards for what is within and outside the normal range. The *Diagnostic and Statistical Manual of Psychiatric Disorders* maintains this medical model, identifying what types of cognitive, emotional and behavioral responses are within or outside an agreed-upon range of normal. However, many definitions of "normal" behavior are based on culturally specific expectations. What parents expect of their children can vary greatly, depending on the culture and the life circumstances of the family.

   Even when our practice of cultural humility helps us explore and understand the different expectations of different cultures, we tend to categorize certain patterns of relationships and behaviors as dysfunctional. Evolutionary theory is a helpful antidote to our tendency to judge behavioral differences as symptoms of illness–the evolutionary perspective helps us see how some symptoms may not be the expression of illness but may be adaptations to challenging conditions. For example, the behaviors associated with the different manifestations of insecure attachment may be seen as psychopathology. However, they can also be understood as adaptations to parents' limitations in their ability to offer responsive parenting. Fierce independence and avoidance of close relationships can be understood more empathically when seen as a life-affirming adaptation to limited parental support and nurturing. Anxious clinging and need for reassurance can also be understood as adaptations that were reinforced by an intermittently responsive parent.

   Evolutionary theory can also offer possible answers to questions about why it can be so difficult to be happy, while it is so easy to become preoccupied with dangers and the inevitable losses in living life as a human. It is not as important to the survival of the species for humans to be happy and content as it is for humans to effectively navigate the dangers of life in order to survive long enough to procreate and raise healthy offspring. One can speculate about whether this is a reason that spiritual practices have developed since the beginning of recorded human history: It takes practice, learning and the development of perspective taking in order to enjoy the beauty of life in the midst of inevitable pain, suffering and loss. Seen through an evolutionary lens, even the symptoms of depression can be understood as offering an adaptive advantage, an "involuntary defeat strategy" that may facilitate accepting defeat (Durisko et al., 2015) and staying within the protective bonds of the community.

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Appendix: Module 5 (Trauma), Session 1: What Is Trauma?

Trauma comes from the Greek word for “wound.” Trauma is an important and complicated subject. It can be anything from a natural disaster or genocide to a microaggression that overwhelms the coping skills of a person, a family or a community. Traumatic experiences are widely prevalent and are associated with both behavioral and chronic physical conditions. This is especially so when traumatic events occur during childhood and when there is an absence of empathic caregivers. Trauma is difficult to diagnose and treat because traumatic events are routinely forgotten, repressed, denied or cut out from memory. However, they return and are repeated and magnified, both in the individual and in society. They result in deficits in personality development, substance abuse, depression, anxiety, post-traumatic stress disorder (PTSD), psychosis and self-destructive behaviors. Moreover, the impact of trauma depends on the effect of the trauma on the specific individual. Trauma is interrupted history that is repeated, often out of conscious awareness. The new narrative creates more history, often with re-traumatization and symptom formation, but potentially with working through and healing.

Adverse childhood experiences (ACEs) were defined in a Kaiser Permanente study in seven categories. These included psychological, physical or sexual abuse; violence against the mother; and living with household members who were substance abusers, mentally ill or even imprisoned. The breadth of exposure to these experiences showed a graded relationship to multiple risk factors for several of the leading causes of death in adults. Subsequent studies in what became known as “trauma-informed care” expanded the ACEs to 10 categories and found that they caused negative effects on physiological, cognitive, behavioral and psychological functions. Exposure to trauma can make it more difficult for children to distinguish between safe and unsafe situations and may lead to significant changes in their own protective and risk-taking behavior. Children who continue to live in dangerous family and/or community circumstances may have greater difficulty recovering from a traumatic experience. Traumatic experiences evoke strong biological responses that can persist and alter the normal course of neurobiological maturation. Cortical structures (e.g., the prefrontal cortex) are disinhibited, leaving subcortical structures (e.g., the amygdala) in an aroused state.

Among the complexities of trauma care is whether the trauma is a physical or psychological injury. For instance, one of the earliest examples of trauma was “railway spine.” Injuries in railway accidents caused physical injury but also often psychological injury. The same was true for “shell shock” in WWI. In fact, the British government banned the use of the term because many soldiers did not have physical injuries at all, but what later became known as “battle fatigue” and then PTSD. Physical injuries were, and still are, viewed by soldiers as more heroic and patriotic than psychological injuries, which are sometimes called “silent” or “hidden” wounds of war and considered a sign of weakness.

Another complexity is whether the trauma is a past event (which persists either consciously or unconsciously) or an ongoing dynamic process. Freud’s early hysterical patients “suffered from reminiscences.” The cathartic talking treatment was supposed to cure the patient of symptoms related to the repressed memory of the trauma. But these traumas tended to recur in later settings, including the treatment relationship (transference), which is another complexity of trauma treatment. If there is not sufficient safety and trust in the treatment relationship, re-traumatization will occur, rather than working through in a collaborative manner.

Symptoms occur when a metaphoric “stimulus barrier” is broken by a trauma. Among them are dissociation, memory loss, loss of a sense of time, depression, anxiety and personality disorders. In

PTSD, symptoms include hyperarousal, numbing, flashbacks and nightmares. In child abuse, children become confused and identify with the aggressor, incorporating their guilt and shame. Another defense is to become a wise baby or parentified child. Especially when trauma is early and severe, personality development is impacted and the self-concept is fragmented, resulting in multiple personality disorder or dissociative identity disorder.

Treatment approaches must first focus on establishing safety and trust, then character strengthening before risking exposure to the traumatic memory. Otherwise, re-traumatization may occur. Recovery from severe trauma may be a lifetime project requiring family and community resources to assist with abstinence from alcohol or drug use and with securing housing. Then physical and bodily treatments may be utilized to calm the hyperaroused state. If a trusting relationship can be built with a therapist, then psychotherapy can be tried.

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Appendix: Module 5 (Trauma), Session 3: Psychotherapy of Trauma Part One: Principles of Treating Traumatized Individuals

Janet's psychotherapeutic approach to post-traumatic stress consisted of the following stages:
1. Stabilization, symptom-oriented treatment and preparation for liquidation of traumatic memories 2. Identification, exploration and modification of traumatic memories 3. Relapse prevention, relief of residual symptomatology, personality reintegration and rehabilitation

Common Stages in Psychotherapy of Trauma

Stage	Patient Activity	Therapist Activity	Therapeutic Relationship
Assessment	Reports events, symptoms, problems and goals.	Obtains history, shares early formulations. Presents treatme options.	Agreement on initial frame.
Support	Expands story and focuses on coping with curre stress.	Provides guidance on how to handle crises. Establishes safety for patient.	Roles of a therapeutic partnership are defined.
Exploration of meanings	Expands on meaning to the self of the trauma and it sequelae.	Clarifies how emotions and ide are linked.	Therapeutic alliance deepened by experience of safety.
Re-narration	Works on themes previously avoided.	Encourages tolerance of dysphoric emotional states. He the patient modify dysfunction beliefs.	Negotiation of how to handle difficult moments.
Re-schematization	Plans how to restore a sense of self-efficacy.	Helps patient modify internal working models and core attitudes.	Expectations for the future are reappraised realistically.
Termination	Rehearses plans for how to cope with future problem	Highlights the most helpful insights.	Emphasis on safe separation.

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Appendix: Module 5 (Trauma), Session 4: Psychotherapy of Trauma Part Two: Specific Approaches and Special Considerations

Therapist's Aims in Treating Trauma
Educate patient about symptom formation.
Counteract both flooding and excessive inhibition of expression. Teach affect tolerance and calming techniques.
Piece together dissociated fragments of memory. Clarify and challenge irrational beliefs and augment rational plans of action.
Modify maladaptive attitudes.
Heighten the patient's sense of safety, emotional control and interpersonal skills.

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A trusting relationship is foundational in psychotherapeutic treatment.

Exposure techniques and risk of re-traumatization is part of treatment. Learning to cope helps with the re-narrative process.

Avoidance and intrusions (re-experiencing) in therapy helps the patient deal with increments of traumatic experience in a safer environment.

In trauma-focused psychotherapies, patients who focus on a particular event often go through stages. In this session a discussion of examples of the techniques used as individuals go through emotional processing and revision of stories can follow the technical progressions illustrated in the table above.

Patients with trauma histories often first require structural safety (housing, support for sobriety, physical safety).

Within psychotherapy treatment, the task is to establish a safe relationship between the patient and the therapist. Once a trusting relationship has been established, psychotherapy treatment may proceed with the above stages as rapidly as the patient can learn new ways of self-understanding and coping. Some patients may progress rapidly to the deeper stages, and others may primarily need support.

Appendix: Module 7 (Interpersonal Stance), Session 1: What Is a Therapeutic Relationship?

(*This appendix material can be reviewed to supplement the didactic material with additional exercises and information.)*

1. More effective therapists generally form better alliances with their patients, have better facilitative interpersonal skills and provide an emotionally activating relationship (Laska, 2014).

2. What is more important: the choice of psychotherapy approach for a particular disorder or the style of therapeutic interaction with the particular patient?
    a. Different "bona fide psychotherapies produce similar outcomes, once the researchers' allegiance effect is identified and controlled" (Wampold & Imel, 2015)
    b. Psychotherapy should be matched to the particular patient rather than to a particular disorder. The frame and action of the psychotherapy may change as we update our understanding of the patient. (Every psychotherapy is "personalized medicine.")

3. Present a summary of the literature on the association between factors in the therapeutic relationship and positive outcomes in psychotherapy. Discuss the common factors and how they are described and measured in the literature. The purpose of this is to prepare residents to respond to statements like, "CBT has the most randomized controlled trials showing efficacy–so why aren't you doing just CBT?"
    a. Research findings on therapy outcomes can be summarized by the statement of the Dodo Bird from *Alice's Adventures in Wonderland*: "Everybody has won and all must have prizes."
    b. Many meta-analyses later, we are not finding anything that different. From www.therapeutic-alliance.org: "A great deal of research has been conducted demonstrating that the therapeutic alliance is one of the most robust predictors of treatment success in all forms of psychotherapy."
    c. What are the common factors (definition from Laska article): The CF approach (Frank & Frank, 1993; Wampold, 2001) conceptualizes psychotherapy as a socially constructed and mediated healing practice. The CF model focuses on factors that are necessary and sufficient for change:
        i. An emotionally charged bond between the therapist and patient
        ii. A confiding healing setting in which therapy takes place
        iii. A therapist who provides a psychologically derived and culturally embedded explanation for emotional distress
        iv. An explanation that is adaptive (i.e., provides viable and believable options for overcoming specific difficulties) and is accepted by the patient
        v. A set of procedures or rituals engaged in by the patient and therapist that leads the patient to enact something that is positive, helpful or adaptive.

4. Reaching agreement on what we mean when we use terminology and engaging learners in developing their definition of "interpersonal stance."
    a. What are examples of times you have felt the interpersonal stance of another?
    b. What are examples of times when you have needed an interpersonal stance from another person and found it lacking?

5. What is meant by "therapeutic alliance"? (This is a term that is hard to define, but it is important for trainees to have a sense of how it is used.)
    a. Definition: The therapeutic alliance is composed of three components:
        i. Bond between therapist and patient
        ii. Agreement about the goals of therapy
        iii. Agreement about the tasks of therapy (Bordin, 1979)
    b. Most trainees and many practitioners think primarily about the emotional bond between the patient and the therapist, but the alliance includes a shared understanding of the problem, the causes and the treatment.
    c. Definition from www.therapeutic-alliance.org: The therapeutic alliance refers to the quality of the relationship between patient and therapist. It consists of a purposeful collaboration (the extent to which the therapist and patient work together on agreed-upon tasks and goals) and affective
    d. "... the alliance is not a static variable but rather a fluctuating, emergent property of the therapeutic relationship that is negotiated between patients and therapists at both explicit and implicit levels throughout the course of treatment."

6. Though a therapist/trainee may feel that they are taking a therapeutic stance, actively eliciting feedback and observing is important because patients will not necessarily perceive what is felt on the side of the therapist.
    1. Patients who have struggled in their emotional and interpersonal development and patients with traumatic experiences may not as easily experience the therapeutic stance of the therapist, which can impair the development of the therapeutic alliance. For these patients, it is especially important to maintain an active awareness of the level of trust and safety in the relationship.

7. Exercises:
    a. Write down characteristics of "therapeutic stance" and "anti-therapeutic stance."
        i. Examples: Specific interpersonal skills for the clinician–authenticity, transparency, warmth, empathy, reflective capacity, attentiveness to nonverbal communication
    b. Discuss ways you have created, or have felt that others created space for, emotional experiencing.
    c. Write down reasons a therapeutic stance might not be perceived by a patient.
    d. Write down basic actions a therapist can take to confirm that the patient feels safe and heard and feels that they can trust the therapist.
    e. Show a short clip from Rogers and Perls (and maybe Ellis) to elicit reflections on the impact of the different styles. Can include the debrief with Gloria, from Part 3, minutes 32:36-36:36.

8. Assign practice: What characteristics do you see in yourself (either improving or declining with medical training) that contribute to your therapeutic stance? Introduce principles of deliberate practice and how each student can practice this week as they identify areas of strength and challenge.
    a. Choose a characteristic you want to improve (e.g., attending to subtle emotional cues, self-awareness, self-regulation in difficult sessions, NOT avoiding difficult emotions, fostering emotional experiencing).

b. Focus on this task in patient encounters (or other encounters).
c. Get immediate feedback from patients, from an observing clinician if possible.
d. To get better, we have to move past our comfort zone, and we usually feel exhausted by the effort until these skills become more natural for us: The Principle of Deliberate Practice.

Appendix: Module 7 (Interpersonal Stance), Session 3: How to Create a Therapeutic Relationship

(*This appendix material can be reviewed to supplement the didactic material with additional exercises and information.)*

Consider providing the handout by Jonathan Shedler, Ph.D., titled: Beginning Therapy: The "Frame" (https://jonathanshedler.com/wp-content/uploads/2023/06/Beginning-therapy-handout-1-the-frame.pdf)

How do we create a therapeutic relationship? (What skills do we need to develop and practice?)

- Nonjudgmental awareness of emotional experience in self and other.
- Regulation of emotional reactivity in self and other.

How do you keep it going, keep the patient talking and opening up about more things, not shutting down?

From *Traditional Practices and Modern Clinical Practice*: The path to healing always starts with suffering. The goal of the first encounter is to empathically validate the patient's suffering and to understand how this pattern of suffering can become a starting point for healing.

1. Appropriate empathic validation.
    a. Unconditional positive regard
    b. Warm acceptance of the patient's parts
    c. Nonjudgmental awareness
        i. Linehan: like a blanket spread out on the ground and the leaves are falling on it
2. Nonjudgmental awareness of emotional experience in the self as one listens to the patient.
    a. How to practice this acceptance of/welcoming of feelings that arise in therapy
        i. Understanding the development of the patient
        ii. Mentalizing about the patient's current state to form hypotheses, and confirming hypotheses by eliciting the patient's own narrative
        iii. Maintaining attention to the therapist's own positive and negative emotional reactions to the patient without acting on them
            1. Mindfulness is deliberate attention to the present moment without judgment
    b. Some students may bring up the guidelines of mindfulness practice (e.g., from DBT or MBSR or traditional meditation practices). If not, this can be brought up as a practice.
    c. Discussion of mindfulness practices may spontaneously bring up the above skills, which can be written on a whiteboard for the class to reflect on or suggested/identified by the teacher if needed.

        For more on mindfulness, read Thich Nhat Hanh's commentary on the Four Noble Truths: It is possible to heal and experience peace through particular practices that have traditionally included breath awareness (mindfulness meditation), the support of empathic others (a friend or family member, a therapist, a practice group or sangha) and teachings (understanding and acceptance of the realities of life) that help keep our

experience in perspective and enable us to let go of the mental activity that increases our suffering.

We also need to become aware of and let go of the mental activity (self-devaluing, predicting the worst, fanning the flames of anger with internal ranting) that prevents us from being with things just as they are in this moment.

3. Self-regulation throughout the process of accepting our own feelings:
    a. How to listen, experience and reflect while keeping our own feelings within a range that does not overwhelm our capacity for self-reflection and cognitive processing
4. Nonjudgmental awareness of emotional experience in the patient:
    a. How to respond empathically
    b. What are examples of genuine validation?
    c. Importance of identifying emotional responses and understanding causes (psychoeducation)
    d. Responsiveness to "patient's attachment style, racial/ethnic culture, therapy preferences, religious/spiritual commitment, emotional reactance, stage of change, and coping style" (Norcross & Wampold, 2018)
    e. Unconditional positive regard: "To the extent that the therapist finds himself experiencing a warm acceptance of each aspect of the client's experience as being a part of that client, he is experiencing unconditional positive regard."
        i. What this is not:
            1. Agreeing with bad or harmful behaviors
            2. Denying your negative emotions about the patient
5. Helping the patient regulate difficult emotional experiences so that the patient can continue to use self-reflection and can experience a different outcome from self-expression.
6. For more discussion, if examples are needed, this is how the three therapists in the videos describe their work:

From Suzanne Bender's book:
Five tools to cultivate a therapeutic alliance: How is it different from social conversation?

1. Asking more about the material the patient brings up as important
2. Asking, "Why now? Are you seeing a clinician?"
3. Validating affect
4. Framing the consultation as "our task" (highlighting the process of working together)
5. Explaining the consultation procedure as it unfolds
    a. Carl Rogers (from video)
        i. Being real, genuine, transparent
        ii. Expressing caring for and prizing of the patient
        iii. Understanding their inner world
    b. Fritz Perls
        i. The "equation": awareness, present time, reality
        ii. Get hold of what is happening on the surface, in the here and now, in the "I-thou" relationship
        iii. Manipulate and even provoke the patient to be more genuine, integrated and in touch with real emotions in the relationship, to promote maturation
    c. Albert Ellis

i. Identify the “simple exclamatory sentences” that are irrational (what are often called “automatic thoughts”)
ii. Help patients understand how they are constantly “reindoctrinating” themselves with these beliefs
iii. Get them to practice “positive opposite” behaviors

d. What all three approaches have in common: encouraging the patient to identify maladaptive patterns of behavior, thought and reactivity to emotional experience; moving toward a more integrated and genuine way of relating to self and other.

6. Home practice: Bring in an example of using awareness of/attunement to self and other, or regulation of affect in self or other, during a clinical encounter.
7. Alan’s suggestions for practice: potential assignments include some skills practice of mindfulness, or an assignment for learners to purposefully reflect on and then discuss an easy or difficult experience of their internal emotional state/response during a clinical encounter with a supervisor or colleague.
8. Possible additional assignments:
    a. Before the next session, try practicing mindfulness of your internal emotional state while alone, with another person or in a group.
    b. Discuss an especially easy or an especially difficult patient encounter with a supervisor or a colleague, and what may have happened in your inner experience during it.

Additional Notes:

1. Asking questions that build the therapeutic alliance
    a. Clarify/explain this more–using questions to explore areas of meaning and relevance to the treatment goals
    b. Following up and staying on emotional nuances and turns

When a couple or family is in the room, the therapeutic alliance is more complex. Family members commonly arrive with differing beliefs about the problem itself, explanations for the problem, willingness to be in therapy at all, and different concerns regarding the age and gender of the therapist. (In heterosexual couples especially, the partner who is a different gender from the therapist will frequently feel outvoted.) The therapist must maintain multiple alliances and be an accurate observer of the system as well as the individuals.

The primary bonds and emotional reactions are developing and occurring among family members rather than in individual therapy, where the relationship is between the patient and the therapist. When we’re working with more than one individual, the emotional energy, intensity or focus will be directed among the other family members in the room. The therapist tries to help them connect better. The therapist is then tasked to build and maintain multiple alliances, rather than focusing on only one “transference” or relationship, which would be the focus of a therapeutic dyad. The therapist’s task is to act as a container, facilitator and sometimes educator for the family to come to a shared understanding of the issues and to facilitate communication and connection. The goal is to increase healthy attachment bonds and decrease conflict. For a deeper view of communication in groups, you may review the systems module.

Reference: Rait, D. S. (2000). The Therapeutic Alliance in Couples and Family Therapy. *Journal of Clinical Psychology*, 56(2), 211-224. https://doi.org/10.1002/(sici)1097-4679(200002)56:2

Appendix: Module 7 (Interpersonal Stance), Session 4: What If? Understanding Challenges and Ruptures in the Relationship as Opportunities

(*This appendix material can be reviewed to supplement the didactic material with additional exercises and information.)*

1. Discuss the importance of a patient's attachment and trauma history in understanding their style in a therapeutic relationship (see Systems and Trauma modules).
2. Discuss how to recognize dysregulated states, how to understand their possible trajectories, and how to use one's own emotional resources in the co-regulation of intense emotional experience.
3. Introduce and describe the general concept of the interpersonal style.
    a. Note that patients do not uniformly report or present their traumas, especially early on.
        i. Dissociation
    b. Importance of patient's attachment and trauma history in understanding their style in a therapeutic relationship.
        i. "Transference," "conditioning," habitual behaviors, childlike ways of solving problems or other "nondenominational" ways of describing how the presenting problem reflects an unspoken need (will relate to states of mind and formulation as well).
        ii. Observing, being curious about our own emotional reactions to the patient, without acting out our feelings.
            1. Observing personal boundaries
            2. Use of supervision: importance of being able to talk freely about one's reactions
            3. Importance of the interpersonal stance of the supervisor: the "therapist-supervisor match"
            4. Considering gender, cultural, class, racial and religious similarities and differences in patient-therapist and therapist-supervisor match
            5. What do we do when we can't validate the patient's interpretation but we want to validate the patient's emotional experience (e.g., when the patient perceives the therapist as attacking, and the therapist sees self as neutral in tone)?

Addressing and repairing ruptures:

1. Recognizing and attending to ruptures (nonverbal and verbal communications).
2. Acknowledging in the moment: "I just did/said something that was upsetting–help me understand."
3. Bringing up interaction from a previous session.
4. Exploring patient's reaction nonjudgmentally.
    a. Clarifying patient's wish/disappointment.
    b. Understanding whether this is part of a pattern experience in other relationships: opportunity for growth and insight into the patient's past experiences and development.
5. Attending to and noticing the therapist's own emotional reactions toward the patient during ruptures and discussing with supervisors or colleagues.
    a. Exploring therapist's role nondefensively.

b. Ruptures can occur on the side of the clinician toward the patient. How we decide to think and feel about this retrospectively can influence the therapeutic relationship.

CLINICAL VIGNETTES

MODULE 1–Introduction

Vignette #1

Common factors in the ED

Samantha, a 23-year-old woman, came to the emergency department in an emotional crisis, expressing that she could no longer bear her distress. She remained guarded, refusing to share details about what had triggered her crisis, though she described nightmares, hypervigilance and growing detachment from others over the past few months.

During her evaluation, Samantha repeatedly said, "I just can't do this anymore" when asked if something specific had occurred. Recognizing her reluctance, the psychiatrist focused on accepting Samantha's present emotions, aiming to build trust without pressuring her to disclose the trauma.

Samantha's symptoms–difficulty sleeping, flashbacks and isolation–suggested trauma, but the psychiatrist shifted the conversation to understanding her fear and helping her feel validated without probing for details. As Samantha described feeling constantly on edge and avoiding triggers she couldn't name, the psychiatrist used empathy and positive regard to explore these emotions while avoiding direct questions about the trauma.

While the trauma remained undisclosed, the psychiatrist reframed Samantha's helplessness by discussing how trauma impacts people and what steps and treatments could lead toward healing. This approach allowed Samantha to consider a path forward without feeling pressured to reveal what she wasn't ready to share. Through empathy, acceptance and positive regard, the psychiatrist built a safe environment for Samantha, helping her see the possibility of healing despite the unspoken trauma.

Questions

1. How do the common factors of *positive regard* and *acceptance* help in building a therapeutic alliance when a patient is unwilling to disclose the index trauma event? What techniques could the psychiatrist use to express *positive regard* and *acceptance*?
2. How is *offering hope* beneficial when working with patients in crisis? The presence of which factors make *offering hope* more effective?
3. What clinical and community resources could be helpful to this patient? How could you use your knowledge of common factors to help educate or reassure the patient about what to expect in future treatment settings?
4. How can you use the therapeutic alliance to assess safety issues such as current domestic violence, suicidal ideation, etc., in a patient who may be reluctant to reveal these issues?

MODULE 2–Neuroscience

Vignette #1

Inpatient

Steve, a 43-year-old man, is admitted to a quaternary care hospital for an exacerbation of lupus. The patient's outpatient endocrinologist expresses frustration and requests that the admitting physician consult psychiatry to help address the patient's long-standing poor medication adherence.

During the evaluation, the patient is irritable and unhappy to be seen by a psychiatrist. He complains that his wife has been nagging him excessively about his medications. Eventually, he acknowledges that he dislikes taking medication because he has difficulty having to "rely" on treatment. He shares that his lupus feels like a challenge to his sense of independence and freedom, a feeling that is very important for him to maintain.

He also reports that keeping up with impossible chronic work demands from his boss makes it difficult to focus on his health, and that he has noticed himself "freezing up" when his boss comes to his office with a certain look. Eventually, he admits that he has been taking longer to fall asleep because he has been "thinking a lot," and he is waking up earlier than he wants to.

Questions

1. How do the physiological changes caused by stress affect lupus?
2. How do attachment styles affect information processing in patients facing illness? Avoidantly attached persons tend to defensively suppress social emotions through top-down prefrontal deactivation, even when just asked to observe their feelings. (The neural substrates of social emotion perception and regulation are modulated by adult attachment style. https://doi.org/10.1080/17470919.2011.647410) Also, note the epigenetic suppression of the oxytocin receptor gene.
3. How could you use your understanding of the neurobiology of attachment to help the patient, family and physician understand why they are having difficulties with agreeing on a treatment plan?
4. How do you use your understanding of the neurobiology of threat processing to help calm the stress responses that the participants here are having? What deactivation strategies can you use?

Vignette #2

Outpatient Clinic
A 25-year-old female seeks treatment for social anxiety disorder. She reports that she is increasingly socially withdrawn out of fear of harsh judgments. Nonetheless, she feels lonely and wants this to change.

Questions

1. From a predictive processing framework, what is the maladaptive prediction? How does the patient's social withdrawal play a role in maintaining certainty in the prediction?
2. Prediction errors can prompt revision of predictions through extinction or memory reconsolidation. How can this idea guide psychotherapy?

MODULE 3–Attachment
Vignette #1

Psychopharm consultation for postpartum depression
As the psychiatrist assigned to the Women's Health Clinic, you are asked to review the medications for Ms. C, whose postpartum depression has not responded adequately to an SSRI. Now 12 months postpartum, Ms. C continues to report crying over small things, feeling panicky "out of the blue," and blaming herself for her own mother's exhaustion and poor health, as she had to move back home to get help with the baby. At a visit to her obstetrician, she reports feeling overwhelmed by financial stress and isolation. In addition, the obstetrician reports concern that the infant has delayed developmental milestones and appears difficult to soothe.

Questions

1. In addition to reviewing symptoms of depression and response to medication, what other questions do you want to ask this mother?
2. How might Ms. C's depression impact her infant's attachment relationship? How might that type of attachment be related to the concerns noted about the child's development?
3. What services might be of benefit to her?
4. What interventions and resources could be of benefit to the baby?

Reference: Lyons-Ruth, K., Connell, D. B., Crunebaum, H. U., & Botein, S. (1990). Infants at Social Risk: Maternal Depression and Family Support Services as Mediators of Infant Development and Security of Attachment. *Child Development*, 61, 85-98.

Vignette #2

Couples Therapy

Mr. Thomas and Ms. Miller have been married for 25 years. They have engaged in couples therapy for short periods of time, for help with stressful situations: during the lack of intimacy following the birth of their first child, the strain of caring for an elderly parent who moved into their home, and now, with conflict over how to raise their three teenagers.

They argue frequently about their very different approaches. Mr. Thomas, a successful corporate lawyer, prides himself on his self-reliance. He grew up with a father who worked long hours and was rarely home and a mother who was drinking, making her an unreliable caregiver. He feels that his children benefit from having the freedom to learn from their own mistakes during their teenage years: after all, they are getting much more help and guidance than he ever got. Ms. Miller grew up with a single mother who had recurrent depression. Her mother could be a warm and loving presence, but became emotionally distant and irritable when depressed. Ms. Miller struggles with anxiety, which she tries to manage by close monitoring and control of her children's behavior, in order to "keep them safe."

Mr. Thomas and Ms. Miller frequently blame each other for being "too controlling" or "too hands-off" with the children. Mr. Thomas has become more distant in response to his wife's anxiety-driven efforts to engage him, while Ms. Miller has become increasingly anxious about being abandoned.

Questions

1. As the therapist for this couple, how does your understanding of their childhood attachment experiences help you to make sense of their current conflict?
2. How might a better understanding of these different styles help the couple recognize their maladaptive responses and explore new ways of interacting?

MODULE 4–Systems Theory
Vignette #1

Inpatient Adolescent Unit

A 16-year-old girl, Emily, was admitted to the inpatient psychiatric unit following a suicide attempt. She overdosed on her mother's prescription medications to end her life. Emily had been battling depression for several months, compounded by school stress, social isolation and unresolved family conflicts. Her parents, overwhelmed by their daughter's actions, had not slept for days and were experiencing high levels of fear, confusion and helplessness.

During the first family meeting, Emily's parents presented as highly anxious and were not open to learning anything new due to their emotional exhaustion. They expressed feelings of guilt and shame, questioning how they could have missed the signs of their daughter's distress. Both parents vacillated between anger, frustration and despair. They asked for advice but were too overwhelmed to process any new information or suggestions. The therapist, Dr. Harris, began the session with a calm and nonjudgmental approach, focusing on reflective listening and providing validation for the parents' emotions. Dr. Harris explained that during times of crisis, it's essential to prioritize emotional support and stabilization rather than diving into problem-solving or diagnostic explanations. Instead of giving direct advice, the therapist modeled supportive techniques, such as active listening and asking the parents to focus on just being present with Emily, offering her emotional reassurance.

Key considerations:

Parental support: Dr. Harris supported the parents by helping them understand that their first step in supporting Emily was to reconnect with her emotionally rather than trying to fix her problems immediately. Validating the parents' fears and confusion helped de-escalate the situation.

Questions

1. What is the best way to support parents who are in a state of emotional exhaustion and fear when their child is in crisis?
2. How can a family genogram that focuses on patterns of depression, loss or addiction help you understand the biopsychosocial factors that led to Emily's suicide attempt?
3. What role might cultural or school-related pressures have played in Emily's sense of despair and isolation?

Community Setting

Mr. Wilson, a 78-year-old man with advanced dementia and several medical complications, has been residing in a continuing care retirement community (CCRC) that provides independent living, skilled nursing, and dementia unit or hospice care. He and his wife have been living together in independent living, and she is increasingly exhausted. His family is struggling to make decisions about his treatment plan, and they are unable to agree on who should take the lead in his care.

The family dynamics are strained. The sibling who lives locally has a clear understanding of Mr. Wilson's deteriorating condition and is advocating for the dementia unit or hospice care, while another sibling who lives out of state is in denial about the severity of their father's condition, believing that his health will improve. Their mother, overwhelmed and physically exhausted, feels powerless in the decision-making process and is uncertain of her rights to advocate for her husband's needs.

The disagreement among the siblings is rooted in long-standing family conflicts and differing perspectives about their father's care. The therapist working with the family, Dr. Lee, observes that their shared history of poor communication and unresolved issues is hindering their ability to work together. Dr. Lee engages the family in discussions about how their past interactions are influencing their present decision-making.

During therapy, Dr. Lee employs nonjudgmental listening techniques, creating a space where each family member feels heard without feeling criticized. This approach helps reduce the intensity of the arguments and opens a dialogue about the realities of Mr. Wilson's condition as well as each family member's feelings of grief, fear and responsibility.

As part of the larger care system, Dr. Lee ensures that the medical team, including doctors and nurses, regularly provides accurate and clear updates about Mr. Wilson's condition. This consistent communication helps clarify the prognosis for the family and offers support in transitioning from skilled nursing to hospice care.

Questions

1. How does the family's shared history of strained relationships prevent them from working together effectively now?
2. How does the healthcare system, including staff and structured communication, play a role in assisting the family to move between different levels of care?
3. How can nonjudgmental listening techniques help family members cope with their grief, fear and conflicting emotions as they navigate the difficult decisions around end-of-life care?

Professional Training

A psychiatry residency process group is made up of eight PGY3 residents and their faculty process group leader, Dr. Campbell. During one group session, the resident members talk about being upset about something going on in their residency program; they feel that their program director did not give them the needed information regarding upcoming changes in the call requirements for the coming year. During the session, they make disparaging comments about the program director, but they do not address her directly.

Questions

1. If you were the group leader, Dr. Campbell, how would you address the comments being made in the group about the program director?
2. How might the group think about the parallels between what might be happening in the group space and what might be happening outside in the larger residency space?

MODULE 5–Trauma

Vignette #1

VA PTSD Clinic

Private M served in the Army in the Vietnam War. He developed nightmares and flashbacks on his return to the States. He was unable to attend fireworks displays on the 4th of July. He was treated in a veterans group at the Outreach Center and later followed at the VA in a medication clinic. After his symptoms were managed adequately with an SSRI and gabapentin, he returned for his next psychopharm appointment, reporting his flashbacks and nightmares worsened when his son reached the same age as a Vietnamese boy he had witnessed killed in a village. He resumed drinking and was isolating himself.

Questions

1. What steps would you take?
2. Was his trauma repressed or dissociated?
3. Was his trauma encoded in memory at all?

Vignette #2

Legal System

Koa is a 17-year-old Native Hawaiian cisgender male who is being referred to juvenile justice services after failing multiple attempts at diversion. He has been homeless and out of school for the past year. While in school, Koa remembers several instances of racial discrimination from both peers and teachers. In one instance, a classmate physically attacked him while making racially derogatory remarks. When Koa fought back to defend himself, he was suspended from school. His family has faced years of transgenerational trauma, marked by colonization, cultural suppression and land dispossession. His father is incarcerated due to having his parole revoked, and his mother passed away three years ago from cardiovascular disease.

When you meet Koa, he is barely making any eye contact. He refuses to speak with you and has a defensive posture. He appears to be on edge and uncomfortable.

Questions

1. What are some of the factors contributing to Koa's current clinical presentation?
2. What are some steps you can take in providing trauma-informed and culturally compassionate care for Koa?
3. What kind of community and educational resources should you consider referring Koa to?

MODULE 6–Formulation

Vignette #1

Pediatric Consultation Service
A 4-year-old girl is brought to the pediatric emergency room by her mother "because she can't move her arm." She has bruises on her face and a hematoma on her forehead. Physical exam and CAT scan of the head showed no indication for neurosurgical intervention. Mother reports she was at work and her partner was caring for the child. When the mother came home, she found her daughter crying and in pain. The mother's partner said the girl had tripped going down the stairs, and he tried to catch her by grabbing her arm. Following sedation and closed reduction of the dislocated elbow, the child is resting comfortably in her hospital room. Protective services has been contacted and will determine whether the child can be sent home after discharge.

The consultation service has been asked to evaluate the child to make a recommendation on whether psychiatric treatment is indicated. When you arrive to talk with the child, she is lying in bed, holding a doll with her uninjured arm and watching cartoons with her mother sitting nearby. You find her to be surprisingly calm, given the distressing events of the day. When you ask her how she is feeling, she says "good" and smiles. You comment that she has had a difficult day, and she simply turns back to the TV. When it is clear that she is not going to talk about what happened, you ask the mother to step outside with you. The girl does not react to her mother leaving the room but continues watching TV.

Once you and the mother step into the hall, the mother bursts into tears and begs you not to take the child from her.

Questions

1. How would you describe the child's modulation of affect, and what does it suggest about her capacity for experiencing difficult emotions?
2. How would you describe the mother's modulation of affect and what it suggests about her style of dealing with difficult emotional experience?
3. If you had more time to interview this child over the course of her hospital stay, what techniques might you use to learn more about what is happening in her life and how she is managing the emotional stress of her home life, her hospitalization and the uncertainty of where she will go when she is discharged?
4. How do the recommended interventions for acute trauma (psychological first aid, see Trauma Module, session #3) inform the approach you will take in interviewing the child? In interviewing the mother?

Vignette #2

Outpatient Psychotherapy

For a time, Mrs. Sea felt confused about her identity as a single woman after the death of her husband, James. She had always depended on James for guidance and wondered if she could cope alone. This topic led her to an *agony of grief* state where her self-concepts made her feel lost, as if she were an empty woman. She complained of panic attacks for the first time in her life, brought on when she thought about dating a new man. While she desired intimacy in a new relationship, she imagined that her deceased husband and his relatives would criticize her for infidelity. If she lived alone without romantic relationships, Mrs. Sea could stabilize her *cool and poised* state but lose the opportunity to form an intimate partnership.

When discussing the possibility of a new relationship, her feelings would alternate between safe and dangerous. Her self-state would become dangerous when she schematized herself needing to be a faithful wife to James and not a wife who might be cheating. The panic attacks helped her avoid anticipated guilt and shame. The reappraisal of her attitudes during therapy could lead to new identity and relationship schemas that might help her feel autonomous and ready for a guilt-free new couples relationship.

Questions

1. Does the shift of focus to the present and near future help the patient revise her schemas of the past?
2. Discuss how this might lead to a modification of the patient's attitudes and new behavior.

MODULE 7–Interpersonal Skills

Outpatient Psychotherapy

Carlos, a 32-year-old Latino male, arrives for his scheduled follow-up appointment in the outpatient clinic. He has a history of bipolar I disorder, which has been in remission for the past 18 months. Carlos was first diagnosed in his early 20s, and after several episodes of mania and depression, he has found stability with a combination of medication and psychotherapy. He has adhered to his treatment plan, which includes mood stabilizers and regular therapy sessions.

As he enters the room, he greets the psychiatrist with a smile but quickly shifts into a more assertive posture, shoulders pinned back, arms crossed over his chest. He mentions feeling "OK" but adds that he's recently started feeling "annoyed" and worries about his potential to relapse. He explains that although he has not experienced any significant mood shifts, he's been noticing some irritability and an increase in his overall energy.

Carlos is employed as a marketing manager, a position he finds both rewarding and stressful at times. He attributes much of his recent restlessness to increased work demands. He also mentions that his relationship with his partner has become strained, with more frequent arguments about balancing work and personal time.

Throughout the session, the therapist adopts a calm and attuned interpersonal stance, demonstrating active listening and reflecting on Carlos' concerns with empathy. The therapist reassures Carlos that his experiences of irritability and restlessness are not uncommon, especially under duress, and explores the emotional and environmental triggers that might be contributing to these feelings. By mentalizing Carlos' internal experiences, the therapist helps him consider triggers for his restlessness, such as workplace stress or minor disruptions in his routine.

The therapeutic alliance remains strong as the psychiatrist and Carlos collaboratively review his goals for therapy, which include managing work stress more effectively and improving communication in his relationship. They also discuss adjusting his current medication or revisiting some coping strategies he's learned in therapy. Carlos expresses gratitude for the support and leaves the session feeling reassured and motivated to continue his self-care practices.

Questions

1. How did the therapist's interpersonal stance contribute to Carlos feeling reassured and supported during the session, and what specific techniques were used to strengthen the therapeutic alliance?
2. In the context of the vignette, how did the therapeutic relationship facilitate Carlos' exploration of his concerns about restlessness, and why is this collaborative process crucial for maintaining a strong affective bond between the therapist and patient?

Self-Assessment Test Questions

MODULE 1: INTRODUCTION TO INTEGRATIVE PSYCHOTHERAPY

Session 1: An Integrative Approach to the Therapeutic Encounter

Question 1: What is the primary focus of an integrative approach to psychotherapy?

A. Diagnosing specific mental disorders and providing targeted treatments for each disorder
B. Utilizing a single therapeutic technique or treatment element to address a particular mental health issue
C. Adopting a flexible orientation that draws from multiple theories and interventions to understand a person's unique psychological needs
D. Following a structured treatment plan based on a specific theoretical model

Correct answer:

C. Adopting a flexible orientation that draws from multiple theories and interventions to understand a person's unique psychological needs

Question 2: Which of the following characteristics is essential for therapeutic listening and responding?

A. Employing a confrontational approach to challenge the patient's beliefs and behaviors
B. Focusing on providing helpful advice and solutions to the patient's problems
C. Demonstrating empathy, emotional fluency and reflective capacity to understand the patient's internal states
D. Maintaining a professional distance to avoid getting emotionally involved in the therapeutic process

Correct answer:

C. Demonstrating empathy, emotional fluency and reflective capacity to understand the patient's internal states

Question 3: What aspect of therapist-patient communication has been shown to be most important in promoting change in psychotherapy?

A. Strict adherence to a single theoretical approach to address the patient's issues
B. Encouragement that patients avoid exploring difficult emotions or memories during therapy
C. Establishment of a strong therapeutic alliance and shared goals between the patient and therapist

D. A primary focus on a person's cultural and family system factors

Correct answer:

C. Establishment of a strong therapeutic alliance and shared goals between the patient and therapist

Question 4: Which competency is most important in psychotherapy, regardless of treatment setting and theoretical orientation?

A. Matching the right theoretical psychotherapy orientation to the specific mental disorder
B. Maintaining a professional demeanor and avoiding emotional involvement with patients
C. Recognizing maladaptive patterns in patients without bringing awareness to them
D. Demonstrating empathy, warmth and the capacity to establish and manage an alliance with the patient
E. Giving good advice about what a patient should do in a particular situation

Correct answer:

D. Demonstrating empathy, warmth and the capacity to establish and manage an alliance with the patient

Session 2: Practice Through Clinical Case Illustrations and Discussion

Question 1: Which of the following illustrates a way in which a psychotherapeutic encounter can lead to change?

A. Avoiding emotional connection to maintain a professional boundary with the patient
B. Focusing solely on the patient's childhood experiences to understand their current challenges
C. Providing immediate solutions and advice to the patient's problems
D. Allowing the patient to feel understood and validated in their emotional state

Correct answer:

D. Allowing the patient to feel understood and validated in their emotional state

Question 2: What role does emotional connection play in therapeutic change?

A. Emotional connection is unnecessary and may hinder the therapeutic process
B. Emotional connection helps the therapist maintain objectivity and avoid personal involvement
C. Building emotional connection supports the patient's ability to explore and tolerate feelings
D. Emotional connection can lead to dependency and should be avoided in therapy

Correct answer:

C. Building emotional connection supports the patient's ability to explore and tolerate feelings

Question 3: In psychotherapeutic encounters, how can self-reflection contribute to the process of change?

A. By using introspection to focus on external factors influencing the patient's challenges
B. By encouraging the patient to maintain a self-sufficient stance and avoid vulnerability in therapy
C. By helping the patient recognize patterns of cause and effect in their internal experiences and interpersonal interactions
D. By providing immediate solutions and advice for the patient's problems to avoid discomfort during self-reflection

Correct answer:

C. By helping the patient recognize patterns of cause and effect in their internal experiences and interpersonal interactions

Question 4: How should clinicians respond to patients who express vulnerability and the need for others?

A. By reinforcing the importance of maintaining emotional distance from others and minimizing personal involvement
B. By avoiding exploration of patients' painful emotional experiences, to prevent discomfort
C. By providing empathy and emotional connection, thus allowing patients to explore and tolerate their feelings
D. By focusing on diagnosing specific mental disorders to guide targeted treatments

Correct answer:

C. By providing empathy and emotional connection, thus allowing patients to explore and tolerate their feelings

MODULE 2: NEUROSCIENCE

Session 1: Models of Mind in Brain–Evolutionary Psychology

Question 1: What is the primary objective of evolutionary forces concerning human behavior?

A. Promoting happiness and well-being in individuals
B. Ensuring the passing on of genes to the next generation
C. Fostering long-term social relationships and connections
D. Facilitating the pursuit of individual success and achievement

Correct answer:

B. Ensuring the passing on of genes to the next generation

Question 2: How does evolutionary psychology view psychopathology?

A. It considers psychopathology as a result of poor adaptation to modern society
B. Psychopathology is seen as an outcome of happiness being prioritized over reproductive fitness
C. Evolutionary forces promote happiness as a means to overcome psychopathological conditions
D. Psychopathology is regarded as an evolutionary adaptation to specific challenges

Correct answer:

D. Psychopathology is regarded as an evolutionary adaptation to specific challenges

Question 3: According to "life history theory," under which circumstances can impulsive behavior be considered adaptive from an evolutionary standpoint?

A. When it leads to long-term social status improvement
B. In cases where lifespan is significantly prolonged
C. Impulsive behavior is always maladaptive and contrary to reproductive fitness
D. When lifespan is anticipated as being limited and social status is low, favoring a "live fast/die young" strategy

Correct answer:

D. When lifespan is anticipated as being limited and social status is low, favoring a "live fast/die young" strategy

Question 4: Which of the following hypotheses is emphasized by evolutionary psychology about depression as an "involuntary subordinate strategy"?

A. Low serotonin levels lead to depression
B. Depression may be an adaptation that communicates social defeat
C. The dorsolateral prefrontal cortex is hypoactive in depression
D. Depression is caused by inflammation

Correct answer:

B. Depression may be an adaptation that communicates social defeat

Question 5: Evolutionary psychology hypotheses emphasize that psychopathology may reflect mainly …

A. Brain disease
B. A failure of the ego
C. Neurotransmitter dysfunction
D. An adaptation to adversity that promotes reproductive fitness

Correct answer:

D. An adaptation to adversity that promotes reproductive fitness

Session 2: Models of the Mind in Brain–Extinction and Memory Reconsolidation

Question 1: Change in psychotherapy is believed to reflect modification in memory and connectivity within neural networks. Which of the following processes are considered most important in mediating the change?

A. Axonal sprouting
B. Memory reconsolidation and/or extinction
C. Changes in myelination
D. Increased inflammation

Correct answer:

B. Memory reconsolidation and extinction

Question 2: The engram as defined in key reference 4 (Guskjolen & Cembrowski, 2023) is…

A. A neural network with fixed synaptic connections
B. The neural substrate that encodes memories
C. The neural substrate of consciousness
D. None of the above

Correct answer:

B. The neural substrate that encodes memories

Question 3: Memory can be destabilized

A. During its storage
B. When the memory is activated during retrieval
C. Only when serotonergic medications are present
D. Only during ECT or when anti-NMDA medications (such as ketamine) are present

Correct answer:

B. When the memory is activated during retrieval

Question 4: Which is **false** about extinction and memory reconsolidation in trauma treatment?

A. Extinction and memory reconsolidation are the main mechanisms mediating psychotherapeutic change
B. Extinction has been proposed to involve a memory that competes with the trauma memory
C. Memory reconsolidation has been proposed to involve rewriting the trauma memory, at least

for a different context

D. Extinction and memory reconsolidation have been shown to be the same neurobiological process

Correct answer:

D. Extinction and memory reconsolidation have been shown to be the same neurobiological process

Session 3: Models of the Mind in Brain–Predictive Processing and Schema

Question 1: Predictive processing theory in the context of psychotherapy primarily involves:

A. The bidirectional relationship between expectations and actual experiences
B. Identifying biomarkers for implicit self-schema in experimental conditions
C. Exploring how neurotransmitters bias our perceptions
D. Measuring self-serving bias in individuals with agentic self-schema

Correct answer:

A. The bidirectional relationship between expectations and actual experiences

Question 2: Which of the following self-schemas is associated with emotions and visceral experiences in the here and now?

A. Narrative self
B. Agentic self
C. Experiential self
D. Interoceptive self

Correct answer:

D. Interoceptive self

Question 3: According to predictive processing theory, depression is caused by (choose the best answer):

A. Excessive influence of actual experiences
B. Excessive influence of dysfunctional predictions
C. Aggression turned inward
D. Low serotonin synthesis

Correct answer:

B. Excessive influence of dysfunctional predictions

Question 4: Schemas are believed to be mediated by which of the following neural substrates?

A. Distributed neural network connecting multiple brain areas
B. Prefrontal cortex alone

C. Amygdala alone
D. Periaqueductal gray alone

Correct answer:

A. Distributed neural network connecting multiple brain areas

Session 4: Models of the Mind in Brain–Complexity Theory

Question 1: Complexity theory, as applied to the mind and brain, involves which of the following features?

A. Linear dynamics and fixed attractor states
B. Self-isolation and absence of feedback loops
C. Emergent properties and multiple meta-stable states
D. Hierarchical organization without top-down effects

Correct answer:

C. Emergent properties and multiple meta-stable states

Question 2: In the context of the brain as a complex adaptive system, what is the role of attractor states?

A. Attractor states represent fixed and unchangeable neural configurations
B. A healthy brain remains fixed in a single attractor state, representing a stable cognitive state
C. Attractor states are important for psychological functions such as memory, attention and decision-making
D. The brain does not have any attractor states; it operates in a continuous flux

Correct answer:

C. Attractor states are important for psychological functions such as memory, attention and decision-making

Question 3: According to the outline, which concept is associated with the idea that small changes in conditions can lead to disproportionate changes in the system over time?

A. Linear dynamics
B. Negative feedback loops
C. Top-down effects
D. Nonlinear dynamics

Correct answer:

D. Nonlinear dynamics

Question 4: Interpersonal neurobiology emphasizes that the brain operates within larger systems, such as family, society and culture. What does “isomorphism” refer to in this context?

A. The rigidity of interpersonal systems
B. The replication of attractor states within psyches and societies
C. The absence of feedback loops in interpersonal interactions
D. The independence of brain functions from social contexts

Correct answer:

B. The replication of attractor states within psyches and societies

Session 5: Creating a Connection/Bonding

Question 1: Which neurotransmitter/neuropeptide is specifically associated with attachment and bonding behaviors?

A. Dopamine
B. Oxytocin
C. Serotonin
D. Epinephrine

Correct answer:

B. Oxytocin

Question 2: Avoidant attachment has been associated with:

A. Epigenetic changes of the promoter area, decreasing transcription of the oxytocin gene
B. Excessive insula activity during social rejection
C. High striatal activity reflecting reward when observing one's infant
D. None of the above

Correct answer:

B. Excessive insula activity during social rejection

Question 3: The role of neurotransmitters and neuropeptides in play behavior is primarily associated with:

A. Increased levels of oxytocin and epinephrine during social interactions
B. Decreased dopamine levels during playful activities
C. Enhanced learning and social bonding experiences
D. Suppression of nurturing and caregiving tendencies

Correct answer:

C. Enhanced learning and social bonding experiences

Question 4: How might understanding the role of neurotransmitters and neuropeptides in social behavior impact the doctor-patient relationship?

A. It has no significant implications for the doctor-patient relationship

B. Understanding these mechanisms can lead to better treatment adherence in patients
C. Physicians can prescribe medications to manipulate neurotransmitter levels in patients
D. Knowledge of these neurochemical processes can enhance empathy and rapport-building with patients

Correct answer:

D. Knowledge of these neurochemical processes can enhance empathy and rapport-building with patients

Session 6: Establishing Safety and Regulation/Approaches to Underregulated States

Question 1: Which system in the body is responsible for the neurotoxic effects of chronic stress?

A. Autonomic nervous system
B. HPA axis (cortisol)
C. Inflammation
D. Sympathetic surge

Correct answer:

C. Inflammation

Question 2: What is the primary purpose of affect labeling in responding to an acute stress state?

A. To heighten prediction error through attentional shift
B. To reduce amygdalar activation and regulate emotions
C. To dampen sympathetic arousal through opioid release
D. To create new healing experiences through nonverbal communication

Correct answer:

B. To reduce amygdalar activation and regulate emotions

Question 3: Which technique emphasizes safety in responding to an acute stress state and involves both cognitive and affective components?

A. Cognitive reappraisal to heighten prediction error through attentional shift
B. Use of nonverbals and empathy to create new healing experiences
C. Affect labeling to reduce amygdalar activation
D. Opioid release from attachment to dampen sympathetic arousal

Correct answer:

A. Cognitive reappraisal to heighten prediction error through attentional shift

Question 4: How can empathy and nonverbal communication be utilized in responding to underregulated states during psychotherapy?

A. By releasing opioids to enhance sympathetic arousal
B. By emphasizing cognitive reappraisal and prediction error

C. By enhancing safety and creating new healing experiences
D. By reducing amygdalar activation through affect labeling

Correct answer:

C. By enhancing safety and creating new healing experiences

Session 7: Working at Therapeutic Change/Neuroplasticity

Question 1: From the perspective of neuroplasticity, what are the two main processes of change that play a significant role in therapy?

A. Top-down brain circuits and bottom-up circuits
B. Fear extinction and memory reconsolidation
C. Contextual cues and sense of agency
D. Predictive processing and interoception

Correct answer:

B. Fear extinction and memory reconsolidation

Question 2: Which neurobiological process is associated with amplifying prediction error in the brain?

A. Predictive processing
B. Top-down brain circuits
C. Memory reconsolidation
D. Bottom-up circuits

Correct answer:

A. Predictive processing

Question 3: How does fear extinction differ from memory reconsolidation in the context of neuroplasticity?

A. Fear extinction involves amplifying prediction error, while memory reconsolidation focuses on top-down brain circuits
B. Fear extinction is about erasing fear memory completely, while memory reconsolidation modifies existing memories
C. Fear extinction is a bottom-up process, whereas memory reconsolidation is a top-down process
D. Fear extinction relates to contextual cues, while memory reconsolidation is associated with interoception

Correct answer:

B. Fear extinction is about erasing fear memory completely, while memory reconsolidation modifies existing memories

Question 4: How do effective therapy models utilize the neurobiological processes of fear extinction and memory reconsolidation?

A. All therapy models primarily rely on memory reconsolidation for change
B. Therapy models like CBT focus on fear extinction, while psychodynamic approaches emphasize memory reconsolidation
C. Mindfulness-based therapies utilize top-down brain circuits for change, while family therapy focuses on bottom-up circuits
D. Effective therapy models utilize combinations of fear extinction and memory reconsolidation processes

Correct answer:

D. Effective therapy models utilize combinations of fear extinction and memory reconsolidation processes

Session 8: Healing

Question 1: Which of the following is NOT considered one of the speculated clinical correlates of therapeutic change?

A. Improved self-regulation
B. Less alexithymia (emotional fluency)
C. Increased phobic and traumatizing memories
D. More self-compassion

Correct answer:

C. Increased phobic and traumatizing memories

Question 2: How does affect tolerance relate to predictive processing and extinction/memory reconsolidation in the context of therapeutic change?

A. Affect tolerance leads to decreased emotional fluency and less self-compassion
B. Predictive processing and extinction/memory reconsolidation contribute to increased affect tolerance
C. Affect tolerance is unrelated to the therapeutic change process
D. Increased affect tolerance hinders the process of integration instead of fragmentation

Correct answer:

B. Predictive processing and extinction/memory reconsolidation contribute to increased affect tolerance

Question 3: Which of the following is NOT a clinical correlate of therapeutic change related to revised narratives/schemas (DMN)?

A. Less perfectionism and shame
B. Improved self-regulation
C. Expanded and nuanced narratives
D. Increased phobic and traumatizing memories

Correct answer:

D. Increased phobic and traumatizing memories

Question 4: How do the speculated clinical correlates of therapeutic change contribute to improvements in relationships and problem-solving?

A. By decreasing interoceptive awareness and tolerance
B. Through increased fragmentation and less integration
C. By promoting self-compassion and emotional fluency
D. By reducing metacognition and attribution of agency

Correct answer:

C. By promoting self-compassion and emotional fluency

MODULE 3: ATTACHMENT

Session 1: Our Earliest Relationships

Question 1: Which of the following best defines an attachment relationship?

A. A friendship between peers at school
B. A close relationship with a pet
C. A bond with caregivers who provide regular care
D. A connection with a favorite toy or possession

Correct answer:

C. A bond with caregivers who provide regular care

Question 2: According to Mary Ainsworth's "Strange Situation" observations, how did children with secure attachment respond when their caregiver left and returned?

A. They showed no distress when the caregiver left and ignored the caregiver upon return
B. They explored the playroom freely before the caregiver left, showed distress at separation and were comforted upon the caregiver's return
C. They cried excessively in the caregiver's presence and refused to play with toys
D. They displayed contradictory behaviors such as strong attachment followed by avoidance or freezing

Correct answer:

B. They explored the playroom freely before the caregiver left, showed distress at separation and were comforted upon the caregiver's return.

Question 3: What characteristics are associated with caregivers who have a secure attachment relationship with their children?

A. Inconsistent and unattuned to the child's needs
B. Avoidant of physical and emotional closeness with the child
C. Being attentive, attuned and responsive to the child's needs
D. Telling the child they don't have to feel so upset when they are crying

Correct answer:

C. Being attentive, attuned and responsive to the child's needs

Question 4: Attachment theory has evolved in response to various factors, including:

A. The influence of video games and media on child development
B. Research in developmental neuroscience
C. The popularity of online social networking among children
D. The rise of single-parent families

Correct answer:

B. Research in developmental neuroscience

Session 2: Failures in Attachment and Opportunities for Repair

Question 1: What is the internal working model proposed by Bowlby in the context of attachment?

A. A model for understanding the internal conflicts of children with traumatic experiences
B. The neurobiological basis for understanding social communication
C. A framework for assessing a child's cognitive, social-emotional and physical development
D. A mental representation formed through a child's experience of their relationship with a caregiver

Correct answer:

D. A mental representation formed through a child's experience of their relationship with a caregiver

Question 2: Which of the following is NOT a known potential consequence of adverse childhood experiences (ACEs)?

A. Increased risk of heart disease and diabetes later in life
B. Higher likelihood of substance abuse and depression in adulthood
C. Improved academic achievement and better job prospects
D. Greater chances of obesity and early death

Correct answer:

C. Improved academic achievement and better job prospects

Question 3: What does "ghosts in the nursery" primarily focus on in relation to infants and parents?

A. How infants thrive when parents provide sensitive trauma-informed therapy
B. Clinical examples of infants' responses to post-traumatic stress, depression and neglect in parents
C. The intergenerational impact of war, famine and racism on infants' development
D. The role of benevolent childhood experiences in protecting infants from trauma

Correct answer:

B. Clinical examples of infants' responses to post-traumatic stress, depression and neglect in parents

Question 4: According to the information provided, how can positive attachment experiences be protective in the face of overwhelming trauma?

A. By encouraging the re-emergence of feelings associated with traumatic experiences
B. By enhancing self-regulation and promoting healthy subsequent relationships
C. By eradicating the impact of early trauma on brain structure and function
D. By identifying specific personality styles associated with different attachment types

Correct answer:

B. By enhancing self-regulation and promoting healthy subsequent relationships

Session 3: Attachment Over the Lifespan

Question 1: According to attachment theory, securely attached infants develop an expectation that other close relationships will offer responsiveness. This facilitates the ability to use flexible emotion regulation strategies, which include:

A. Overregulation of emotions in adult relationships
B. Suppressing emotional reactions in challenging situations
C. Heightening emotional expression to elicit care from others
D. Signaling distress with the expectation of being understood and calming easily when soothed

Correct answer:

D. Signaling distress with the expectation of being understood and calming easily when soothed

Question 2: In the context of attachment theory, what characterizes the preoccupied (anxiously and insecurely attached) individuals described in the Adult Attachment Interview (AAI)?

A. Individuals with this attachment style seem overly focused on attachment relationships and may display ongoing anger or fear of abandonment, extending to current interactions
B. They can reflect on their early relational experiences without becoming overwhelmed, integrating positive and negative feelings
C. Individuals in this category may experience extreme difficulty discussing traumatic events involving loss or abuse
D. Individuals with this attachment style minimize the importance of relationships and emphasize self-reliance in their narratives

Correct answer:

A. Individuals with this attachment style seem overly focused on attachment relationships and may display ongoing anger or fear of abandonment, extending to current interactions

Question 3: Which of the following statements is true about avoidant individuals described in the AAI?

A. They have long, detailed but often incoherent narratives with a preoccupation with attachment relationships
B. They can reflect on their early relational experiences without becoming overwhelmed, integrating positive and negative feelings
C. They minimize the importance of relationships and emphasize self-reliance in their narratives
D. They have extreme difficulty discussing traumatic events involving loss or abuse

Correct answer:

C. They minimize the importance of relationships and emphasize self-reliance in their narratives

Question 4: What is the primary goal of mentalization or reflective functioning in early secure attachment relationships?

A. Developing a preoccupation with attachment relationships to facilitate avoidance of anger or fear
B. Imagining what others may be thinking or feeling to negotiate social interactions
C. Integrating positive and negative feelings in narratives of early relational experiences
D. Encouraging parents to seek supportive therapy relationships for their children

Correct answer:

B. Imagining what others may be thinking or feeling to negotiate social interactions

Session 4: Attachment in the Psychotherapy Relationship

Question 1: Which attachment style is often associated with patients who may come for treatment only when their parents insist or to appease a distressed partner, and may exhibit overtly distancing behaviors during therapy?

A. Anxiously attached
B. Borderline personality disorder
C. Avoidant
D. Dismissive

Correct answer:

C. Avoidant

Question 2: Patients with an avoidant attachment style may exhibit avoidant behaviors in psychotherapy, which can include:

A. Forming a strong connection and an idealizing relationship with the therapist
B. Reacting intensely to perceived disappointments and threats of abandonment
C. Missing sessions and refusing to make further appointments
D. Being openly expressive about their feelings and vulnerabilities

Correct answer:

C. Missing sessions and refusing to make further appointments

Question 3: What is a helpful therapeutic intervention when patients react with anxious or avoidant responses to the therapy relationship?

A. To encourage patients to rely more on their own coping skills
B. To bring the pattern of response to awareness and foster self-reflection
C. To encourage patients to idealize their therapists for constant reassurance
D. To keep encouraging exploration of resistance despite their reluctance

Correct answer:

B. To bring the pattern of response to awareness and foster self-reflection

Question 4: Which of the following is the most appropriate action for the therapist when a patient appears withdrawn in a session after feeling disappointed with the psychotherapy?

A. To ignore the patient's behavior and continue with the planned session
B. To assume the patient's feelings and interpret them accordingly
C. To nondefensively bring up the situation and encourage the patient to explore any feelings and reactions
D. To avoid discussing the patient's feelings to prevent emotional discomfort

Correct answer:

C. To nondefensively bring up the situation and encourage the patient to explore any feelings and reactions

MODULE 4: SYSTEMS THEORY

Session 1: Understanding Family Systems

Question 1: How do the nested subsystems of culture, community, family, self and neurobiology interact within a family system?

A. They operate independently, without any significant interaction or influence on each other
B. The family system is not affected by influences like culture, community or neurobiology
C. The family system interacts with and is influenced by the subsystems of culture, community and neurobiology
D. The family system is solely influenced by the self, and other subsystems have minimal impact

Correct answer:

C. The family system interacts with and is influenced by the subsystems of culture, community and neurobiology.

Question 2: What is the purpose of using a genogram in understanding family systems?

A. To analyze the individual's personality traits and characteristics
B. To identify the primary causes of dysfunction within a family
C. To map out and visualize the relationships and interactions within a family system
D. To assess the effectiveness of therapeutic interventions for the family

Correct answer:

C. To map out and visualize the relationships and interactions within a family system

Question 3: What is the main benefit of using a sand tray or physical objects to construct a genogram for children?

A. It provides a creative outlet for children to distract themselves from their negative emotions
B. It simplifies the genogram process and makes it more engaging for children
C. It helps identify external influences on the child's personal life
D. It eliminates the need for involving the family in the discussion of the genogram

Correct answer:

B. It simplifies the genogram process and makes it more engaging for children

Question 4: How do changes in one part of a family system affect other parts?

A. Changes in one part of the system have no impact on other parts
B. Changes in one part of the system always lead to positive outcomes in other parts
C. Changes in one part of the system influence the system in unpredictable ways
D. Family systems are resistant to changes and ALWAYS maintain a stable structure over time

Correct answer:

C. Changes in one part of the system influence the system in unpredictable ways

Session 2: Characteristics of Family Systems

Question 1: What characteristic distinguishes family systems from other systems?

A. Attachment bonds
B. Feedback loops
C. Boundaries
D. Hierarchy

Correct answer:

A. Attachment bonds

Question 2: What does the concept of "feedback loops" refer to in the context of family systems?

A. The exchange of power and control within the family
B. The level of emotional intimacy and closeness between family members
C. The process of information exchange and communication between members that produces system patterns and dynamics
D. The rigid boundaries that define the roles of family members

Correct answer:

C. The process of information exchange and communication between members that produces system patterns and dynamics

Question 3: Which of these examples illustrates permeable boundaries in a system?

A. Nonfamily members knock before entering the home
B. Parents do not share information about their sexual activities with their children
C. Family members tell no one, including the doctor, about the alcoholism of a family member
D. Parents and children routinely bring home people of other cultures for dinner to introduce new ideas and experiences

Correct answer:

D. Parents and children bring home people of other cultures for dinner to introduce new ideas and experiences

Question 4: How do attachment styles influence family dynamics?

A. In secure attachment, family members feel safe managing stress, distance and conflict, believing they will not lose the relationship
B. In insecure attachment, family members are able to live completely independently of others
C. In secure attachment, family members do not get into conflict with each other
D. Avoidantly attached family members express excessive dependency needs with family members

Correct answer:

A. In secure attachment, family members feel safe managing stress, distance and conflict, believing they will not lose the relationship

Session 3: Family Consultation

Question 1: What is the primary goal of the first family consultation in a psychiatric setting?

A. To diagnose and treat the family members individually
B. To provide intensive family interventions
C. To always decrease the family's responses to intense emotions
D. To understand the family context for the patient and family, and to consider whether further family intervention would be helpful

Correct answer:

D. To understand the family context for the patient and family, and to consider whether further family intervention would be helpful

Question 2: In the context of family consultations, what is the purpose of introducing an agenda and controlled discussion?

A. To limit the number of participants in the meeting
B. To ensure that the family members share only positive experiences
C. To provide structure and focus for the meeting
D. To prevent intense family reactions during the session

Correct answer:

C. To provide structure and focus for the meeting

Question 3: What does "multidirectional partiality" refer to in the context of family consultations?

A. The therapist's ability to be impartial and detached from the family's issues
B. The therapist's capability to be biased toward one family member's perspective
C. The therapist's skill in managing intense family reactions during the session
D. The therapist's capacity to accept and understand multiple family realities without taking sides

Correct answer:

D. The therapist's capacity to accept and understand multiple family realities without taking sides

Question 4: How does family psychoeducation differ from basic family consultation?

A. Family psychoeducation involves diagnosing and treating severe mental illnesses, while basic family consultation is for less severe cases.
B. Family psychoeducation is a one-session meeting, while basic family consultation involves multiple sessions.
C. Family psychoeducation provides information about the illness, support and information for family members and the patient, and communication/behavioral techniques for stress reduction. Basic family consultation focuses on understanding family patterns and providing further direction or, if appropriate, resources.
D. Family psychoeducation does not involve the patient, while basic family consultation includes the patient in the meeting.

Correct answer:

C. Family psychoeducation provides information about the illness, support and information for family members, and communication/behavioral techniques for stress reduction. Basic family consultation focuses on understanding family patterns and providing further direction or, if appropriate, resources.

Session 4: Basics of Working With Couples

Question 1: How does the broader cultural context affect the functioning of couples?

A. It has no significant impact on couples' functioning
B. The broader cultural context is the major source of problems in couple dynamics
C. Cultural norms and values can influence communication and relationship patterns in couples
D. Couples are not affected by cultural factors; their issues are solely internal

Correct answer:

C. Cultural norms and values can influence communication and relationship patterns in couples.

Question 2: Which of the following is NOT a common issue in couple communication and dysfunction?

A. Lack of emotional intimacy
B. Communication styles and patterns of conflict resolution
C. Sexual functioning and intimacy
D. Very different levels of maturity in long-married couples

Correct answer:

D. Very different levels of maturity in long-married couples

Question 3: Which therapeutic approaches are mentioned as good models to start with when working with couples?

A. Cognitive behavioral therapy and mindfulness-based therapy
B. Imago therapy and emotionally focused therapy
C. Psychodynamic therapy and humanistic therapy
D. Dialectical behavior therapy and solution-focused brief therapy

Correct answer:

B. Imago therapy and emotionally focused therapy

Question 4: What is an essential aspect of understanding sexuality in committed couples?

A. Recognizing that all couples experience the same sexual issues and concerns
B. Identifying that sexual issues in couples are always a result of psychological dysfunction
C. Acknowledging that sexual functioning can vary widely among couples and is influenced by individual, couple and cultural factors
D. Assuming that sexual issues in couples can mainly be addressed through medical interventions

Correct answer:

C. Acknowledging that sexual functioning can vary widely among couples and is influenced by individual, couple and cultural factors.

Session 5: Basics of Group Psychotherapy and Organizational/Cultural Groups

Question 1: Which of the following therapeutic factors is associated with learning through observing and imitating others in a group setting?

A. Secure emotional expression
B. Instillation of hope
C. Social learning
D. Awareness of relational impact

Correct answer:

C. Social learning

Question 2: What are the main stages of group formation according to Tuckman's model?

A. Forming, Storming, Performing, Termination
B. Introduction, Development, Maturity, Termination
C. Forming, Storming, Norming, Performing
D. Initiation, Transition, Transformation, Termination

Correct answer:

C. Forming, Storming, Norming, Performing

Question 3: What is the primary purpose of a group contract in group treatment?

A. To establish strict hierarchical authority within the group
B. To provide clear boundaries and contribute to psychological safety
C. To ensure that group members perform their assigned tasks
D. To instill hope and motivate group members to achieve their goals

Correct answer:

B. To provide clear boundaries and contribute to psychological safety

Question 4: How does the systems view of groups explain the interplay between person, role, group and context?

A. It suggests that individuals play different roles based on the context and group dynamics
B. It emphasizes that the individual's personality traits determine their role in the group

C. It focuses on the authority hierarchy within the group and its impact on individuals
D. It states that the group's context has no significant influence on individual behavior

Correct answer:

A. It suggests that individuals play different roles based on the context and group dynamics

MODULE 5: TRAUMA

Session 1: What Is Trauma?

Question 1: What are the different types of trauma that individuals can experience?

A. Physical injury only
B. Psychological injury only
C. Both physical and/or psychological injury
D. None of the above

Correct answer:

C. Both physical and/or psychological injury

Question 2: Which of the following statements about trauma is true?

A. Trauma formation theories suggest that trauma enhances coping strategies
B. Trauma primarily affects individuals during their developmental years
C. Trauma is necessary for personal growth and resilience
D. Trauma overwhelms a person's coping strategies

Correct answer:

D. Trauma overwhelms a person's coping strategies

Question 3: Which of the following is a common presentation of trauma in individuals?

A. Development of new positive coping mechanisms
B. Increased social interactions and support-seeking behavior
C. Reliving traumatic experiences
D. Heightened emotional stability and cognitive clarity

Correct answer:

C. Reliving traumatic experiences

Question 4: What is the relationship between trauma and personality disorders?

A. Trauma has no impact on the development of personality disorders
B. Trauma can lead to personality disorders or traits, but this link is not well established

C. Trauma is the major cause of personality disorders
D. Most personality-disordered individuals have a history of trauma

Correct answer:

B. Trauma can lead to personality disorders or traits, but this link is not well established

Session 2: Social/Cultural Trauma

Question 1: Which of the following statements about historical trauma is true?

A. Historical trauma is solely a result of historical acts of genocide
B. Trauma as a "soul wound" refers to physical injuries caused by historical violence
C. Epigenetic studies have not found any transgenerational trauma markers in the descendants of survivors
D. Historical trauma can result from ongoing forms of structural violence as well

Correct answer:

D. Historical trauma can result from ongoing forms of structural violence as well

Question 2: What are the four elements of each trauma story in the context of refugee trauma?

A. Factual accounting of the events, cultural diversity, judgment, storytelling technique
B. Factual accounting of the events, cultural meaning of trauma, revelations, storyteller-listener relationship
C. History of trauma, individual coping strategies, emotional intensity, cognitive distortions
D. Factual accounting of the events, microaggressions, body-mind connection, social support

Correct answer:

B. Factual accounting of the events, cultural meaning of trauma, revelations, storyteller-listener relationship

Question 3: Which of the following is an essential consideration when working with trauma in LGBTQ+ communities?

A. Ignoring gender identity and using heteronormative pronouns
B. Promoting health disparities and institutional discrimination
C. Avoiding the use of chosen names to maintain anonymity
D. Creating a safe space and using gender-affirming pronouns and chosen names

Correct answer:

D. Creating a safe space and using gender-affirming pronouns and chosen names

Question 4: What is the purpose of the Cultural Formulation Information Interview (CFI) in the DSM-5?

A. To gather information about the prevalence of trauma in specific cultural communities
B. To assess the cultural competence of the psychiatrist in handling trauma cases
C. To understand the impact of cultural factors on an individual's experience of trauma
D. To identify epigenetic markers related to transgenerational trauma

Correct answer:

C. To understand the impact of cultural factors on an individual's experience of trauma

Session 3: Psychotherapy of Trauma Part One: Principles of Treating Traumatized Individuals

Question 1: According to Janet's psychotherapeutic approach, which stage involves stabilization, symptom-oriented treatment and preparation for addressing traumatic memories?

A. Stage 1
B. Stage 2
C. Stage 3
D. None of the above

Correct answer:

A. Stage 1

Question 2: What is a prerequisite for the treatment of trauma, ensuring that treatment does not lead to re-traumatization?

A. Rapid exposure to traumatic memories
B. Building self-regulation and self-compassion
C. Ignoring the patient's preferences in treatment decisions
D. Focusing solely on the patient's traumatic experiences

Correct answer:

B. Building self-regulation and self-compassion

Question 3: What aspect of the patient should inform the treatment of trauma?

A. The patient's socioeconomic status
B. The patient's preference for specific treatments
C. The patient's traumatic experiences only
D. The "person behind the story of trauma"

Correct answer:

D. The "person behind the story of trauma"

Question 4: Which of the following is an important feature of trauma-focused treatment, focusing on new ways of interacting with others?

A. Enhancing emotional dysregulation
B. Decreasing focus on interpersonal functioning
C. Learning to set boundaries in relationships
D. Encouraging isolation and withdrawal from social activities

Correct answer:

C. Learning to set boundaries in relationships

Session 4: Psychotherapy of Trauma Part Two: Specific Approaches and Special Considerations

Question 1: Which of the following therapy approaches primarily focuses on the body and somatic experiences in trauma treatment?

A. Cognitive behavioral therapy (CBT) for trauma
B. Eye movement desensitization and reprocessing (EMDR)
C. Interpersonal psychotherapy (IPT)
D. Acceptance and commitment therapy (ACT)

Correct answer:

B. Eye movement desensitization and reprocessing (EMDR)

Question 2: What is a common feature among various trauma psychotherapies, involving the process of updating an individual's beliefs about their traumatic experiences?

A. Attention to somatic experience
B. Preparatory psychoeducation and framing of treatment
C. Learning procedures like extinction and memory reconsolidation
D. Revising narratives and updating schemas

Correct answer:

D. Revising narratives and updating schemas

Question 3: According to James Chu's article "Ten Traps for Therapists in the Treatment of Trauma," which aspect can be particularly challenging in the treatment of trauma survivors in order to avoid pitfalls?

A. Diagnostic clarification
B. Cultural competence
C. Setting clear boundaries and limits
D. Addressing substance use and addictions

Correct answer:

C. Setting clear boundaries and limits

Question 4: Which therapy approach primarily focuses on enhancing emotion regulation capacities in trauma treatment?

A. Sensorimotor therapy
B. Prolonged exposure (PE)
C. Stress inoculation training (SIT)
D. Supportive psychotherapy

Correct answer:

A. Sensorimotor therapy

MODULE 6: FORMULATION

Session 1: Basic Components of Formulation

Question 1: How does a formulation differ from a differential diagnosis in psychotherapy?

A. A formulation includes only syndromic diagnoses, while a differential diagnosis goes beyond that
B. A differential diagnosis focuses on generating a list of possible diagnoses and syndromes, while a formulation includes an understanding of complex factors beyond those related to diagnoses
C. A formulation involves evidence from facts, while a differential diagnosis relies solely on test results
D. A formulation does not consider cultural and personal relationship factors, unlike a differential diagnosis

Correct answer:

B. A differential diagnosis focuses on generating a list of possible diagnoses and syndromes, while a formulation includes an understanding of complex factors beyond those related to diagnoses

Question 2: What is the purpose of formulating in psychotherapy?

A. To establish a syndromic diagnosis for the patient's condition
B. To guide psychotherapy by explaining the factors leading to distress and problems
C. To prescribe specific treatment techniques for the patient's condition
D. To provide a definitive answer to the patient's problems based on test results

Correct answer:

B. To guide psychotherapy by explaining the factors leading to distress and problems

Question 3: According to the describe-review-link model for organizing formulation, what are the steps involved in constructing psychodynamic formulations?

A. Describing cultural factors, reviewing developmental history and linking to current symptoms
B. Describing problems and patterns, reviewing the family history, and linking to genetic factors
C. Describing the patient's complaints, reviewing the treatment history and linking to current life events
D. Describing problems and patterns, reviewing the developmental history and linking to organizing ideas about development

Correct answer:

D. Describing problems and patterns, reviewing the developmental history and linking to organizing ideas about development.

Question 4: What is the significance of sharing the formulation with the patient during psychotherapy?

A. It helps the patient gain a better understanding of their medical diagnosis
B. It allows the patient to choose a specific treatment technique for their condition
C. It enhances the therapeutic alliance and empowers the patient in the treatment process
D. It is a requirement for legal and ethical purposes in psychotherapy

Correct answer:

C. It enhances the therapeutic alliance and empowers the patient in the treatment process

Session 2: Focusing Observations to Use in Formulation

Question 1: During the assessment of a patient, what is the significance of observing the patient's mental status changes?

A. To identify conflicts and avoidances in the patient's life
B. To understand the patient's goals and obstacles
C. To evaluate the effectiveness of psychotherapy techniques
D. To gain insight into the patient's emotional regulation and states of mind

Correct answer:

D. To gain insight into the patient's emotional regulation and states of mind

Question 2: Which of the following techniques is recommended when dealing with excessive avoidances in a patient during the interview?

A. Encouraging the patient to explore overwhelming feelings
B. Supporting the patient in staying present with overwhelming feelings
C. Observing shifts between undermodulated and overmodulated states
D. Addressing the patient's warning signs for under-control of feelings

Correct answer:

B. Supporting the patient in staying present with overwhelming feelings

Question 3: What does the "protective" aspect in the helpful grid refer to in the formulation process?

A. Identifying the patient's protective coping mechanisms
B. Evaluating the patient's prognosis for recovery
C. Understanding the factors that perpetuate the patient's problems
D. Recognizing the sources of support and strengths the patient can rely on

Correct answer:

D. Recognizing the sources of support and strengths the patient can rely on

Question 4: How can a formulation be revised as psychotherapy progresses through different stages?

A. By focusing solely on the patient's biological determinants
B. By observing mental status changes and conflicts in the patient's life
C. By identifying the initial precipitating factors leading to the current problems
D. By evaluating the progress in changing aspects of maladaptive functioning

Correct answer:

D. By evaluating the progress in changing aspects of maladaptive functioning

Session 3: Formulating What Can Change Next

Question 1: During the assessment stage of psychotherapy, what is the key aim for the therapist?

A. Highlight the most helpful new attitudes
B. Expand on the implications of the current focus for the patient
C. Define roles in a therapeutic partnership
D. Obtain history and make early formulations

Correct answer:

D. Obtain history and make early formulations

Question 2: In the attitudinal change stage of psychotherapy, what does the therapist aim to do?

A. Help the patient modify dysfunctional beliefs
B. Describe states in which symptoms occur
C. Provide suggestions to stabilize emotional problems
D. Educate the patient about symptom formation

Correct answer:

A. Help the patient modify dysfunctional beliefs

Question 3: What is the purpose of configurational analysis in psychotherapy formulation?

A. To highlight the most helpful new attitudes
B. To describe the patient's states of mind during therapy sessions
C. To plan how to increase safety in therapy sessions
D. To explore meanings, memories and patterns of relating to others

Correct answer:

D. To explore meanings, memories and patterns of relating to others

Question 4: During the "bringing treatment to a close" stage of psychotherapy, what is the key aim for the therapist?

A. Highlight the most helpful new attitudes
B. Emphasize safe separation
C. Describe states in which symptoms occur

D. Obtain history and make early formulations

Correct answer:

B. Emphasize safe separation

Session 4: Formulation of Identity and Relationship Patterns and How They Might Change in Psychotherapy

Question 1: How can a psychiatrist use the therapeutic alliance to facilitate change in psychotherapy?

A. By interpreting the roles of self and others in the patient's life
B. By recognizing patterns of personalization and depersonalization
C. By observing the patient's style of interaction and trust in the alliance
D. By addressing the impact of privilege and cultural influences

Correct answer:

C. By observing the patient's style of interaction and trust in the therapeutic alliance

Question 2: In psychotherapy, what does it mean to have "good goodbyes"?

A. It refers to positive interactions between the therapist and significant others in the patient's life
B. It signifies the termination of therapy when the patient has achieved all their goals
C. It denotes a supportive technique for suggesting new patterns of interaction in relationships
D. It indicates the setting of the stage for a positive and constructive therapy termination

Correct answer:

D. It indicates the setting of the stage for a positive and constructive therapy termination

Question 3: How can a psychiatrist help patients recognize maladaptive habits in their relationships?

A. By identifying the impact of stressors and cultural influences
B. By drawing the patient's attention to patterns that occur in the therapeutic relationship
C. By suggesting new ways of seeing self and others in relationships
D. By clarifying and interpreting the patient's emotional reactions in therapy

Correct answer:

B. By drawing the patient's attention to patterns that occur in the therapeutic relationship

Question 4: What is an example of how supportive techniques can be used to suggest new patterns of interaction?

A. Bringing attention to personalization and depersonalization experiences

B. Clarifying and interpreting the roles of self and significant others in the patient's life
C. Suggesting new ways of interacting or forming relationships in the context of withdrawal from social interactions
D. Examining the impact of cultural and educational influences on the patient's development

Correct answer:

C. Suggesting new ways of interacting or forming relationships in the context of withdrawal from social interactions

MODULE 7: INTERPERSONAL STANCE AND THE THERAPEUTIC RELATIONSHIP

Session 1: What Is a Therapeutic Relationship?

Question 1: What are three elements of the therapeutic alliance as described in the literature?

A. Cognitive restructuring, exposure therapy and mindfulness techniques
B. Empathy, prescription of medications and reflective listening
C. The use of art therapy, play therapy and group therapy sessions
D. The affective bond between therapist and patient, mutual agreement about the goals of therapy/treatment, and mutual agreement about the tasks of therapy/treatment

Correct answer:

D. The affective bond between therapist and patient, mutual agreement about the goals of therapy/treatment, and mutual agreement about the tasks of therapy/treatment

Question 2: Why is the therapeutic interaction with a particular patient considered more important than the choice of a specific psychotherapy for a particular disorder?

A. Specific psychotherapy techniques are not effective in treating any disorder
B. Patients benefit equally from different therapists who subscribe to the same type of psychotherapy model
C. The therapeutic interaction addresses the root cause of the disorder more effectively
D. The therapeutic interaction establishes a foundation for effective psychotherapy regardless of the specific approach

Correct answer:

D. The therapeutic interaction establishes a foundation for effective psychotherapy regardless of the specific approach

Question 3: Which of the following is a concrete example of a working therapeutic alliance?

A. A patient and doctor agree about what history and treatments to review during a medical check-up, and they focus the visit on discussing these topics
B. A lawyer provides guidance and advice during a meeting with a client
C. A therapist uses cognitive-behavioral techniques in a group therapy session
D. A psychiatrist considers and then prescribes medications in a psychiatric hospital setting after interviewing the patient

Correct answer:

A. A patient and doctor agree about what history and treatments to review during a medical check-up, and they focus the visit on discussing these topics

Question 4: How are the common factors in treatment described and measured in the literature?

A. "Common factors" refers to the use of medication in treatment, and they are measured by the dosage administered
B. Common factors are specific techniques used by therapists and measured by the number of sessions in which they are applied
C. Common factors represent elements present in all effective therapies, and they can be measured through patient ratings of therapist empathy, positive regard, genuineness and collaboration
D. Common factors encompass the severity of the patient's disorder and are measured through standardized psychological assessments

Correct answer:

C. Common factors represent elements present in all effective therapies, and they can be measured through patient ratings of therapist empathy, positive regard, genuineness and collaboration

Session 2: Why Is the Therapeutic Relationship Important?

Question 1: Which of the following concepts is associated with D. W. Winnicott and involves creating a safe and supportive environment for the patient in therapy?

A. Positive regard
B. "Playing catch" with patients throughout the interaction
C. Person-centered counseling
D. Holding environment

Correct answer:

D. Holding environment

Question 2: How can "serve and return" interactions be considered within psychotherapy?

A. They can refer to the therapist providing advice, teaching and insight-building
B. They can involve the therapist attending to the internal experiences of patients and actively responding
C. They are emotional expressions and experiences shared between the therapist and patient
D. They represent learning new skills and psychoeducation provided by the therapist

Correct answer:

B. They can involve the therapist attending to the internal experiences of patients and actively responding

Question 3: Which concept, associated with Wilfred Bion, involves the therapist's ability to receive and understand the patient's emotional experiences and thoughts?

A. Creating a secure base for the patient
B. Therapeutic relationship
C. Containment
D. Holding environment

Correct answer:

C. Containment

Question 4: Which therapeutic approach is associated with Carl Rogers and emphasizes the importance of the therapist's genuineness, empathy and unconditional positive regard?

A. Cognitive behavioral therapy
B. Person-centered counseling
C. Supportive psychotherapy
D. Psychodynamic psychotherapy

Correct answer:

B. Person-centered counseling

Session 3: How to Create a Therapeutic Relationship

Question 1: How can "mindfulness" be relevant to the practice of psychotherapy?

A. In the therapist's ability to analyze the patient's past experiences
B. In the patient's capacity to understand the therapist's emotions
C. In the therapist's attention and awareness of moment-to-moment emotional experiences
D. In the patient's ability to predict the outcome of therapy

Correct answer:

C. In the therapist's attention and awareness of moment-to-moment emotional experiences

Question 2: Which of the following skills allows the therapist to consider and provide potential explanations for the patient's thoughts, feelings, beliefs and behaviors?

A. Emotional awareness
B. Mindfulness
C. Mentalization
D. Empathic statements

Correct answer:

C. Mentalization

Question 3: Which of the following is NOT a technique for developing the therapist's ability to create a therapeutic relationship?

A. stablishing trust and expressing interest
B. Using empathic statements and mirroring
C. Encouraging emotional avoidance in the patient
D. Facilitating a narrative in the therapy sessions

Correct answer:

C. Encouraging emotional avoidance in the patient

Question 4: How should ruptures in the therapeutic alliance and relationship be addressed?

A. Ignoring the ruptures to prevent further complications
B. Focusing solely on the patient's perspective without considering the therapist's role

C. Acknowledging and discussing the ruptures to repair the therapeutic relationship
D. Terminating the therapy when ruptures occur to avoid potential harm

Correct answer:

C. Acknowledging and discussing the ruptures to repair the therapeutic relationship

Session 4: What If? Understanding Challenges and Ruptures in the Relationship as Opportunities

Question 1: What factors influence an individual's interpersonal style?

A. Attachment style
B. Developmental challenges and traumas
C. Family and societal systems
D. All of the above

Correct answer:

D. All of the above

Question 2: How can ruptures in the therapeutic relationship be beneficial for treatment?

A. Ruptures provide opportunities for therapists to terminate the therapeutic relationship
B. Ruptures help reinforce the therapist's authority in the relationship
C. Ruptures offer opportunities for growth, understanding and deeper exploration of issues
D. Ruptures indicate the need for more assertive therapeutic interventions

Correct answer:

C. Ruptures offer opportunities for growth, understanding and deeper exploration of issues

Question 3: Which of the following methods is NOT used to help patients regulate their emotions?

A. Practicing mindfulness skills
B. Practicing new and adaptive behaviors
C. Practicing emotional awareness and communication
D. Encouraging emotional suppression and avoidance

Correct answer:

D. Encouraging emotional suppression and avoidance

Question 4: Which of the following describes how therapists can help regulate their own emotions when providing treatment?

A. Ignoring their emotions and focusing solely on the patient's needs

B. Maintaining boundaries and professional behavior, and utilizing supervision to discuss their own emotional reactions and challenges in the treatment
C. Venting their emotions to the patient to establish a stronger bond
D. Using emotional manipulation to influence the patient's feelings

Correct answer:

B. Maintaining boundaries and professional behavior, and utilizing supervision to discuss their own emotional reactions and challenges in the treatment