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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Dates of Revision: October 29th, 2023

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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 which 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. ACGME requirements in psychotherapy are becoming ever more lean, 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 their own unique foundational theories and methods. The time dedicated to this teaching is insufficient and as a result, it is our impression that residents do not generally 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 does not only describe a model of eclectic technique use, it 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) 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 lays emphasis on research findings that all bona fide psychotherapies work relatively as well as others (the "dodo bird effect") and that non-specific or "common factors" play a critical role in the outcome of psychotherapy. It takes in mind the findings of placebo studies, and studies on clinician stance, that the therapeutic relationship is a vital factor in determining patient outcome. 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, 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 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, 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 some 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, 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 an 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. Have an understanding of 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 may be unprepared for their longitudinal psychotherapy experiences.

The curriculum is also appropriate for learners in other disciplines intending 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 is 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. These are 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” are supplemental materials that may be helpful, but are not strictly necessary.

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 which 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 1st- and 2nd-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 be applicable to all treatments, not just psychotherapy treatments. 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 your residents at whatever year of training is most appropriate to the needs.

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 for each session in the additional document.

Pre/Post Test Questions:
See Assessment Test Questions document

Additional Methods for Psychotherapy Learning Assessment

We also encourage programs to evaluate resident progress towards 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, and
- Feedback/reflection from the residents about their own performance.

AADPRT Milestone Assessment for Psychotherapy (A- MAP)

Direct observation of 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 the form can be obtained at the following web-site:

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 web-site:
https://www.acgme.org/globalassets/pdfs/milestones/psychiatrymilestones.pdf

MODULE 1: INTRODUCTION TO INTEGRATIVE PSYCHOTHERAPY

How does talking with an empathic, non-judgmental 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 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; that leads 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
2. Discuss how teaching specific treatment approaches (e.g. Dialectical Behavioral Therapy 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 towards 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
            1. Examples: "affect phobia" treatments and exposure to obsession-inducing triggers both 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
            1. Schemas or core beliefs in CBT
            2. Transference in psychodynamic psychotherapy
    b. Theory and understanding derived from multiple areas of study
        i. i.e. Integral Metatheory (looking at problems from different perspectives)
    c. Willingness to consider and learn from a variety of theories and schools
3. 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 patient and 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

4. Explore and discuss residents' ideas and experiences about what makes a clinic encounter "psychotherapeutic"
5. Discuss how a clinician's interventions can lead to positive changes for patients
6. 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).
   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).
   Offers specific guidelines for initial consultation in the context of an integrative approach to psychotherapy

3. Norcross, J. C. (2016). Integrative psychotherapy. In 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 Resource, Session 1

Session 2: Practice through Clinical Case Illustrations and Discussion

This session will review, clarify and consolidate the concepts introduced in session 1, and review the exercise and homework. Since this module is introductory, Session 2 focuses more on review and 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 this 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. Encourage examples of situations in which these skills did not work and explore 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 patient can feel vulnerable, 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.
   For a case example of how emotional connection with a therapist brings about change.

MODULE 2: NEUROSCIENCE

This module sets the stage 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 relationship and behavior. It is organized around an understanding of the therapeutic experience as consisting of an emotional **bond** or connection, the interactive expression and **regulation** of emotion, the **re-organization** of experience through the process of therapeutic change, and the opportunity for **healing**. After an introduction to key theories in session 1, each subsequent session of this module will cover these aspects of therapeutic relationship from the perspective of some of the most relevant and interesting discoveries in neuroscience.

Session 1: Models of Mind in Brain–Evolutionary Psychology

Learning Objectives

1. Residents will understand how evolutionary psychology can help explain psychopathology

Outline

1. Evolutionary Psychology
2. Evolutionary forces promote passing on genes to next generation
    a. Reproductive Fitness over happiness
3. Psychopathology as evolutionary adaptation
    a. Depression/low mood as "involuntary defeat strategy" may facilitate accepting defeat (see Durisko et al reference)
    b. Impulsive behavior can be adaptive (with respect to passing on genes) if lifespan is quite limited and social status is low. ("Live fast/Die Young" strategy)
    c. Reciprocal Altruism
    d. "Tit for tat" strategy was successful in the iterated "prisoner's dilemma" (in Kaplan and Sadock)

Key References

1. Del Giudice, & 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. (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. doi:10.1016/j.jad.2014.09.032

4. Nesse, R. M. M. (2017). Evolutionary Foundations for Psychiatric Research and Practice In B. J. S. Sadock, Virginia A.; Ruiz, Pedro (Ed.), *Kaplan and Sadock's Comprehensive Textbook of Psychiatry (10 ed.)*: Wolters Kluwer Health. Kindle Edition.

Additional References

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

Learning Objectives

1. 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.

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.

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.

Additional References

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.

2. Lane, R. D. (October 2021). A brain-based approach to psychotherapy. *Psychiatric Times*. Retrieved from [URL or DOI if available] (if the article is from an online source).

Session 3: 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, hemispheric specialization

Outline

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.

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.

3. Farb, N., et al. (2015). Interoception, contemplative practice, and health. *Frontiers in Psychology*, 6, 763. doi: 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. doi: 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.

2. "Surprise" and the Bayesian Brain: Implications for Psychotherapy Theory and Practice. (March 2019). *Frontiers in Psychology*. DOI: 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.

4. McNally, G. P., Johansen, J. P., & Blair, H. T. (2011). Placing prediction into the fear circuit. Trends in Neurosciences, 34(6), 283-292.

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

Learning Objectives

1. 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. Small change in conditions may precipitate a major change in the system
    e. Feedback loops
    f. Multiple meta-stable states
2. The Brain as 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 themselves in psyches and in societies: Scapegoating in societies is a form of splitting and 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

2. Hayes, A. M., & Andrews, L. A. (2020). A complex systems approach to the study of change in psychotherapy. *BMC Medicine*, 18, 197.

Additional References

1. Holland, J. H. (2014). *Complexity: A Very Short Introduction* (1st ed.). Oxford, United Kingdom: Oxford University Press.

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 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. "Love Actually: The Science Behind Lust, Attraction, and Companionship." *Harvard Medical School - Science in the News*. https://sitn.hms.harvard.edu/flash/2017/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. doi: 10.3389/fnhum.2012.00212.

Session 6: Establishing Safety and Regulation/Approaches to Under-Regulated States

Learning Objectives

1. The resident will become familiar with the neural correlates of under-regulated 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. HPA axis (cortisol),
    c. inflammation
    d. neurotoxicity of chronic stress
    e. fragmentation of neural networks (PFC offline from sympathetic surge)
2. Responding to an acute stress state (under-regulated 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 new, healing, experience
    e. Opioid release from attachment dampens sympathetic arousal

Key References

1. Fear and the Defense Cascade - Clinical Implications and Management. (2014). *Harvard Review of Psychiatry*.

2. Tabibnia, G. (2020). An affective neuroscience model of boosting resilience in adults. *Neuroscience & Biobehavioral Reviews*, 115, 321-350. Doi: 10.1016/j.neubiorev.2020.05.005. Epub 2020 Jun 6. PMID: 32522489.

3. Feelings into words - contributions of language to exposure therapy. (2012). *Psychological Science* (see especially Introduction and Discussion).

Additional References

1. The Inflammatory Reflex. (2002). *Nature*.

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.

3. Feder, A., Nestler, E. J., & Charney, D. S. (2009). Psychobiology and Molecular Genetics of Resilience to Stress. In T. P. Steckler, N. Kalin, & J. M. H. M. Reul (Eds.), *Handbook of Stress and the Brain* (Vol. 15, pp. 633-642). Elsevier.

Session 7: Working at Therapeutic Change/Neuroplasticity

Learning Objectives

1. 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. doi: 10.1016/j.nlm.2013.11.014. Epub 2013 Dec 7. PMID: 24321650; PMCID: PMC4156287.

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. doi: 10.1017/S0140525X14000041. Epub 2014 May 15. PMID: 24827452.

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

Session 8: Healing

Learning Objectives

1. 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 yields improvements in relationships and problem-solving (show simple clinical examples for relatable broad categories. relate it to a therapy encounter, and changes in both participants)

Key References

1. Lane, R. D. (Editor), & Nadel, L. (Editor). (2020). *Neuroscience of Enduring Change: Implications for Psychotherapy* (1st Edition). Oxford University Press.

2. Gilboa, A., et al. (2017). Neurobiology of schemas and schema-mediated memory. *Trends in Cognitive Sciences*, 21(8), 618-631. doi: 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, PhD: Decoding Mother-Infant Interaction, https://www.youtube.com/watch?v=-60yYJvztJ8; or,
    b. Beatrice Beebe, PhD: Joining Your Baby's Distress Moments, https://www.youtube.com/watch?v=NI3BRYd7XfY; on how to recognize healthy attachment as critical in the development of emotional experiencing.
    c. Ed Tronick, PhD: Still-Face Experiment, https://www.gottman.com/blog/research-still-face-experiment/
    d. Secure, Insecure, Avoidant Ambivalent Attachment in Mothers in The Strange Situation Experiment, https://www.youtube.com/watch?v=DRejV6f-Y3c
2. Define, discuss "attachment relationships:"
    a. Relationships to 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 would stay with the child for a few minutes, until Mother's return. The toddlers' responses to Mother's leaving and returning were observed and characterized by Ainsworth as:
    i. Secure: when the safety and reassurance of the relationship are sought and the relationship provides relief of distress. The child explored the play room freely before 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
    ii. 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

1. 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, had prolonged distress. Mothers of anxiously attached children were observed to be inconsistent, not attuned.
2. 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.
3. Disorganized: Child had no consistent strategy for managing distress. Behaviors are 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 toddlers fearful response. (eg 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 relationship of psychotherapy.
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.
   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. 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 flier 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.), The maturational processes and the facilitating environment (pp. 37-55). London: Hogarth Press.

Additional References

1. Nolte, T., Guiney, J., Fonagy, P., Mayes, L. C., & Luyten, P. (2011). Interpersonal Stress Regulation and the Development of Anxiety Disorders: An Attachment-Based Developmental Framework. Frontiers in Behavioral Neuroscience, 5. https://doi.org/10.3389/fnbeh.2011.00055

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.

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" (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 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 into personal history and practical parenting support
2. How does stressed attachment differ from healthy attachment?
    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 (ACE's, see 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 lead 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 to understand the longstanding 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" Reference #3: Alicia Lieberman and her colleagues identified clinical examples of how early benevolent childhood experience ("BCE's") 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." (ref #3 below).
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 &Amp; Human Development, 24(5), 543–560. https://doi.org/10.1080/14616734.2022.2030132

Additional References

1. Kim-Spoon, J., Herd, T., Brieant, A., Peviani, K., Deater-Deckard, K., Lauharatanahirun, N., Lee, J., & King-Casas, B. (2021). Maltreatment and brain development: The effects of abuse and neglect on longitudinal trajectories of neural activation during risk processing and cognitive control. Developmental Cognitive Neuroscience, 48, 100939. https://doi.org/10.1016/j.dcn.2021.100939 Open access https://reader.elsevier.com/reader/sd/pii/S187892932100030X?token=18B3A3CDE6A4B5989A5B471B0EDA12EE5FE327219E6E9DB788DBE234A7BD13A910360C01E23F1BAF81E5BF3B7C8AD9AB&originRegion=us-east-1&originCreation=20220515005620

2. Levine, A., & Heller, R. (2019). Attached: Are you Anxious, Avoidant or Secure? How the science of adult attachment can help you find – and keep – love (Main Market). Bluebird.
Popular press article

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.

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, under-regulation, or over-regulation 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, that 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 over-regulation 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 relationship.
    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 of 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 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 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) 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 Adult Attachment Interview (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 (eg, "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, 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, 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 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.

Key References

1. Ensink, K., Berthelot, N., Bernazzani, O., Normandin, L., & Fonagy, P. (2014). Another step closer to measuring the ghosts in the nursery: preliminary validation of the Trauma Reflective Functioning Scale. Frontiers in Psychology, 5. https://doi.org/10.3389/fpsyg.2014.01471

2. Girme, Y. U., Jones, R. E., Fleck, C., Simpson, J. A., & Overall, N. C. (2021). Infants' attachment insecurity predicts attachment-relevant emotion regulation strategies in adulthood. *Emotion*, *21*(2), 260–272. https://doi.org/10.1037/emo0000721

3. Levine, A., & Heller, R. (2019). Attached: Are you Anxious, Avoidant or Secure? How the science of adult attachment can help you find – and keep – love (Main Market ed.). Bluebird.

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

Additional References

1. Ainsworth, M. D. S., Blehar, M. C., Waters, E., & Wall, S. (1978). Patterns of attachment: Assessed in the Strange Situation and at home. Hillsdale, NJ: Erlbaum.

2. Bowlby J (1973). Attachment and loss: Vol. 2. Separation. New York, NY: Basic Books.

3. Ensink, K., Berthelot, N., Bernazzani, O., Normandin, L., & Fonagy, P. (2014). Another step closer to measuring the ghosts in the nursery: preliminary validation of the Trauma Reflective Functioning Scale. Frontiers in Psychology, 5. https://doi.org/10.3389/fpsyg.2014.01471

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Compares attachment research based on self-report (eg Adult Attachment Interview) and research based on social psychology experiments to test causal hypotheses to develop a model for understanding and future research on attachment theory and personality development

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14. Zimmer-Gembeck MJ, Webb HJ, Pepping CA, Swan K, Merlo O, Skinner EA, Avdagic E and Dunbar M, 2017. Is parent–child attachment a correlate of children's emotion regulation and coping? International Journal of Behavioral Development, 41, 74–93.

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 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 non-directive ways.
    a. When a therapy is non-directive, 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 (eg. 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, Skills Manual) can help patients learn to stay present with difficult experience.
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.

4. Examples of different presentations:
    a. "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).
    b. "Anxiously attached" behaviors
        i. Patients with anxious attachment styles may initially form a strong connection, or even 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. (Gunderson, 2015)
5. 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 circumstance, 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, non-defensively, 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 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.

Key References

1. Wallin, D. J. (2007). Chapter 2, The foundations of attachment theory. In *Attachment in psychotherapy* (pp. 11–24). The Guilford Press.
   Chapters 2 and 3 provide a good structure for residents to learn about attachment, without being too cumbersome

2. Lyons-Ruth, K. (The two-person unconscious: Intersubjective dialogue, enactive relational representation, and the emergence of new forms of relational organization. Psychoanalytic Inquiry, 19: 576-617
   Excellent reading for faculty.

3. Wallin, D. J. (2007). Part IV, Attachment Patterns in Psychotherapy. In *Attachment in psychotherapy* (pp.191-255). The Guilford Press.

Additional References

1. Winnicott, D. W. (1965) The Theory of the Parent-Infant Relationship (1960). The Maturational Processes and the Facilitating Environment: Studies in the Theory of Emotional Development 64:37-55.
   For original reference to the "holding environment."

2. Hoffman, L., Rice, T., Prout, T., & Centre, P. P. C. (2015). Manual of Regulation-Focused Psychotherapy for Children (RFP-C) with Externalizing Behaviors: A Psychodynamic Approach (Psychological Issues) (1st ed.). Routledge.
   For discussion of "implicit emotion" as a neuroscience term similar to the psychodynamic term, "defense."

3. Linehan, M. M. (1993). Skills Training Manual for Treating Borderline Personality Disorder (First Edition). The Guilford Press.

4. Gunderson, JG (2014). Handbook of Good Psychiatric Management for Borderline Personality Disorder. Amer. Psychiatric Publishing.

5. Plakun, E.M. (1998). Enactment and the treatment of abuse patients. Harvard Review of Psychiatry, 5(6): 318-25

6. Bowlby, J. (1982). Attachment and loss: Vol. 1. Attachment. London: Hogarth Press and the INstitute of Psycho-Analysis (Original work published 1969)

MODULE 4: SYSTEMS THEORY

The goal of the systems 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) contri

butes significantly to positive adaptation or to individual or relational dysfunction. There is extensive research (Heru 2006) which 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, workplace, 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 our 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 current 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 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

1. Glick, I., et al. (2016). Couples and Family Therapy in Clinical Practice (5th Edition). UK: Wiley/Blackwell. Chapter 1: The Field of Couples and Family Therapy: Development and Definition

2. Heru, A. M., & Drury, L. (2006). Overcoming Barriers in Working With Families. *Academic Psychiatry*, 30, 379-384. https://doi.org/10.1176/appi.ap.30.5.379

Additional References

1. Glick, I., et al. (2016). *Couples and Family Therapy in Clinical Practice* (5th Edition). UK: Wiley/Blackwell. (for teacher preparation, can be used throughout the module as needed.)

2. McGoldrick, M., Gerson, R., & Shellenberger, S. (2020). *Genograms: Assessment and Intervention* (4th Edition). New York: Norton.

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, nested subsystems
2. Residents will understand ways to assess family structure and functioning
3. Residents will review 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 non-family 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 non-monogamy, 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

2. 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 skills of 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 diagnosis, 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 in which information about the illness, how families can help and practice in communication techniques are used

Key References

1. Use sections of SAFE program https://www.ouhsc.edu/safeprogram/

2. Miklowitz, D. (2004) The role of family systems in severe and recurrent psychiatric disorders: A developmental psychopathology view. *Development and Psychopathology* 16: 667-688

Additional References

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

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, Chapters 15, 16, 17

2. Hendrix, H., PhD, & Hunt, H. L., PhD. (2019). *Getting the Love You Want: A Guide for Couples: Third edition*. St. Martin's Griffin.

3. Johnson, S. M. (2019). *Attachment Theory in practice: Emotionally Focused Therapy (EFT) with Individuals, Couples, and Families*. Guilford Publications.

Additional References

1. Levine, S. B., MD. (2019). *Psychotherapeutic approaches to sexual problems: An Essential Guide for Mental Health Professionals*. American Psychiatric Pub.

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

Learning Objectives

1. Residents will learn basic terms and concepts to describe groups - 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 psychiatry settings, the residency program, the university, and wider cultural and organizational contexts
5. Review 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.

2. Green, L. R., Barlow, S., & Kaklauskas, F. J. (2020). Ch 4: Therapeutic Factors. In F. J. Kaklauskas & L. R. Greene (Eds.), *Core Principles of Group Psychotherapy: An Integrated Theory, Research, and Practice Training Manual*. Routledge.

3. Green, L. R., & Kaklauskas, F. J. (2020). Ch 7: Group Development. In F. J. Kaklauskas & L. R. Greene (Eds.), *Core Principles of Group Psychotherapy: An Integrated Theory, Research, and Practice Training Manual*. Routledge.

4. Green, Z. G., & Molenkamp, R. J. (2005). The BART System of Group and Organizational Analysis Boundary, Authority, Role, and Task. https://www.semanticscholar.org/paper/The-BART-System-of-Group-and-Organizational-Role-Green-Molenkamp/29cdfab7f00f8b4990e802bdad813a6ac750f018

Additional References

1. MacColl, G.J. (2014). The Group Contract Revisited. Group 38(2), 103-113. https://www.muse.jhu.edu/article/844658.

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 Events (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. The overlap between developmental trauma and Borderline Personality Disorder
    g. Intergenerational trauma
        i. Epigenetics

ii. Systems

Key References

1. Amanda, E., & Patricia, C. (2014). Neurobiology and the Impact of Trauma. In *Trauma-Informed Care: How Neuroscience Influences Practice.* Routledge.

2. Yehuda, R., Hoge, C. W., McFarlane, A. C., Vermetten, E., Lanius, R. A., Nievergelt, C. M., & Hyman, S. E. (2015). Post-traumatic stress disorder. *Nature Reviews Disease Primers*, 1, 15057. https://doi.org/10.1038/nrdp.2015.57

3. See Appendix Resource for Session 1

Additional References

1. Horowitz, M. J., MD. (2020). *Treatment of Stress Response Syndromes, second edition*. American Psychiatric Pub.

2. Herman, J. L. (2015). *Trauma and recovery: The Aftermath of Violence--From Domestic Abuse to Political Terror*. Hachette UK.

3. Oral, R., Ramirez, M., Coohey, C., Nakada, S., Walz, A., Kuntz, A., Benoit, J., & Peek-Asa, C. (2016). Adverse childhood experiences and trauma informed care: the future of healthcare. Pediatric research, 79(1-2), 227–233. https://doi.org/10.1038/pr.2015.197

4. Van Der Kolk, B. (2014). The body keeps the score: Mind, Brain and Body in the Transformation of Trauma. Penguin UK.

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 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 (ex. loss of land and culture in Native American community)
   d. Acknowledgement of colonial violence
   e. Epigenetic studies on transgenerational trauma (ex. epigenetic markers in children of Holocaust survivors)
   f. Trauma is relational – treatment needs to incorporate concepts of interrelatedness and interconnectedness (vs. only cognitive approach)
3. 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?
4. Trauma and LGBTQ+ community
   a. LGBTQ+ community 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

5. Learn about resources available
    a. Online resources
    b. Community groups

Key References

1. Jarvis, G. E., Kirmayer, L. J., Gómez-Carrillo, A., Aggarwal, N. K., & Lewis-Fernández, R. (2020). Update on the Cultural Formulation Interview. *Focus* (American Psychiatric Publishing), 18(1), 40–46. https://doi.org/10.1176/appi.focus.20190037

2. Amanda, E., & Patricia, C. (2014). Understanding Types of Trauma. In *Trauma-Informed Care: How Neuroscience Influences Practice*. https://doi.org/10.4324/9781315815572

Additional References

1. American Psychiatric Association. (2013). DSM-5 Cultural Formulation Interview. Retrieved from: https://www.psychiatry.org/File%20Library/Psychiatrists/Practice/DSM/APA_DSM5_Cultural-Formulation-Interview.pdf

2. Levounis, P., & Yardbrough, E. (2020). *Pocket Guide to LGBTQ Mental Health: Understanding the Spectrum of Gender and Sexuality*. APA Publishing.

3. Mollica, R. F. (2006). *Healing Invisible Wounds: Paths to Hope and Recovery in a Violent World*. Nashville, TN: Vanderbilt University Press.

4. Avalos N. (2021). What Does It Mean to Heal From Historical Trauma?. *AMA journal of ethics*, *23*(6), E494–E498. https://doi.org/10.1001/amajethics.2021.494.

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6. Comas-Díaz, L., Hall, G. N., & Neville, H. A. (2019). Racial trauma: Theory, research, and healing: Introduction to the special issue. *The American psychologist*, *74*(1), 1–5. https://doi.org/10.1037/amp0000442

7. Kirmayer, L. J., Gone, J. P., & Moses, J. (2014). Rethinking historical trauma. *Transcultural psychiatry*, *51*(3), 299–319. https://doi.org/10.1177/1363461514536358

8. Ehrensaft, D. (2011). *Gender Born, Gender Made: Raising Healthy Gender-Nonconforming Children* (3rd Revised Edition). The Experiment.

9. Yarbrough, E. (2018). *Transgender Mental Health*. APA Publishing.

10. National Child Traumatic Stress Network. (2015). Safe Places, Safe Spaces [Video]. Retrieved from https://www.nctsn.org/resources/safe-places-safe-spaces-creating-welcoming-and-inclusive-environments-traumatized-lgbtq-0

11. Ahmed, S., Dominguez, M., Forstein, M., Hermanstyne, K., Garcia, L., Leli, U., Yarbrough E., (2023). Stress & Trauma Toolkit for Treating LGBTQ in a Changing Political and Social Environment. Retrieved from: https://www.psychiatry.org/psychiatrists/diversity/education/stress-and-trauma/lgbtq

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. Treatment proceeds in stages:
    a. Janet's three stage model
    b. Horowitz's model (see formulation module)
2. 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 (ie substance use, suicidality, medical illnesses, etc)
        ii. Address environmental and behavioral concerns (e.g. housing, safety and stability, domestic violence, social supports, finances etc)
3. Traumatic experiences are unique and there is a "person behind the story of trauma" that should inform the treatment
4. Attention to the body
    a. Education about physiological effects of trauma
    b. Somatically-oriented techniques are often helpful
5. 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
6. Engagement in exposure and desensitization

    a. Facilitating the return to socialization and prior activities, engaging in new behaviors and activities
7. 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. See Appendix Resource for Session 3

2. 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

3. Arthur, E., Seymour, A., Dartnall, M., Beltgens, P., Poole, N., Smylie, D., & Schmidt, R. (2013). Trauma-informed practice guide. BC Provincial Mental Health and Substance Use Planning Council. Retrieved from: https://cewh.ca/wp-content/uploads/2012/05/2013_TIP-Guide.pdf

4. Butler, L. D., Critelli, F. M., & Rinfrette, E. S. (2011). Trauma-informed care and mental health. *Directions in Psychiatry, 31*(3), 197-212.

Additional References

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2. National Institute for the Clinical Application of Behavioral Medicine. (2023). Retrieved from: https://www.nicabm.com/experts/a2-bessel-van-der-kolk-google/?del=gssmebessel.16&network=g&utm_source=google&utm_medium=cpc&utm_campaign=9718985185&ad_group_id=99190633883&utm_term=%2Btrauma%20%2Bbessel&utm_content=572033571827&gclid=CjwKCAjwrfCRBhAXEiwAnkmKmfrFJtL04SWasXQPCndeU56dDWxLHal8NArKK5rb8uetDNFOV2IhDxoCEbQQAvD_BwE

3. Brief Eclectic Psychotherapy (BEP). (2017.). Retrieved from: https://www.apa.org/ptsd-guideline/treatments/brief-eclectic-psychotherapy

4. Nakazawa DJ (2015). Child Development: 8 Ways People Recover From Post Childhood Adversity Syndrome. Retrieved from : https://www.psychologytoday.com/us/blog/the-last-best-cure/201508/8-ways-people-recover-post-childhood-adversity-syndrome

5. 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.

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

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

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

Outline

1. Survey of specific approaches:
    a. Treatments can occur individually, or if this is 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: Cognitive Behavioral Therapy (CBT) for Trauma, Prolonged Exposure (PE), Cognitive Processing Therapy (CPT), Narrative Exposure Therapy (NET), Brief Eclectic Psychotherapy (BEP)
    d. Non-Trauma Focused treatments are also possible, including: Stress inoculation Training (SIT), Present-Centered Therapy (PCT), Interpersonal Psychotherapy (IPT), Dialectical Behavior Therapy (DBT), Acceptance and Commitment Therapy (ACT), Accelerated Experiential Dynamic Psychotherapy (AEDP), Skills Training in Affect and Interpersonal Regulation (STAIR), Seeking Safety, and Supportive Psychotherapy
2. Commonalities amongst approaches:
    a. Learning procedures: extinction and memory reconsolidation
    b. Preparatory psychoeducation and framing of treatment (ie expectations, difficulties)
    c. Emotion regulation capacities
    d. Attention to somatic experience
    e. Revising narratives/updating schema
3. 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
        i. Practitioners trained in higher socioeconomic areas can unknowingly recommend activities and exposures to patients in high crime/dangerousness areas that puts them at the risk of

retraumatization/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 on "Ten traps for therapists in the treatment of trauma" notes attention needed in the treatment of trauma survivors to:
   i. Trust
   ii. Distance
   iii. Boundaries
   iv. Limits
   v. Responsibility
   vi. Control
   vii. Denial
   viii. Projection
   ix. Idealization
   x. Motivation

Key References

1. See Appendix Resource for Session 4

2. Norman, S., Hamblen, J., & Schnurr, P. P. (2010, July 27). *Overview of Psychotherapy for PTSD*. https://www.ptsd.va.gov/professional/treat/txessentials/overview_therapy.asp#two

3. Chu, J. (1988). *Ten traps for therapists in the treatment of trauma survivors*. Dissociation: Progress in the Dissociative Disorders, 1, 24-32.

Additional References

1. VA National Center for PTSD. (n.d.). Talk Therapy. Retrieved from https://www.ptsd.va.gov/understand_tx/talk_therapy.asp

2. Horowitz, M. J. (2021). *Treatment of Stress Response Syndromes, 2nd Edition.* American Psychiatric Pub.

3. Horowitz, M. J. (2018). *Formulation as a Basis for Planning Psychotherapy Treatment.* American Psychiatric Pub.

MODULE 6: FORMULATION

Formulation is a guide to knowing where you are in therapy: how to begin, what to attend to, when to intervene, 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 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 a 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 is a formulation.
   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 technique 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)
3. Sharing formulation with the patient (Gordon, Reiss)

Key References

1. Horowitz, M. (2019). *Formulation as a Basis for Planning Psychotherapy Treatment* (2nd ed., Chapter 1). American Psychiatric Press.

2. Cabaniss, D. L., Cherry, S., Douglas, C. J., Graver, R. L., & Schwartz, A. R. (2013). Part One: Introduction to psychodynamic formulation. In *Psychodynamic Formulation* (pp. 3-15). Wiley-Blackwell.

3. Gordon, C., & Reiss, H. (2005). The formulation as a collaborative conversation. *Harvard Review of Psychiatry, 13*(2), 112-123.

4. Hoyos, C., & Cortese, S. (2023). Beyond diagnosis: Formulation-storytelling and maps. *Journal of the American Academy of Child Psychiatry, 62*(2), 120-122.

Additional References

1. Henderson, S. W., & Martin, A. (2014). Case formulation and integration of information in child and adolescent mental health. In J. M. Rey (Ed.), IACAPAP e-Textbook of Child and Adolescent Mental Health. Geneva: International Association for Child and Adolescent Psychiatry and Allied Professions. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4884904/
   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 formulation as stages of psychotherapy progress

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, under-modulated and over-modulated 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," that 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 4 (or 5 or 6 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., MD. (2018b). *Formulation as a Basis for Planning Psychotherapy Treatment* (2nd ed., Chapter 2, States of Mind). American Psychiatric Pub.

2. Sim, K., Gwee, K. P., & Bateman, A. (2005). Case formulation in psychotherapy: Revitalizing its usefulness as a clinical tool. *Academic Psychiatry, 29*, 289-292.

3. Winters N., Hanson G., Stoyanova V. (2007). The case formulation in child and adolescent psychiatry. *Child & Adolescent Psychiatric Clinics of North America*, 16, 111–132.

Additional References

1. Eells, T. D. (2022, April 22). *Handbook of Psychotherapy Case Formulation, Third Edition*. The Guilford Press.

2. Cultural Formulation Interview. (2013). American Psychological Association. https://www.psychiatry.org/File%20Library/Psychiatrists/Practice/DSM/APA_DSM5_Cultural-Formulation-Interview.pdf

Session 3: Formulating What Can Change Next

Learning Objectives

1. 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, under-modulated and over modulated 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 as related to **Current Stage of Therapy**

Stage of Therapy	Patient Activity	Therapist Activity	Therapeutic Relationship
Assessment	Reports history, symptoms, problems, and preferences	Obtains history, makes early formulations. Provides educational information. Discusses treatment options.	Agreement on initial frame.
Support	Frank disclosure. Attention on how to cope with current stress.	Provides suggestions to help stabilize emotional problems. Establishes preliminary focus for possible next stage.	Defining roles in a therapeutic partnership.
Exploration of meanings	Expands on implications for self of current focus	Clarifies how emotions and ideas are linked to problems	Agree on where to pay attention.

Attitudinal change (re narration, re schematization)	Works on themes previously avoided.	Helps the patient modify dysfunctional beliefs.	Future relationship plans are examined and negotiated realistically.
Bringing Treatment to a Close (Termination)	Considers gains and reviews plans	Highlights the most helpful new attitudes.	Emphasis on safe separation.

Reference: Horowitz, M. (2022). Stages of Psychotherapy for Stressor-Related Disorders. *Journal of Psychiatric Practice*.

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 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.

Reference: Horowitz, M. (2019). *Formulation as a Basis for Planning Psychotherapy* (2nd Ed.). American Psychiatric Association.

*For example: The patient (self) may be in a role of feeling unfairly criticized by 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 References

1. Horowitz, M. J., MD. (2018b). *Formulation as a Basis for Planning Psychotherapy Treatment* (2nd ed., Chapters 1 and 2). American Psychiatric Pub.

Additional References

1. Eells, T. D. (2022, April 22). *Handbook of Psychotherapy Case Formulation, Third Edition*. The Guilford Press.

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 session, to facilitate change in psychotherapy
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 other 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, of 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., MD. (2018b). *Formulation as a Basis for Planning Psychotherapy Treatment* (2nd ed.). American Psychiatric Pub.

2. Horowitz, M. D. J. (2005). *Understanding Psychotherapy Change: A Practical Guide to Configurational Analysis*. American Psychological Association (APA).

3. Horowitz, M. J. (1987). *States of Mind: Configurational Analysis of Individual Psychology* (2nd ed.). Plenum Medical Book Co/Plenum Press.

Addendum

Case Example:

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 from safe to dangerous. Her self-state 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 to feel autonomous and ready for a guilt-free new couples relationship.

Sample questions for discussion could follow this case example.

MODULE 7: INTERPERSONAL STANCE AND THE THERAPEUTIC RELATIONSHIP: *4 Classes, 4 Questions: What? Why? How? And 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 therapeutic elements of all effective psychotherapy treatments: elements 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 treatments.

Session 1: What is a Therapeutic Relationship?

Learning Objectives

1. The resident will understand what are 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 non-therapeutic manner

Outline

1. Summarize literature on the association between factors in the therapeutic relationship and positive outcome 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 non-verbal expression.
    b. In therapy, 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," 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 the brings therapist and patient towards 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 resource for further discussion questions and exercises

Key References

1. See Appendix Resource for Session 1.

2. Stubbe, D. (2006). The Therapeutic Alliance: The Fundamental Element of Psychotherapy. Focus, 16(4), 402–403.

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 non-verbal 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, and progresses:
    a. From an emotional bond or connection between the therapist and patient
    b. Through the interactive expression and regulation of emotions
        i. Often referred to as "co-regulation"
    c. Thus, facilitating the re-organization 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 resource for discussion questions and exercises

Key References

1. See [Appendix Resource] 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.
4. Lanman, M. (1998). The human container: Containment as an active process. Psychodynamic Counselling, 4(4), 463–472. https://doi.org/10.1080/13533339808402523

Additional References

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 the "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. Discuss how an effective therapist is capable of maintaining a non-judgmental awareness and understanding of the inner experiences of both the patient and the therapist themselves
    a. Mindfulness allows for attention and awareness of moment to moment emotional experiences in the therapist and 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. Or, 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"

3. 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 they are and where they are, but does not mean expressing approval of maladaptive, inappropriate, or dangerous actions
4. 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
5. 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 of 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 Resource for Session 3

2. Bender, S., Messner, E., & Trinh, N. (2022). Initiating an alliance and assessing safety, and Enhancing the therapeutic alliance and eliciting history. Becoming a Therapist, Second Edition: What Do I Say, and Why? (Second ed.). The Guilford Press, 33-80.

3. Wallin, D. J. (2007). Chapter 2, The foundations of attachment theory. In Attachment in Psychotherapy (pp. 11–24). The Guilford Press.
   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/

Additional References

1. Wallin, D. J. (2007). Chapter 17, *Mentalizing and Mindfulness: the Double Helix of Psychological Liberation (pp. 307-338)*. The Guilford Press.

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 therapies
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 an "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 the 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 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, from the therapist, or from 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 on the part of the therapist
    a. Liking or disliking the patient too much
    b. Romantic or sexual feelings about 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 Center for Alliance Focused Training Website, on Confrontation: "This is a waste of time," a demonstration of non-judgmental, relationship-focused skills to overcome an impasse.

Key References

1. See Appendix Resource for Session 4

2. Bender, S., Messner, E., & Trinh, N. (2022). Chapters 15-16, Managing impasses, Empathic lapses. Becoming a Therapist, Second Edition: What Do I Say, and Why? (Second ed.). The Guilford Press, 325-342.

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

3. 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

Additional References

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

Please note that the appendix resources remain under development.

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 group into pairs of listener and speaker, with option to add a "third" who observes, gives feedback.
    b. Give guidelines for listening with
        i. **genuine curiosity** (so that the listener tries to be aware of assumption 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**, gaps, that could be fruitful opportunities for the speaker to pause, reflect, discover something new about what they are feeling or thinking
        v. **the listener is not there to make suggestions, advise, or try to make the person feel better or worse**, but simply to understand what happened, what was difficult about it for the speaker. Without asking "why" it was difficult, the listener may hear clues to guide the speaker in understanding "why."

    c. Give prompt for "real play:"
        i. "One of the difficult clinical experiences I have had this week is…," or,
        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 technique to return to in the next session
4. Assign 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.
5. Listening exercises:
    a. Divide group into pairs of listener and speaker, with option to add a "third" who observes, gives feedback.

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 micro-aggression 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 upon the effect of the trauma on the specific individual. Trauma is interrupted history which 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 (ACE) were defined in a Kaiser Permanente study in seven categories. These included psychological, physical, or sexual abuse; violence against mother; or 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 ACE’s 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 that can 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 often also 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, 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 down the hyper-aroused state. If a trusting relationship can be built with a therapist, then psychotherapy can be tried.

Optional References

1. Kudler, H. (2017). The psychoanalytic concept and treatment of psychological trauma: an evolving perspective, in *APA Handbook of Trauma Psychology*: Vol. 2. *Trauma Practice*, Gold, S.N. ed.

2. Poster, M. (2013). Thoughts on war, trauma, and the need for diplomacy*, Int'l. Forum of Psychoanalysis*, 23 (1): 1-9.

3. Stolorow, R.D. (2007). *Trauma and Human Existence*, New York: Routledge.

4. Varese, F., Smeets, F., Drukker, M., Lieverse, R., Lataster, T., Viechtbauer, W., Read, J., van Os, J., & Bentall, R. P. (2012). Childhood adversities increase the risk of psychosis: a meta-analysis of patient-control, prospective- and cross-sectional cohort studies. *Schizophrenia bulletin*, *38*(4), 661–671. https://doi.org/10.1093/schbul/sbs050

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6. Ferenczi, S. (1932). Confusion of tongues between the adults and the child - (the language of tenderness and of passion). *International Journal of Psychoanalysis, 30*, 225-230.

7. Caruth, C. (2016). *Unclaimed Experience: Trauma, Narrative, and History*. Baltimore, MD: Johns Hopkins University Press.

8. Davoine, F., & Gaudilliere, M. (2004). *History beyond Trauma*. New York: Other Press.

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10. Horowitz, M. (2015). *Stress Response Syndromes* (5th ed.). NY: Roman and Littlefield.

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.

Table 1: 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 treatment options.	Agreement on initial frame.
Support	Expands story and focuses on coping with current 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 sequelae.	Clarifies how emotions and ideas are linked.	Therapeutic alliance deepened by experience safety.
Re-narration	Works on themes previously avoided.	Encourages tolerance of dysphoric emotional states. Helps the patient modify dysfunctional 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 problems.	Highlights the most helpful insights.	Emphasis on safe separation.

(Table 1 from: Horowitz, M. J. (2021). *Treatment of Stress Response Syndromes, 2nd Edition.* American Psychiatric Pub.)

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.

(Table above from: Horowitz, M. J. (2021). *Treatment of Stress Response Syndromes, 2nd Edition.* American Psychiatric Pub.)

Trusting relationship is foundational in psychotherapeutic treatment.

Exposure techniques and risk of re-traumatization (part of treatment, learning to cope helps with re-narrative process.

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

Typical therapist aims in psychotherapeutic treatment of trauma.

In trauma-focused psychotherapies, patients who focus on a particular event often go through stages. In this lecture, 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 following Table.

Liquidation = desensitization (contemporary language)

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

Within psychotherapy treatment, then the task is to establish a safe relationship between patient and therapist. Once a trusting relationship has been established, psychotherapy treatment may proceed with the following 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 primary 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 and 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 summary of literature on the association between factors in the therapeutic relationship and positive outcome 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 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 a “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 (from Laska paper, referenced below, as a quote from Bordin paper–do we need to reference Bordinas well? (Bordin, 1979–looking for this reference)
    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 bond (the degree of mutual respect and trust and understanding).”
    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.
    a. 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 non-verbal communication
    b. Discuss ways you have created, or have felt that others created space for emotional experiencing
    c. Write down reasons why 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 clips from Rogers, 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 (eg, attending to subtle emotional cues, self-awareness, self-regulation in difficult session, 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 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 2: Why is the Therapeutic Relationship Important?

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

Why is the Therapeutic Relationship Important in all Psychotherapy Approaches? The Therapy Relationship as both the “facilitating environment” and the “active ingredient” in change. Main message: In an effective psychotherapy, the patient discovers that feelings that seemed intolerable or overwhelming can be safely experienced and understood in the context of the therapeutic relationship. This allows for greater self-acceptance, self-understanding, and confidence in dealing with the unpredictability of life and relationships.

1. Begin with exercise reflecting on how Carl Rogers and Fritz Perls respectively engage with Gloria to create a therapeutic space. (Other favorite clips can be used as well)
2. How has the “Therapeutic Space” been defined and described
    a. “container” (Bion)
    b. “holding environment” (Winnicott)
3. What happens in this “holding environment?”
    a. Trusting the relationship enough to be spontaneous, truthful
    b. To allow emotions to arise
    c. To tolerate uncomfortable feelings
    d. To experience feelings, memories, impulses that, under normal circumstances, we hide or deny
4. This allows for identification of old, maladaptive, and childlike patterns of relationship to be expressed in a non-judgmental space
5. The therapist response allows the patient to experience different consequences of expressing these feelings, thoughts, and impulses, than in the past
    a. Elaborate on allowing new experiences, safety
6. This allows the patient to recognize new, more intentional, and more mature ways of dealing with old, immature, and maladaptive patterns of relating to self and other
7. Open Discussion is 7a more suited to session 3?
    a. How does a therapist feel during therapy?
    b. What do a therapist and a patient do together in any therapy?
    c. How does a patient feel during therapy?
8. Home Practice:
    a. Can you practice “playing catch” (serve and return) with a patient, even outside of a psychotherapy?
        i. Insert description here
    b. Can you facilitate a process of safe discovery with a patient, using this exercise?
        i. This week, look for moments in your clinical encounters when a patient avoids a topic, changes the subject, or disrupts the interaction with angry or distracting behavior. Notice what happened before the “avoidance” behavior. It can be as inconspicuous as self-reassurance that does not seem genuine (“But that’s alright”). Or it can be as clear as someone saying, “I never talk about that.”

Explore whether you can encourage the patient to return to whatever experience was avoided, and whether the patient can safely approach what was being avoided. Can your empathic validation (eg. “I can imagine how painful that was”) give the patient permission to experience feelings that seemed forbidden or overwhelming in earlier relationships?

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)*

How do we create a therapeutic relationship? (What Skills do we need to develop and practice?) Non-judgmental 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, opening up more things, not shutting it 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. Integrate this into the outline 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. Non-judgmental 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
            1. Insert definition of mentalization here
        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 (eg 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 following skills, which can be
        i. Written on a white board for the class to reflect on
        ii. Or suggested/identified by the teacher if needed

For more on mindfulness: from 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.
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, reflect, while keeping our own feelings within a range that does not overwhelm our capacity for self-reflection and cognitive processing
4. Non-judgmental 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 experience 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 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, in touch with real emotions in the relationships, 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 “re-indoctrinating” 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 (one, through assigned practice of “positive opposite behavior”).

7. Home Practice: Bring in example of using Awareness of /attunement to self and other; or regulation of affect in self or other, during a clinical encounter.
8. Alan’s suggestions for practice: potential assignment 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?

9. Possible additional assignments:

Before the next session, try practicing mindfulness of your internal emotional state while alone, with another person, or in a group.
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:

a. Asking questions that build the therapeutic alliance
   i. Clarify/explain this more– using questions to explore areas of meaning and relevance to the treatment goals?
   ii. 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 than 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 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. What the therapist is doing is to try 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, that 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 about communication in groups, you may review the systems module.

Rait, Douglas. J Clin Psychol . 2000 Feb;56(2):211-24

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 importance of 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, 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 (relate to Systems Unit? Trauma unit?)
        i. "Transference," "conditioning," habitual behaviors, child-like ways of solving problems, or other "non-denominational" 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, religious similarities and differences in pt-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 (eg 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 (non-verbal 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 non-judgmentally
    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 towards the patient during ruptures, and discussing with supervisors or colleagues
    a. Exploring therapist's role non-defensively

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