MODULE 1–Introduction

Vignette #1

Common factors in the ED

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

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

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

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

1. How do the common factors of *positive regard* and *acceptance* help in building a therapeutic alliance when a patient is unwilling to disclose the index trauma event? What techniques could the psychiatrist use to express *positive regard* and *acceptance*?

2. How is *offering hope* beneficial when working with patients in crisis? The presence of which factors make *offering hope* more effective?

3. What clinical and community resources could be helpful to this patient? How could you use your knowledge of common factors to help educate or reassure the patient about what to expect in future treatment settings?

4. How can you use the therapeutic alliance to assess safety issues such as current domestic violence, suicidal ideation, etc. in a patient who may be reluctant to reveal these issues?

MODULE 2–Neuroscience

Vignette #1

Inpatient

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

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

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

1. How do the physiological changes caused by stress affect lupus?

2. How do attachment styles affect information processing in patients facing illness?

> Avoidantly attached persons tend to defensively suppress social emotions through top-down prefrontal deactivation, even when just asked to observe their feelings (The neural substrates of social emotion perception and regulation are modulated by adult attachment style - https://doi.org/10.1080/17470919.2011.647410). Also note epigenetic suppression of oxytocin receptor gene.

3. How could you use your understanding of the neurobiology of attachment to help the patient, family, physician understand why they are having difficulties with agreeing on a treatment plan?

4. How do you use your understanding of the neurobiology of threat processing to help calm down the stress responses that the participants here are having? What deactivation strategies can you use?

Vignette #2

Outpatient Clinic

A 25-year-old female seeks treatment for social anxiety disorder. She reports that she is

increasingly socially withdrawn out of fear of harsh judgements. Nonetheless, she feels lonely and wants this to change.

1. From a predictive processing framework, what is the maladaptive prediction? How does the patient's social withdrawal play a role in maintaining certainty in the prediction?

2. Prediction errors can prompt revision of predictions through extinction or memory reconsolidation. How can this idea guide psychotherapy?

MODULE 3–Attachment

Vignette #1

Psychopharm consultation for postpartum depression

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

1. In addition to reviewing sx of depression and response to medication, what other questions do you want to ask this mother?

2. How might Ms. C's depression impact her infant's attachment relationship? How might that type of attachment be related to the concerns noted about the child's development?

3. What services might be of benefit to her?

4. What interventions and resources could be of benefit to the baby?

Reference: Lyons-Ruth, Karlen; Connell, David B.; Crunebaum, Henry U.; and Botein, Sheila. *Infants at Social Risk: Maternal Depression and Family Support Services as Mediators of Infant Development and Security of Attachment.* Child Development, 1990, 61, 85–98.

Vignette #2

Couples Therapy

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

They argue frequently about their very different approaches. Mr. Thomas, a successful corporate lawyer, prides himself on his self-reliance. He grew up with a father who worked long hours and was rarely home, and a mother who was drinking made her an unreliable caregiver. He feels that his children benefit from having the freedom to learn from their own mistakes during their teenage years: after all, they are getting much more help and guidance than he ever got. Ms. Miller grew up with a single mother who had recurrent depression. Her mother could be a warm and loving presence, who became emotionally distant and irritable when

depressed. Ms. Miller struggles with anxiety, which she tries to manage by close monitoring and control of her children's behavior, in order to "keep them safe."

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

1. As the therapist for this couple, how does your understanding of their childhood attachment experiences help you to make sense of their current conflict?

2. How might a better understanding of these different styles help the couple to recognize their maladaptive responses and explore new ways of interacting?

MODULE 4–Systems Theory

Vignette #1

Inpatient Adolescent Unit

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

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

Key Considerations:

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

1. What is the best way to support parents who are in a state of emotional exhaustion and fear when their child is in crisis?

2. How can a family genogram that focuses on patterns of depression, loss, or addiction help you understand the biopsychosocial factors that led to Emily's suicide attempt?

3. What role might cultural or school-related pressures have played in Emily's sense of despair and isolation?

Vignette #2

Community Setting

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

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

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

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

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

1. How does the family's shared history of strained relationships prevent them from working together effectively now?

2. How does the healthcare system, including staff and structured communication, play a role in assisting the family to move patients between different levels of care?

3. Emotional Support: How can non-judgmental listening techniques help family members cope with their grief, fear, and conflicting emotions as they navigate the difficult decisions around end-of-life care?

Vignette #3

Professional Training

A psychiatry residency process group is made up of 8 PGY-3 residents and their faculty process group leader, Dr. Campbell. During one group session, the resident members talk about being upset about something going on in their residency program; they feel that their program director did not give them needed information regarding upcoming changes in the call requirements for the coming year. During the session, they make disparaging comments about Dr. Campbell, but they do not address her directly.

1. If you were the group leader, Dr. Campbell, how would you address the comments being made about her in the group?

2. How might the group think about the parallels between what might be happening in the group space and what might be happening outside in the larger residency space?

MODULE 5–Trauma

Vignette #1

VA PTSD Clinic

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

1. What steps would you take?

Other questions:

2. Was his trauma repressed or dissociated?
3. Was his trauma encoded in memory at all?

Vignette #2

Legal System

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

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

1. What are some of the factors contributing to Koa's current clinical presentation?

2. What are some steps you can take in providing trauma informed and culturally compassionate care for Koa?

3. What kind of community and educational resources should you consider referring Koa to?

MODULE 6–Formulation

Vignette #1

Pediatric Consultation Service

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

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

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

Questions:

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

Vignette #2

Outpatient Psychotherapy

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

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

Questions:

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

MODULE 7–Interpersonal Skills

Vignette #1

Outpatient Psychotherapy

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

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

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

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

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

1. How did the therapist's interpersonal stance contribute to Carlos feeling reassured and supported during the session, and what specific techniques were used to strengthen the therapeutic alliance?

2. In the context of the vignette, how did the therapeutic relationship facilitate Carlos' exploration of his concerns about restlessness, and why is this collaborative process crucial for maintaining a strong affective bond between the therapist and patient?