Psychotherapy Guidelines

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Version of 6/29/2026

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Why Should Someone Who Can Be a “Prescriber” Learn Psychotherapy?

If you are trained as a “prescriber”: Let’s review 6 reasons to learn about psychotherapy even though the marketplace currently wants MDs and NPs to be “prescribers.”

1. So you will know when not to prescribe or when to deprescribe: e.g. when there are psychotherapeutic methods that can work as well as or better than pharmacological methods without long term problems.

Many of the most prevalent psychiatric conditions can respond well to psychotherapy, without incurring the problems of sometimes encountered with meds; among these conditions are anxiety, depression, insomnia, anger control, and post-traumatic stress. Probably at least 80% of outpatients have at least one of these.

Of course, there are problems where psychotherapy isn’t as effective, e.g. dementia, acute psychosis, acute mania, acute alcohol withdrawal… Psychotherapy doesn’t tend to reduce the core symptoms of ADHD, but the comorbidities of ADHD (including the 5 conditions I listed above) can be as important as, or more important than, the core symptoms. It’s important to note that many people who have a condition responsive to psychotherapy either can’t or won’t participate in psychotherapy.

Among the most commonly prescribed psychotropic drugs are the SSRIs and the antipsychotics. Most antipsychotic prescriptions are not for psychosis. The benzodiazepines are still prescribed often. With all these, the evidence for efficacy is based on short term randomized controlled trials; the evidence for continuing efficacy over decades is more problematic, and the evidence for dependency and withdrawal effects, oppositional tolerance, homeostatic counterregulation, is accumulating. This could be the subject of a very long session in itself.

2. The ability to discriminate effective from ineffective approaches. So you will know how psychotherapy should be done, so that if you are the prescriber and someone else is the therapist, you aren’t under the impression that “psychotherapy has been tried and doesn’t work,” versus “this particular therapist is ill-informed.”

3. So that you can maximize the mental health impact of even fairly brief encounters as a prescriber. A study reanalyzed a trial of imipramine versus placebo. “The proportion of variance in the BDI scores due to medication was 3.4% ($p < .05$), while the proportion of variance in BDI scores due to psychiatrists was 9.1% ($p < .05$).” Presumably, the interpersonal skills and psychotherapeutic efficacy of the different prescribers made the difference. (To read this study see McKay et al., 2006, Psychiatrist effects in the psychopharmacological treatment of depression, Journal of Affective Disorders.)

4. Psychotherapy is really trying to impart to people the art of living well. How to live well, and how to impart the ability to do so to people, are the supreme questions for humanity, throughout the ages.

Answers to these questions, if implemented, would solve most of the world's problems. You get to spend your time on the most worthwhile of questions.

5. You can, if you want, be primarily a psychotherapist and not a prescriber despite the marketplace. This is particularly easy if you're in private practice. You can be one of the increasingly rare but desirable psychiatrists who provide integrated treatment, letting the ample behavioral sample you get during therapy inform medication decisions.

6. We're on the cusp of the AI revolution. Prescribing psychotropic meds is an algorithmic enterprise, and books of psychopharmacology algorithms have been produced and are useful. Probably a much larger portion of psychopharm is replaceable by AI than psychotherapy is. At this point, AI can make some pretty glaring errors, but I would be surprised if even at this stage of the game it loaded people up with polypharmacy the way a good number of human prescribers do. It is possible that within a decade, AI can equal the most competent prescribers, limited only by the research information available and whether it can all get into the AI databases. (For an imperfect analogy, to my knowledge, no human chess player has ever beaten Stockfish 18 or comparable engines.) On the other hand, generating the psychopharmacology research information that determines the algorithms, and the research ideas, according to my guess will be much more difficult to replace by a machine.

Nonspecific, or relationship aspects of therapy

You're probably familiar with the research finding that the quality of the therapeutic alliance and the relationship between therapist and patient is a very strong predictor of therapeutic success. I think sometimes therapists use this idea as an excuse for thinking that all they have to do is to be nice to the patient and they'll do just as well as if they gained expertise in specific methods. In my observation that's not true. People can like their therapist and go for many, many sessions without getting better. Part of having a good relationship with the patient entails being able to present to the patient a logical, plausible course of action that will help the patient get better, and that's the goal of almost everything written about therapy, including the rest of this booklet.

But I want to mention two of the "nonspecific" relationship-building skills at the outset. One is awareness of your own tones of voice. Your facial expressions will often go along with your tones of voice, in expressing one of these:

Large approval or enthusiasm
Small to moderate approval or enthusiasm
Neutral
Disapproval

One activity is to listen to someone say various phrases, and classify what you hear coming across in the tones of voice.
Another is to have someone give you a phrase and a degree of approval, or pick them yourself, and see how well you can say the phrase with the specified degree.

A second nonspecific skill is doing empathic reflections, paraphrasing what you understand the patient to be communicating, to make sure you got it right, and more importantly, to let the patient know you got it. People can learn to do reflections quickly, especially if you give them a prompt like, “What I hear you saying is ___.” But to do them really well is not an easy skill at all. It entails very focused concentration on what the other person is saying, and encapsulating the most important part of it in your reflection, in the most helpful way possible. In Appendix 1 of this booklet, there’s a sample dialogue where someone speaks and someone else does reflections. One way to use this is just to pick the better reflection. Another way to use this is to hear or read the speaker’s utterance, and then come up with your own reflection, and then compare it to the reflections given. Think to yourself, how does the one I came up with compare with the ones that are supplied?

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There are three parts to the rest of this. First is getting clear on goals and how to achieve them, for both you and the patient. Second is getting familiar with a bunch of exercises that help achieve these goals. And third is being familiar with the big ideas behind a variety of psychotherapeutic orientations and techniques.

Part 1: Getting Goals and Structure into Psychotherapy

Directionlessness versus goal-orientation

Sometimes psychotherapy is conducted in a way that feels directionless. The patient comes in and tells about the problems that are present and what’s going on in their life. The therapist listens, asks some questions, maybe makes some comments or suggestions, and the session ends. This gets repeated. The topics depend on what’s on the patient’s mind each time. There may or may not be continuity from one session to the next. The patient may or may not enjoy having someone to talk with. But it’s often unclear that anything is being accomplished. Both therapist and patient may eventually get the feeling that they are floundering.

A remedy to this is goal-orientation: figuring out what therapy is trying to do, delineating that specifically, tailoring the methods used specifically toward those goals, and monitoring progress toward those goals throughout therapy.

Transforming complaints, symptoms, and diagnoses into “to do more often” goals

Eliciting a chief complaint and a problem list are things you’ve been doing ever since you started clinical work. Inquiring about symptoms and designating one or more syndrome-oriented diagnoses are activities you’re very familiar with, and I won’t go over that. These are pretty readily translatable into goal statements. There’s a difference, though: complaints and problems and diagnoses are usually things you want to get rid of, whereas usually the most useful goal statements are positive outcomes you’d like to create, or positive things you’d like to do more often. So if a complaint is “I feel so depressed,” a follow-up question might be, “Can you envision what you would be doing or thinking or feeling more often if your depressed feeling were totally gone?” And an eventual restatement in terms of things to do more often might be, “So, you’d like to be able to feel really good about your own good

choices and the good things other people do, and feel lots more energy and motivation to do fun or useful things." If a problem is "I have so much anxiety around people – I just stay away from people because of that." An eventual translation into a goal statement might be, "You'd like to be able to socialize with people in a way that's tolerable, even fun, for you, and for the other people, is that right?" From behaviorism we know that it's more effective to reinforce desirable behaviors than to focus only on getting rid of negative ones, because it's much easier to use positive reinforcement for that strategy.

Let's do a very quick translation exercise. Please translate each of these into a statement of the positive outcome the patient might like to see, and ask the patient if that goal statement is accurate.
1. Suppose the patient says, "I can't control my temper. I just have these angry outbursts, and regret them later. I particularly lose it when anybody criticizes me, even a little."
2. Suppose the patient says, "I'm addicted to goofing off online. I waste huge amounts of time scrolling around and accomplishing nothing."
3. Suppose the patient says, "The people I hang out with make me screw up. It seems like they think of nothing but smoking weed and doing cocaine or meth if they can get it."

Another way of inquiring about goals involves getting a happiness rating from the patient. On a scale of 0 to 10, where 0 is totally miserable, and 10 is getting tremendous enjoyment from life, and 5 is neutral, where the good and bad balance each other, what's the average happiness been over the last couple of weeks? If the patient gives a low rating (or really anything under 10): What do you imagine would cause the happiness rating to go up? If the patient lists changes in the external world, like I would win the lottery or the people in my life would act better, acknowledging and validating that response while following up with: Any changes in your own habits or ways of reacting that you can imagine making the happiness rating go up?

A similar method is to ask the patient to envision that they are living the best possible life. What would it look like? What would they be doing? What would be going on? How would they be acting or thinking differently? Are there any of those changes that the person would like to bring about in this real life?

Goal-oriented reframes

We can formalize a type of utterance used to translate complaints into goals, and call it goal-oriented reframes. The patient says, "X is a problem," and the therapist responds, "Shall we put solving problem X on our goals list?" If the patient is willing to do this, something very important has happened: A complaint about oneself, someone else, or a situation has been transformed into a goal for improvement of one's handling of it.

Sometimes the patient does not want to adopt a goal. For example, a special case occurs when the patient complains about someone else's behavior, but does not want to adopt any goal having to do with deciding how to respond to it or think about it or tolerate it or avoid it – the patient feels that they are doing everything they can and it's the other person who needs to change, not them. In that case, there may come a time (consciously chosen by the therapist) for the therapist to say something like, "Of course, I can't change the other person's behavior; the one who can learn some improved way of thinking, feeling, or behaving in this therapy is you. Nonetheless, if you want to talk about your dissatisfaction, we can see if that turns out to be helpful for you."

We've done a tiny bit of practice at goal oriented reframes in translating the three complaints earlier. For more practice, see Appendix 2. There are two ways of using this. You can just answer the question, which of the therapist's responses is a goal oriented reframe and which is a reflection. Or, you can read the speaker's utterance, make up a reflection, and make up a goal oriented reframe, and then compare what you make up to the examples given.

After a goal-oriented reframe, what?

The goal-oriented reframe is not just a one and done utterance. There's a whole possible sequence of events around it. These don't all have to happen immediately. And sometimes they don't have to happen at all.

1. The patient complains about something or other – situation, self, or other person. This ___ is bad.

2. Therapist makes a goal oriented reframe: It's sounding like you'd like to handle ___ situation in ___ way more often, is that right? Should we consider it a goal to decide what to do about ____? Do I understand that you'd like to figure out how to make this different result occur? Or more tentatively: Should we consider adopting a goal of improving that situation?

3. Patient agrees to the possibility that this is a goal.

4. Therapist writes down the possible goal.

5. Therapist and patient **celebrate** that the goal has been set, on the grounds that setting a goal is the first and often the most important step in accomplishing it.

6. Therapist asks: Why would you want to achieve this goal? What would be the advantages? If this were accomplished, would your life satisfaction rating go up? If you visualize having accomplished this, does that vision feel good, feel like life is better? The list of reasons to accomplish the goal has been called the internal sales pitch. Or if there is ambivalence, you can discuss pros and cons. If the patient decides this isn't a goal they want to work at, you reflect that and officially cross it off the list (for now at least).

7. Therapist and patient keep referring back to the written goals list, brainstorming ways of accomplishing the goals, celebrating any steps in the right direction. One option: celebrate any steps that promote progress toward goals at the beginning of each session, and at the end of each session, brainstorm ways of making progress between now and the next session. And in the middle of the session, therapist watches out for any thoughts or ideas that can promote progress toward goals, and reinforces them. Another option: periodically rate each of the goals on the list on a scale from 0% of the way to the goal (no progress) to 100% of the way toward the goal (complete progress). Use that monitoring to decide whether to keep on with current strategy or go back to the drawing board and think of different strategies.

The pathway from downer statements to celebrations: "Bad me, I have this bad habit of responding to a certain situation" → "Hooray, I've adopted a goal to improve my habit of responding to that situation."

"Bad other, they do this thing I don't like" → "Hooray, I've adopted a goal of making the best possible choices about how to deal with the other person." (Avoid them? Use differential reinforcement to change them? Use assertion? Rule of law? Conflict resolution paradigm? …)

“Bad circumstances, I am the victim of bad luck” → “Hooray, I’ve adopted the goal of making the best possible choices on how to play the unfortunate hand I’ve been dealt.”

“Bad whatever” → “Hooray, I’ve adopted the goal of heightening my attention to the good whatevers.”

What is psychotherapy for? Two or three overarching goals

In the course of establishing goals, we have overarching goals, and then we have subsidiary goals to help reach those, and others to help reach those, in a sort of branching tree. I find it useful to simply tell people what I think the overarching, central goals are, rather than asking them to reinvent the wheel. Almost always, any goals that have already been formed can readily be seen as bearing on these overarching goals. I tell people that I have two big goals in working with everyone I work with: first, that they have a happy life, and second, that they help other people lead a happy life. Two of the factors that come out when we look at bunches of psychiatric symptoms are internalizing and externalizing – problems that make you unhappy are internalizing, and those that make others unhappy are externalizing. If we think of the opposites of these, we get the two big goals: the happiness and well-being of oneself, and that of the others one affects.

These two goals find expression in lots of philosophical and religious treatises. “Love thy neighbor as thyself” appeared in the book of Leviticus several centuries BCE. A similar statement attributed to Mohammed in about the 6th or 7th century CE is “None of you truly believes until he loves for his brother what he loves for himself.” Hillel said, “If I’m not for myself, who will be; if I’m only for myself, what am I?” in about the first century BCE. Lao Tsu a few centuries BCE said the same idea a little more obliquely: “If you want to awaken all of humanity, then awaken all of yourself… The greatest gift you have to give is that of your own self-transformation.” John Stuart Mill, in *Utilitarianism*, Chapter 2, said, “The happiness which forms the utilitarian standard… is not the agent’s own happiness alone, but that of all concerned.” Peter Singer, in 2009, wrote “Living an ethical life is not a sacrifice; it is a fulfillment.”

There are times when these two goals are in conflict with one another, when people clash with each other in competitive, zero-sum games. But very much of the time, these goals are in synergy. When one is making others happy, they tend to get feedback from others that feels good. When they are feeling good, they have more energy to put into enhancing the happiness of others than when they are feeling really bad. For this reason, internalizing symptoms and externalizing symptoms tend to be correlated with each other, and several empirical studies have documented this.

But I often add a third important goal: Using patience and fortitude and problem-solving when the first two goals aren’t working out. Why is this important? So people don’t just think, I’m unhappy, I’m making the people I affect mad at me rather than happy, therefore there’s no point to existence. Achieving these goals can take time, and you often need to tough out a lot of discomfort and misery on the way to happiness of self and others. I think of the story of Nelson Mandela, who became president of South Africa, helped end apartheid there, and was awarded the Nobel Peace Prize. I think he was pretty happy about all this. But before that he had to endure 27 years in prison.

I tend to tell patients at the beginning of treatment that these are the goals I always work for on behalf of patients. More specific goals that people form, such as ending panic attacks, reducing self-punishment, not discounting but celebrating their accomplishments, improving relationships, developing healthier habits, getting over compulsions, getting over an addiction, and so forth, can almost always be seen as in the service of these goals. One of the most important tasks at the beginning of therapy is deciding which subsidiary goals will promote the overarching goals best.

"Socializing to the model": Teaching patients about how psychotherapy can work

Here are some default ideas patients have about how therapy works, each which has a little bit of truth:

1. Talk therapy. If I (as patient) talk enough, either something really good will come of that, or the therapist will figure out something really important that can fix things. My job is just to talk.

2. Catharsis? (Venting anger usually does *not* reduce anger! The strategy of "Get it out by expressing it" is NOT recommended if you want less intense anger. On the other hand, being able to talk about topics previously forbidden by shame (often a very emotional experience) can permit problem-solving previously stymied – and lead to #6 below.)

3. Therapist as hired friend. Someone nice. Someone to support me. (I think this wish by the patient should usually eventually be transformed into the goal of the patient's finding a non-hired friend to both support and be supported by.)

4. If I could only figure out why. Why do I, why does someone else… The answer will make it very clear how to solve the problems (I hope).

5. Therapist as personal advice columnist: Get help with particular decisions, from an objective or wiser person.

The idea I think is most useful is the following:

6. Psychotherapy works by learning psychological skills. This means, how to respond "better" to some important classes of situations you face in life. (*Better* is defined as more conducive to happiness of self and others affected. And the learning is more general than what do I do in this situation; it is applicable to classes of situations. For example, anger control training applies to the whole class of provocations or anger triggers.) The adaptive patterns learned can be called psychological skills. Emotional regulation, conflict resolution, courage, decision-making, are examples of psychological skills – many more are listed in Appendices 3 and 4!

Stages of therapy, simplified

We can think of three stages, which (like most stages of most processes) can overlap:

Insight: What am I doing (thinking, feeling)? What are the problematic situations? What are my problematic responses?

Redecision: What would I like to be doing more often, less often? What would I like to do instead of the problematic responses?

Practice: Rehearsal of the desirable patterns, to the point where they become the "prepotent" or automatic responses. This can take lots of repetition. A very important fact, supported by a mountain of evidence, is that rehearsal in fantasy can be very effective at developing habit strength, just as rehearsal in real life can. Fantasy rehearsal is usually much more convenient to carry out, and often more pleasant, than real life or in vivo rehearsal.

Goal-setting via the psychological skills axis

How does one produce happiness in self and others? There are certain psychological skills that aid greatly in the process. Being able to relax, to tolerate frustration, to be appropriately assertive, do have fun social conversation, to feel good about your accomplishments and kind acts, to have a bunch of kind acts in your repertoire, to think before acting, to be rational rather than overly pugnacious in conflict-resolution or joint decision-making, to use self-discipline, to focus effort on tasks long enough, and so forth. Making up your mind to get better at one or more of these, getting clearly in mind what the positive examples are of the skills, and celebrating and feeling good each time one does a positive example is a great way to make progress in therapy, and in life.

I spent a long time reading and thinking and trying to generate a list of what these skills are – the answer to the question, what skills tend to make people mentally healthy? There are 16 groups of them, totaling 62 skills in all. In Appendices 3 and 4 are questionnaires where people can answer two questions: How skilled are you in this one? And how much would you like to get better at this one? There's one questionnaire for the long version and one for the short version.

This isn't a perfect assessment device. The unschooled patient may not have much of a grasp of what some of these mean. They may need a lot more time contemplating which skills would make their life better and which they want to work at. One option worth strongly considering is to give it to the person but ask them ***not*** to fill it out, but instead to think about these questions or even to write notes on them, or to tell you about each one of them. Only after some self-examination is the person really ready to answer these. Even if the patient never fills it out, you can use it as an aid to your own thinking about the patient.

Goal-setting through generalization from patient's narratives. There's another way of arriving at psychological skills goals, that doesn't depend so much on the patient's already being insightful. You can listen to the patient describe their reactions to life circumstances, and you ask yourself, "Which skill would have let the patient handle this better?" If the answer repeatedly comes, "They would have been much better off if they'd had a higher degree of X skill," then you can make a "skills axis diagnosis": getting better at that skill should be a goal of therapy. For example, if you hear vignette after vignette where the patient flew off the handle when criticized, you infer that the skill of handling criticism would make the patient's life better. If you hear examples where when relationships start to get close, the patient feels very threatened and cancels the relationship, you infer that handling closeness in relationships is a skill on the to do list. You can share such reasoning with the patient when you think the patient is ready for it, at a "teachable moment."

The goal of general increase in psychological skills. Having spoken about skills axis diagnosis, and having thought about it for decades, it does seem to me that lasering in on one particular group of psychological skills to work on, while celebrating strengths in the others, is just what many people need, particularly rather successful people who come to therapy. However, for the population as a whole, strengths and weaknesses in psychological skills tend to be pretty highly correlated with one another – those with significant weaknesses in some tend to also be weak in others. This of course is found with syndromal diagnosis as well: the people who have any one diagnosis tend to have others – comorbidity is so rampant that some researchers have argued for a single dimension of psychopathology. (See Caspi et al., 2023, The General Factor of Psychopathology….) This argues for not putting a huge premium on figuring out which skills are most deficient, but launching into broad-based overall skills training. In particular, it argues for celebration of positive examples in any of the skill areas, because there's hardly any psychological skill whose improvement won't contribute to making things better. The advantage of broad based goal setting is that you can proclaim with total honesty that all human beings can benefit from work on all psychological skills, and people don't need to label themselves as having deficiencies, or at least not as being more deficient than others.

Goal-setting through the twelve thought categorization

Cognitive behavior therapists are familiar with lists of cognitive distortions – all or none thinking, jumping to conclusions, mental filter, discounting the positive, etc. Appendix 5 in this booklet lists these and gives examples of these. These are definitely worth pondering. The problem with using them is that they tell how not to think but don't supply a menu for what to think.

The 12 thought categorization, and the 12 thought exercise, are meant to remedy this problem. These are presented in Appendix 6. If you use these with some of your patients, I think you'll find them beneficial. Let's go through the types of thoughts.

Awfulizing, getting down on yourself, and blaming someone else are the triad that acknowledge the badness of something. Awfulizing is telling oneself that a situation, past, present, or future, is really bad or dangerous or undesirable. Getting down on myself is telling myself that my own behaviors or even my self is bad in some way. Blaming someone else is telling myself that someone else's behaviors, or they as a whole are bad. Sometimes each of these is true and it's adaptive to acknowledge the truth. But overdoing or overgeneralizing these tend to get people in lots of trouble. Oh no, this is horrible, what's going to happen is horrendous, obviously creates anxiety; I did something horrible, I'm worthless, create guilt, shame, depression; and that person is bad through and through creates anger and hate.

However: There is such a thing as appropriate use of these three, using them without overgeneralizing or overdoing them. Uh oh, I'm in danger. Oops, I made a mistake, I screwed up. That person is trying to exploit or even endanger me. These types of thoughts are of great survival value and of great value in identifying problems to be solved. So even these first three, the overdoing of which cause such problems, are not something we want to get rid of altogether.

The second three help us to tone down the first three. They are not just the absence of the first three, but active decisions not to overdo the first three. Not awfulizing thoughts are things like, I can handle this, this isn't the end of the world, this may be a pain in the neck but it won't defeat me. Not getting down on myself thoughts are like, I may have made a mistake, but I don't want to punish myself too

much. Not blaming someone else can be like, I don't like what they did, but I have more productive things to do than to keep going over in my mind how bad they are.

The third set of three are logical decision making. Goal-setting: This is the answer to, what do I want to accomplish? What outcome do I want to work toward? What is, or is not, my job description in this situation? Listing options and choosing, which also includes predicting consequences and weighing pros and cons: This is the rational decision making process. And learning from the experience: What, if anything, can I log away from this experience that will help me in dealing with future ones?

The fourth set is celebrating, acknowledging the positive parts of life, the thoughts that tend to generate positive affect. Celebrating luck: It's lucky that this happened, I'm blessed. Celebrating someone else's choice: Someone else did something good, they deserve my gratitude. Celebrating my own choice: I did something good, I deserve to pat myself on the back and feel proud of myself.

Some people are aware, right out of the starting blocks, of the relative frequency with which they think these various thoughts. They can tell you, I get down on myself many times a day; I celebrate my own choice almost never. But with many other people, it's good to give them a questionnaire such as that in Appendix 6, but ask them **not** to fill it out yet. Instead, see if they are willing to take on the homework or "action plan" assignment of observing their own self-talk. With some other people, they need to practice putting thoughts into words before they can even classify their thoughts. But after these steps, sometimes with the therapist's help they can figure out that life would be better with a different frequency distribution. Appendix 6 asks people to rate how often one presently thinks in a certain way, and how often one would desire to. Their being able to come to an informed decision about this is very celebration-worthy, something they hopefully can feel very good about, before they even start to alter the frequency of thoughts. When they are ready for it, Appendix 7 shows a way of making a picture for them of what is going on and what is desired. This sort of picture can be created with very few steps in any spreadsheet program – Excel, Google Sheets, Libreoffice Calc. (If you want to know what to click to get the bar graphe, AI is good at telling you.) Such a picture, and the understandings that go with it, can provide an orienting framework for cognitive therapy.

There are two ways of practicing thought revision. One is "on the spot": when you are actually in the situation that you are responding to. The second is "after the fact": when the situation has passed, and you look back on it, re-imagine it, and practice the desirable thought patterns for the sake of future situations that will resemble this. Thought revision on the spot is great if one can do it, but often times the after the fact rehearsal gets you a bigger return: When you're out of the heat of the moment and you have more time to ponder, your "redecision" comes up with a better response. Even more importantly, you can practice the improved response repeatedly.

The shaping paradigm

Shaping is a term coined by B.F. Skinner to refer to the process of reinforcing successive approximations to goals. Shaping has been the central idea of animal training, ever since Skinner's work in the mid twentieth century. But in my opinion, the idea has been underutilized in people-training.

There are an interpersonal version and an intrapersonal version of shaping. In the interpersonal version, one person watches for movements the other makes in the direction of the goal, and reinforces them,

especially through social reinforcement – acknowledging the positive steps. In the intrapersonal version, people observe themselves for steps in the right direction, and use self-reinforcement through the cognitions I've called celebrating your own choice.

Here's an example of the use of intrapersonal shaping. Someone presents with work block, particularly regarding writing. When observing self-talk, the person discovers themselves saying things like, "That's a stupid sentence. That sounds ridiculous. I'll just humiliate myself by writing that." The person, after learning about shaping, shifts to self-talk like, "Hooray, I'm making progress! Every thing I put down gets me closer to my goal. I can always revise later. I don't have to do everything at once. Just getting down something that reminds me of the idea I want to polish later is celebration-worthy!" The writing process is much freer and more pleasant with the revised self-talk.

The written goals list and encouragement of wishing. The process of psychotherapy can make use of both interpersonal and intrapersonal shaping. The therapist uses the methods we've talked about to make a goals list for the patient. The therapist prints these out on paper, or sends them electronically to the patient. There's a Grimm's fairy tale (The Frog Prince) that starts out, "In olden days, when wishing still made things happen…." The therapist explains that just wishing to be able to accomplish the goals is a helpful and celebration-worthy activity: wishing does tend to make good stuff happen, when what one is wishing for is one's own mobilization of psychological skills – what we pay attention to, work at, try hard at, think carefully about. I think of this as the true analogue of the fairy tale fiction. The therapist recommends that the patient look at the goals list daily and wish for their accomplishment, and let the mind be open to ideas about how to accomplish them.

The process of wishing is greatly aided by what I've called the internal sales pitch. What are the reasons why I want to accomplish this? How would my life be improved? It's good to generate this jointly and to write it down for the patient to refer to.

When the patient arrives for a session, the therapist displays the list of goals, on paper or screen. Two of the first questions in a session can be, "Any progress on any of these to report? Anything you've done to try to produce some progress?" If the patient can report any, you celebrate together. If not, one of the agenda items for that session, or one coming up very soon, is to generate a list of ideas about how to make progress. What are the important situational choice points? What are the behaviors, thoughts, or feelings that can be rehearsed in real life or fantasy, that will move toward goal attainment?

The first or second time you ask the questions, the patient may not have an answer, and it's good not to make the expectations too high. In fact, you might want to say, "I want to get into the habit of asking this, even though I'm not expecting you to be able to report a bunch of triumphs in this regard, right out of the starting blocks. But I think you'll find, you'll come up with more and more ways of making progress, if you keep looking for them." But over time, the patient can get used to watching for the celebration-worthy bits of steps toward the goals, and remember them so as to be able to celebrate them with the therapist.

If the patient just does "talk therapy" and does a lot of talking about what's going on in their life, the therapist can still listen carefully for any utterances that are transformable into goal statements, are examples of progress toward goals, or are positive examples of any psychological skills. If necessary,

the therapist interrupts the talk to celebrate and bookmark these positive steps with the patient. The therapist is looking for “successive approximations” to reinforce, using the shaping strategy.

Near the end of the session, the therapist and patient can brainstorm on the question: what are some ways to make progress on any of these goals between now and next session? An all-purpose way of making progress is figuring out patterns of thought, emotion, or behavior that the patient can fantasy rehearse. Brainstorming ways of making progress toward goals can help therapist and patient decide on action plans or homework to do between sessions.

Dealing with obstacles to goal attainment

Attendance, lateness, appointment-keeping problems. Can you educate about the skill of appointment-keeping and not just give consequences? Appendix 8 is a psychoeducational handout about the skill of appointment-keeping. You can go over this with the patient if you want to try educational versus punitive approaches to appointment-keeping.

Talk without ceasing: Can you help the patient realize this is not the "model" of how it works? Can you arrange an agreed-upon signal for “Please give me a turn to speak”?

Non-doing of homework or “action plans”: Can you explore in non-blaming, motivating way, and if that doesn't work, shift the work to in-session time?

Argumentativeness, "Why don't you, yes but...", “Here's why that won't work”: Can you put the ball in the patient's court? Some ways to to this: Acknowledging that every idea has some cons to it, task is to pick which idea the pro/con balance is greatest. Acknowledging yes, it's possible nothing will work but this is hard to predict without trying. Proposing experiments. Major reason things don't work is they aren't implemented, or that they are given up on too soon. If the patient is completely convinced nothing will solve the particular problem, perhaps we should move to a different topic.

Patient appears to mistrust or be angry at therapist on basis of experience with past relationships (other therapists, parents, others): Can this hypothesis be talked about openly?

Needs to set limits with patients. The following will come up sooner or later; plan how you’ll handle them: sessions running overtime, phone calls from patient in distress, wishes for letters supporting accommodations, wanting to eat, drink, and spill during sessions; not wanting sessions at sufficient frequency for benefit; wish for therapist to conduct treatment via text or email; non-payment of bills; expectation for therapist's attendance at events outside of therapy such as graduations; wanting appointments only at very restricted times; family member presenting not wanting therapy, but under duress from another family member; showing up for appointments with infectious illnesses; patient proposing sexual or romantic activity with therapist; showing up under influence of drugs of abuse or alcohol; communicating suicidal intent and refusing to be hospitalized; speaking very softly and indistinctly....

Part 2: The Concept of Psychological Skills Exercises

If one wants to be successful at basketball, tennis, piano, chess, typing, dancing, surgery, or any other skill, it is obvious that repetitive practice is necessary. (It's estimated that Steph Curry has taken over 3 million practices, during his life, not counting games, at throwing a basketball into a hoop; I believe that he does not count the misses!)

If we conceive of mental health as a set of skills, as listed in Appendices 3 and 4, the idea of devising and encouraging exercises for practice of these skills is an obvious, even inescapable, one.

I think that each of the exercises discussed below is good for improving therapeutic technique, as well as for helping the patient to live better. In other words, if therapist and patient both work on these, perhaps even conceptualize themselves as working on them together, that can give structure and direction to therapy.

You're invited to take a look at 2 books I've written on psychological skills exercises, available in full text on josephstrayhornmd.com.

The Celebrations Exercise

I mentioned earlier that for almost all problems for which people present for therapy, positive examples, which I often refer to as triumphs, in any of the psychological skills can be thought of as steps toward progress.

In the celebrations exercise, therapist and patient take turns in narrating a concrete answer to the question, "What have you done that you're glad you did?" In other words, what's one of your choices that you can celebrate? After narrating the positive example, they decide together which skills it's an example of.

In the version of this I find most useful, the therapist purposely uses self-disclosure, by going first with a positive example. This models for the patient how to come up with examples. The therapist models being concrete rather than vague, using examples that are mundane and not intimate self-disclosure. I like to say, it doesn't need to be the time you won the Nobel Peace Prize. For example: there was a person delivering a pizza who had some trouble finding the place, because the GPS directions weren't good enough; I did some problem-solving with the person to help find the place they were looking for. (Kindness, good decisions) Someone on a train needed to lift a heavy bag down from a rack; I asked them if they would like me to get it for them and when they said yes, I did. (kindness) This morning there were some dirty dishes in my sink; I took a few minutes and washed them and put them in the drying rack. (Productivity) I was at a party, and I introduced myself to someone I hadn't known, and had a nice chat with them. (Friendship-building) I was looking at interesting stuff on the Internet, but decided to quit and go to bed so I would get enough sleep. (Self-discipline). I had an appointment and got stood up, but I kept cool; I used my time well while waiting and didn't speak rudely to the person. (Fortitude, respectful talk). Some delivery people got into the parking lot of my apartment and couldn't get out; I chatted with them just long enough to decide they weren't up to anything bad and opened the gate with my app so they could get out. (Good decisions, kindness.)

A variant of this, in addition to celebrating your own choices, is to celebrate luck and other people's choices as well.

It's been my experience that in a turn-taking exercise like this, it's remarkable how people who are feeling very depressed or anxious can manage to come up with very surprisingly good celebrations, things I never would have heard about and that they might have filtered out of consciousness.

If someone, be they patient or not, can get into the habit of approaching life by grabbing the opportunities to do positive examples of psychological skills when they occur, and celebrating and feeling good about these, this is a game that one can play every day of life, to great benefit.

What if the person can't think of anything, in their whole life, that they're glad they did? First of all you make a note of this condition of mental filter, or poor divergent thinking, or whatever, as a problem that will be extremely celebration-worthy to solve! But then you can plunge into the "celebrations interview" with the patient. Have you ever in your life brushed your teeth? A self-care celebration! Have you ever done any schoolwork? Productivity! Ever taken out any trash? Even walked over to a trash can rather than leaving trash on the floor? More productivity! Have you ever said thank you to anyone in your life? Respectful talk! Did you ever feel mad at anyone but not try to hurt them? Nonviolence! Have you ever wanted something, and not gotten it, without freaking out and having a meltdown? Fortitude! Ever done anything to help someone with anything? Kindness! (You don't need to go through all these, but can stop as soon as you have one, and proclaim the exercise a success for the day!)

Tones of voice

This exercise is very useful for therapists. It's also useful particularly for patients who want to improve social relationships. Various studies have found that patients' feelings of rapport, having a good relationship, feeling understood, etc. are more predictive of positive outcome than therapeutic orientation. One element of relationship-building is the therapist's tones of voice. There are all sorts of dimensions to what is conveyed by tone of voice. There's an energy dimension, a curiosity dimension, enthusiasm, approval, optimism, confidence….

Tones of voice can say lots of different things. For example:

I'm tired and burned out, and I wish you weren't burdening me with this.

Versus:

It's great that people have figured out learning-based ways of getting problems better. We rejoice at any progress we make. We rejoice even at making steps toward a plausible plan for making progress. We put energy into this. We're enthusiastic about the enterprise. We have a default position of positive regard (although it may not be unconditional).

There are some forms of therapy that teach that the therapist should not be reinforcing, should not be a cheerleader for the patient, that this fails to support the patient's autonomy and self-reinforcement capacity. I don't adhere to that idea, believing instead that interpersonal reinforcement increases rather

than decreases self-reinforcement capacity. But even for those who value neutrality, attending to tones of voice should be helpful in achieving their goal.

Discriminating degrees of enthusiasm or approval

Let's simplify all those dimensions I mentioned a few seconds ago, and just think in terms of 3 degrees of enthusiasm or approval:

Neutral
Small to moderate enthusiasm/approval
Large enthusiasm/approval

And, of course, there are tones of disapproval, which are fairly seldom indicated.
I am NOT telling you to say everything with large enthusiasm. I'm just advising you to be aware of the tones of voice that you use. If I were pinned down, I'd say having a baseline of small to moderate enthusiasm and deviating upward or downward from there works best in the type of therapy I do. Here are some sentences that can provide practice in discriminating these degrees of enthusiasm/approval:

Hi Ms. Jones; I'm glad to meet you.
Have a seat, if you please.
I'm very much hoping I can be of help to you.
Can you tell me about yourself, please?
OK, I see. Please tell me more.
Do you have thoughts about anything you would like to get better at, more skilled at, as a result of your therapy experience?
So, that's something you've already figured out. That sounds like an important insight.
If I understand you right, improving relationships is a very important goal for you.

Producing different degrees of approval/enthusiasm

Here are some shorter utterances that are useful in practicing producing different degrees of approval/enthusiasm:

Congrats to you.
You really worked hard.
How did you come up with that idea?
You're talking about something important.
Forming a goal is the first step in achieving it.
Let's add that to our goals list.
It wasn't easy, but you did it anyway.

What's the takeaway from this to the conduct of therapy? Just to be conscious of your tones of voice and use them in the way you want to use them. In particular, if you do believe that a major mechanism by which therapy works is encouraging the patient to go out and do psychologically skillful behaviors,

that foster goal-attainment, and then come and report those to the therapist and celebrate together, let your tones of voice be celebratory. If you want not to portray an incongruous upbeat cheerful mood when the patient is grieving, (a much less likely problem) that's another of the many circumstances where your own awareness of your tones of voice will help you.

Reflections

Without getting into a review of a large literature, the quality of the therapeutic alliance is a major predictor of positive outcomes of therapy. And schools of thought that give the most attention to cultivating that are often offshoots of Rogerian Therapy, named after Carl Rogers, which Rogers called client-centered therapy and since has been renamed person-centered or person-centered-experiential therapy. This sort of work has also been called nondirective therapy, since it very much emphasizes empathic reflections, or paraphrases of what the client is communicating. Contrary to what some people believe, outcome research, writing, thinking, and meta-analyses on person-centered therapy are ongoing. Positive outcomes are being reported; in some studies it has stood up well when compared with CBT. Another school of thought greatly emphasizing empathic reflections is motivational interviewing. And finally, there are several types of parenting training methods and couples and family therapeutic methods that have relied very strongly upon training the therapy clients themselves to use reflections with each other. It is a kind, caring thing to focus your attention single-mindedly upon understanding what some other person is saying, and to check out your understanding. It feels good to have someone do a reflection, where you think, "You nailed it, you were really paying attention, and you understood me!"

I've found it easier to teach people (including both adults and fairly young children) to do reflections if I give the first part of the sentence and let them finish it with the reflection. Here are prompts I've used:

So you're saying ____?
What I hear you saying is _____.
In other words, _____?
So if I understand you right, _____?
It sounds like _____.
Are you saying that _____?
You're saying that _____?

Reflections of feeling:
It sounds like you felt ____ when that happened.
You felt ____ about that?
If I understand you right, you're feeling ___ right now...

What's the difference between high quality person-centered therapy that performs well in meta-analyses, and supportive therapy that is used in lieu of a no treatment control group and doesn't do as well? One difference is that in the high quality therapy, people do "good reflections." People can learn the mechanics of doing reflections quickly, but learning to do them really well is an art that takes time. In the "reflections exercise," one person talks, stopping frequently, and each time, the other does a reflection.

For an exercise, Which reflection do you think is better, see Appendix 1.

Listening with four responses

If a listener, either in therapy or real life, does a reflection after every single utterance of the other person, that comes across as very unusual. On the other hand, if the listener mixes in reflections with 3 other types of responses, they just sound like a good listener. Teaching people the “listening with four responses” exercise can be a very useful social skills training module. One person talks, and stops frequently; the other responds in one of the 4 ways each time. Here are the 4 responses:

Reflections
Follow-up questions e.g. What happened next? Tell me more, please. What was your response to that?
Facilitations (the name given to utterances like um-hmm, I see, OK, yes, humh, Oh? Right…)
Positive feedback: Good point. I’m glad you’re talking about this. Congrats, it’s great that you were able to do that! You worked hard, and your work paid off!

The twelve thought exercise

In the twelve thought exercise, you take any situation, bad, good, or indifferent, and make up thoughts about the situation that are examples of each one of these twelve ways of thinking. The situation does not need to be one you’re facing or have faced in the past – in fact, at the beginning, it’s often better if the situation is obviously for the sake of an exercise rather than derived from current life.

Here’s an example. Situation: I played a game of chess with my friend, and I lost.
Awfulizing: Oh no, this is really bad, I hate getting beat!
Getting down on self: I made some stupid mistakes.
Blaming someone else: My opponent looks so smug and conceited, that jerk.
Not awfulizing: This was only a game, after all.
Not getting down on myself: Every chess player makes blunders; it won’t do any good to punish myself.
Not blaming someone else: My opponent feels good about winning, just as I would have if I’d won. That’s not a sin, it’s just normal.
Goal-setting: I want to keep a good relationship with my friend. I want to improve my chess game.
Listing options and choosing: I can congratulate my friend. I can suggest that we go outside and take a walk, or shoot some hoops, or just hang out and have a chat. I think I’ll congratulate, and see what my friend wants to do.
Learning from the experience: I left my king and queen where my opponent could fork them with his knight. I learned to watch out for that situation.
Celebrating luck: I’m glad I have the chance to play and socialize rather than having to scrounge for money or food all the time like some people do.
Celebrating someone else’s choice: I’m glad my friend chose to be with me.
Celebrating my own choice: I’m glad I was a good sport and a good host.

Here’s another example. Situation: I put on a singing and guitar performance that people really like. I did a great job, except for being a bit off pitch on two or three notes.
Awfulizing: When I was off pitch, that sounded disgusting. People probably hated it.
Getting down on myself: I should have practiced more. I was not prepared enough.

Blaming someone else: Those audience members probably are so spoiled, they feel entitled to a perfect performance.
Not awfulizing: No real performance has every pitch perfect; it's not the end of the world.
Not getting down on myself: I practiced enough. I have had other things to do with my time.
Not blaming someone else: If some people in the audience didn't enjoy this, that's OK. Everyone has their own taste. And lots of people did enjoy it.
Goal-setting: I want to give myself credit for a good performance. I want to continue to improve.
Listing options and choosing: I can celebrate the positive parts of my performance. I can invest in the equipment that feeds back your pitch so I can get better and better at it. I can record my practices and listen to them to give myself feedback. I'll pick the first and the third.
Learning from the experience: I learned that people can really enjoy a performance that isn't totally perfect.
Celebrating luck: I'm glad I got to put this performance on, and I'm glad I even have the luxury of doing music, unlike lots of people in the world.
Celebrating someone else's choice: I'm glad that people clapped and smiled and said nice things to me. I feel grateful to the people who taught me to make music and encouraged me to perform.
Celebrating my own choice: I'm glad for all the parts of the performance that were done really well, and that overall it was a big success. I'm glad I chose not to get too perfectionistic, but to look on the bright side.

What's the purpose of this exercise? It's to develop cognitive flexibility. To do it, if you've been in a rut of thinking about situations in certain reflex habitual ways, you have to get out of that rut. Doing it is meant to give you a fuller repertoire of options, so that you can consciously or unconsciously select, more often, the type of self-talk that will be most useful in whatever situation you're in.

The four thought exercise

In real life, when you're in a situation, it takes too long to go through all twelve thoughts consciously and select the best ones. The four thought exercise is meant to cultivate a default reflex for handling unwanted situations in real life – those that would provoke great anger or anxiety or hopelessness. This exercise is meant to help remedy problems of emotional dysregulation. The four thoughts are a subset of the twelve.

Not awfulizing: I can handle this.
Goal setting: Here's the desired outcome of this situation.
Listing options and choosing: Here are various options … here's the one I think will work best.
Celebrating your own choice: Hooray, I made the best choice I knew how to make. (Not necessarily the best possible choice an omniscient being would make.)

For someone with anger control problems or anxiety, it's very useful for therapist and patient to refer to a list of trigger situations and take turns generating the four thoughts with these, one after the other. You can find such lists of situations to practice with in appendices of books I've written on anger control and anxiety reduction, available in full text at josephstrayhornmd.com.

Brainstorming options

If you are working with problems of emotional dysregulation, i.e. quick descents into maladaptively great fear, anger, or hopelessness, and you want one of the simplest possible exercises to remedy this, the brainstorming options exercise has lots of empirical evidence behind it. (See Chang, E.C., Social Problem Solving, Theory, Research and Training, 2004.) This is of course part of the 12 thought exercise, the four thought exercise, and the Dr. L.W. Aap exercise to be discussed later. Just the very act of thinking, here's one option for responding, OR I could do this instead, probably activates the cortical regions of the brain that are capable of modulating the limbic system's output and modulating the resulting sympathetic nervous system activation. (See Cogdell-Brooke et al., 2020, A meta-analysis of functional magnetic resonance imaging studies of divergent thinking using activation likelihood estimation. Human Brain Mapping) The way I like to do this is by taking turns with the patient, generating options, and after enough have been generated, thinking for just a bit about which one strikes us as best. For hypothetical choice points, where you're mainly focusing on the skill of option-generating, the picking of the best option can be a quick afterthought; for real choice points, prediction of consequences, thinking of pros and cons, figuring out how to get more information, and so forth expand the option selection process.

The decision-making paradigm

Just listing more than one option gets many people more into rational decision-making than they usually get. But if they really want to make a careful decision, they can go through the following steps:
Situation: They fully describe the situation they want to make a choice about, trying to figure out the relevant aspects of it to notice.
Objective-formation: They formulate what they are trying to do. For example, in a confrontation situation, are they trying to teach the other person a lesson, or to avoid losing face, or just to make sure no one gets hurt?
Information-seeking: They get information that might help with the decision.
Listing options: They list options for what to do.
Advantages and disadvantages: They predict consequences of the options worth considering; positive consequences are advantages, and negative consequences are disadvantages.
Deciding: They weigh the advantages and disadvantages (pros and cons) and choose which option, or set of them, is best.
Doing: They actually enact the options they have chosen.
Learning from experience: When they see the result of their decision, they learn from the experience for future decision-making.
This can be remembered by the mnemonic SOIL ADDLE.
I mentioned earlier the patients who have the "advice column" approach to therapy. Sometimes such individuals can be taught the skill of decision-making so they don't need to delegate it to you. Please see proverb that starts, "If you give a person a fish…"

The divergent thinking exercise

This helps prepare for brainstorming options and listing pros and cons, which are subsets of this. There's a question with many possible answers; two people take turns generating possibilities. Examples of questions: Someone forgot something. What did they forget? Someone is scared. What are

they scared of? Someone is proud of themselves; what did they do? Someone had lunch; what did they have?

The shaping game

This can be done with adults as well as children, particularly if you first explain the point of it to the adult: to pratice the shaping paradigm, which is so central to both intrapsychic and interpersonal health. The “shaper” thinks of a behavior that can be done in the room, and writes it down. The “shapee” starts doing things at random. The goal for both is that the shapee will do the behavior. (It’s a cooperative rather than competitive game.) The only way the shaper can give clues is by reinforcing something the shapee has already done. For example – “I’m glad you walked in that direction. Great that you turned a little that way. I like that you’re looking at things on the table. Hey, you picked one of the things on the table! You did it, it was to pick up that book off the table!”
Fantasy: how would the world be different if every dyad within families were expert at the shaping game?

Skills stories

Like the celebrations exercise, only you can make up examples rather than remember them from your own performance.

Pros and cons

Some hypothetical person considers doing some option. You take turns listing either pros or cons, in favor or against doing that option.

Joint decision role-play (Dr. L.W. Aap)

You take a hypothetical conflict or joint decision, and role play it, trying to meet 7 criteria: 1. Defining the problem from your point of view without accusing or bossing. 2. Reflecting to check your understanding of the other person’s point of view. 3. Listing options for plans. 4. Waiting until the listing is finished before critiquing the options. 5. Advantages and disadvantages of options are discussed (not the bad points of the other person). 6. Agreement on something is reached, if only to table the issue. 7. Politeness prevails during the whole discussion. These 7 can be remembered by the mnemonic Dr. L.W. Aap. A challenge is for someone to play both parts. Can you get 14 points, where each person in the dialogue meets all 7 criteria? (Imaginary utopia: people practice rational conflict resolution for even a tenth of a percent as much as Steph Curry has practiced shooting baskets.)

STEBC fantasy rehearsals

For an important type of situation, you imagine yourself in the situation, doing the thoughts, emotions, and behaviors you would most like to do. The C at the end is for celebrating your own choice.
Important variant: With therapist’s collaboration, you write out these rehearsals, and the patient reads them daily. Variant: For a given situation, you make up both a mastery rehearsal and a coping rehearsal. Mastery and miracle begin with the same letter – you imagine that by a miracle, you can handle the

situation with no distress or fear, with confidence, just the way you've carefully decided is best. In a coping rehearsal, you imagine that there is a SUD level but you handle the situation well anyway, and feel good about your courage in tolerating the SUD. Both are useful: mastery rehearsals because this where you want to eventually get to, and coping rehearsals because you are unlikely to be able to jump to that place without some SUDs intervening and you don't want to be thrown off by experiencing unexpected negative feelings.

The loving-kindness meditation

You make wishes: May I become the best I can become. May I give and receive kindness. May I live in compassion and peace. Then you wish the same for one person after another. You may be able to extend such wishing to people you don't like, or to groups, or to humanity as a whole. This apparently originated in Buddhist practice. (See previous brief discussion about wishing actually changing things.) (For a study finding that loving-kindness meditation appears to slow the shortening of telomeres associated with aging, see Nguyen et al. 2019, Loving-kindness meditation slows biological aging in novices…)

Reading handouts or books

Another psychological skills exercise is simply to read about how to do psychological skills, or models of them. If we accept the ideas that psychotherapy is largely about learning better ways of thinking, feeling, or behaving, and that reading is one way that people can learn, it makes sense to make available to patients things to read about whatever they can benefit from learning. The literature on the effectiveness of "bibliotherapy," that is, giving people psychological self-help materials to study, is actually impressive, although my strong suspicion is that the people recruited to be in the studies are more literate than a good fraction of the patients you will see in the clinic. (See Pannu et al., 2025, The Efficacy of Bibliotherapy in Depression Management…) I find that if I ask patients whether they can learn and enjoy learning by reading, they are usually quite candid. For those who want to read as a supplement to the words of wisdom that come out of your mouth, there are a good number of handouts as well as full length books on josephstrayhornmd.com, all of which can be downloaded and used freely. Regarding depression, the books *Feeling Good* by David Burns and *Control Your Depression* by Peter Lewinsohn have been used in several bibliotherapy studies.

Part 3: Big Ideas Behind Various Therapeutic Methods

Psychoeducation

Mental health consists of a set of skills that make life better. Psychological skills are teachable and learnable by educational methods. The set of methods includes all ways that people influence one another, including objective formation, hierarchy, positive relationship, attribution, modeling, practice, reinforcement, instruction, stimulus control, monitoring progress. If we define learning broadly as a change in thought, feeling, or behavior due to experience, and we define skills broadly as patterns of responding, most psychotherapy can be conceived of, via such broad definitions, as skills learning, and thus as a subset of psychoeducation.

Assertion training and social skills training

The big idea of assertion training is finding a happy medium between always giving in and letting people take advantage of you at one end of a spectrum, and being aggressive with people on the other. Being able to state one's wishes without fear or anger is a goal of assertion training. Social skills training covers a wider array of social situations – how to do common rituals, how to conduct conversation, how to be a good listener, how to make invitations, and so forth.

Cognitive therapy: Thought revision

You can improve your life by choosing well what you say to yourself, your self-talk, as well as what mental images you present to yourself. Revising one's habits of self-talk can be life-changing.

To be a little less concise: We are constantly in situations, and we are responding with thoughts, emotions, and behaviors. Thoughts, emotions, and behaviors all influence each other. Changing any one of them for the better can help the other two. If we call a situation and its response with those three aspect a STEB (situation, thoughts, emotions, behaviors) then perceiving what the STEB is and changing some element of it for the better is what cognitive behavior therapy, and perhaps all therapy, are about. Bottom line "STEB and STEB revision" is a major agenda of therapy.

CBT: Behavioral activation therapy

There are two types of desirable actions: those that are fun in the moment, that directly make us happy to do, and those that foster some long term goal, that we are happy to have accomplished once we can check them off the to do list. We can improve life by figuring out which activities we want to do more often, doing them, and celebrating having done them.

CBT: Action plans (formerly known as homework)

The therapist and patient decide jointly on something the patient can do between sessions to make things better, preferably something that can be done every day. Translating thoughts into words, observing one's self-talk and the frequencies of different types, deciding on and carrying out behavioral activation plans, doing any of the exercises listed earlier, carrying out any decisions arrived at in sessions, just watching for ways of progressing on goals and enacting them, trying to do positive examples of any of the psychological skills, celebrating those examples and remembering some of them, doing fantasy rehearsals of any positive actions (including thoughts and feelings), doing behavioral experiments to try something and see if it meets your prediction of how it will be. Therapist checks as to whether it was done, how it went. If it isn't done, therapist and patient problem-solve.

The desensitization paradigm

This paradigm is extremely useful and very much tried and true. It should be strongly considered for all disorders where certain situations elicit an undesirably large amount of negative emotion. This applies to almost all problems with fear, anxiety, anger, aggression, emotional dysregulation, compulsions, some depressive disorders, and the comorbidities of many other primary diagnoses. This implies that desensitization is useful for a very large fraction of outpatients. Directions to patient: First, get to the point of insight where you realize that certain situations elicit more negative emotion than you want them to. The emotion classically spoken of regarding desensitization is fear, but it can also be anger, disgust, embarrassment, guilt, hopelessness, or any other aversive emotion. You learn and practice

relaxation skills, including muscle relaxation. Phase 1 of muscle relaxation is learning to tense and then muscle groups at will; phase 2 is learning to detect whatever tension is there and relax it without purposely tensing first. Several other relaxation strategies are described in various writings, including my book on anxiety reduction. It's important to practice relaxation when you are not in a scary or aversive situation – if you try to treat it only like a prn for negative feelings, it can become associated with these feelings and perhaps even invoke them. Short periods of practice, even a minute or two, are vastly more useful than 0 practice. Then, you list situations that evoke unrealistic or unwanted aversion in you. You rate how distressing each is on a scale of 0 to 10 or 0 to 100 (called the SUD level, Subjective Units of Distress). You seek to list situations low in SUD level as well as the higher ones, to reduce the painfulness of the process and make it more likely that you'll actually do it. Here are ways of coming up with low SUD situations: The fantasy is usually lower than real life exposure. Envision someone else in the situation. Envision that the person handling the situation does it with expertise and equanimity. Imagine the person handling the situation is seen on a video screen. Imagine that the screen is far from you. Imagine that the depiction is in an animated cartoon. You list the situations in order of easiest to hardest to handle – called a hierarchy. The situations can be described verbally or represented in pictures or even videos. Then, you start at the bottom of the hierarchy and practice responding to the situation, either in imagination or real life, while relaxing or doing something else desirable and adaptive. You give yourself enough time in the situation to get really used to it. You don't just passively endure "exposure" to the situations; you practice desirable thoughts and behaviors as responses to the situations. This is aided by the 12 thought categorization that you'll read about later on, and the decision making paradigm you'll also read about – you want to pick the most desirable thoughts and behaviors, and also enact the most desirable emotional response that you can. You celebrate every single success. You gradually work your way up the hierarchy. Err on the side of going up too slowly rather than too quickly. Try to avoid letting the SUD level get so high that you can't help escaping the situation. When that happens, the relief from the distress reinforces escape, so that the urge to escape is higher next time; the urge to escape is almost synonymous with fear. So escapes contingent on too high SUD levels can actually be counterproductive. Err on the side of doing very frequent practice. Keep track of SUD levels, but count both SUD reduction and the ability to handle situations despite a SUD level as two types of success, both of which are worth celebrating.

The operant behavior paradigm

Once you have decided upon behaviors you want to do more often, you try to have those behaviors followed by positive reinforcement. The reinforcers can range anywhere from getting someone else to give you something that is withheld, to letting yourself do a pleasant activity, to simply using positive self-talk with yourself (internal social reinforcement). You move along a hierarchy, from the easiest and simplest to hardest and most complex. Reinforcing successive steps toward a goal behavior is called shaping. Reinforcing the desired behaviors and non-reinforcing the undesired ones is differential reinforcement employed in a positive direction.

Psychodynamic therapy – the idea of defenses

There are various ways that people can defend themselves against bad feelings (repression, regression, projection, humor, sublimation, suppression, intellectualization, reaction formation, etc.) Some defenses are healthier than others – they distort reality less. You can improve your life by choosing healthier defenses.

Psychodynamic thinking – tripartite model

There's a part of us that automatically goes for immediate pleasure (the id); a part that has internalized rules and prohibitions and moral systems (the superego) and a part that makes rational calculations about what's best to do in the long term (the ego). It's good to have an id that is under control but that you don't attempt to suppress or deny totally; it's good to have a superego that is the basis of a conscience but is not too harsh on yourself; it's good to have an ego that can make rational decisions including about how to encourage or downregulate the other two parts. (A tripartite model of psychic structure with certain similarities was advanced by Eric Berne in the use of transactional analysis.)

Relaxation and biofeedback

Part of our emotional responses are physiological high or low arousal, particularly arousal of the sympathetic nervous system, the system responsible for the flight or fight response. We can learn to turn up or down our level of arousal. Devices that measure what's going on with us physiologically, like our heart rate, fingertip temperature, sweat gland output at the fingertips, muscle tension, and pattern of heart rate variability, can give us *biofeedback* that helps us learn to control the degree of arousal. The strategy is: play around (as contrasted to working extremely hard) to see what moves the parameters in either direction, and try to remember how you did it. But even without these measures, there are various techniques that we can use to learn to get into a relaxed state, when we want to. Muscle tension is under voluntary control, and can be sensed directly. Practicing tensing and relaxing muscles, and then practicing relaxing them without first tensing, are very useful exercises. Relaxation skills are very useful in reducing anxiety and anger. Other techniques include the loving kindness meditation, meditation with a mantra, and others.

Breathing retraining for panic

A large fraction of panic attacks are substantially worsened by hyperventilation. Breathing faster is an innate response to fear. A vicious cycle gets started when the brain, erring on the side of caution, mistakes the uncomfortable feeling of too low CO2 for too high CO2 – it thinks it's not getting enough air in and out when in fact the minute volume is too high. (Oxygen levels have nothing to do with all this, unless we're not dealing with garden variety hyperventilation but with asthma, pneumonia, anaphylaxis, pneumothorax, pulmonary edema, arrhythmia with low cardiac output, etc., that can sometimes mimic panic attacks.) As a result, a respiratory alkalosis can get created which is very uncomfortable and which can create panic disorder symptoms. It is helpful for patients to understand this physiology. Three exercises help them avoid the vicious cycle of hyperventilation. Exercise 1: 5 in and 5 out. You look at the seconds display on the stopwatch function of a cell phone, or some other timer. Start inhaling when the digit ends in zero; start exhaling when it ends in 5. A respiratory rate of 6 per minute appears to be close to optimal in aborting incipient hyperventilation. Exercise 2: Hold the breath and cure the hypercapnia. You hold the breath for a little while, until you feel the familiar feeling of air hunger or shortness of breath. As soon as it gets to be just a touch unpleasant, you breath naturally and cure the high CO2. Exercise 3: Hyperventilate and cure the hypocapnia. You take 5, 10, or 15 breaths as deep and fast as possible, with the number titrated to induce just a very slight feeling of lightheadedness. Then you cure that by taking a very slow breath – perhaps 15 or 20 seconds in and 15 or 20 seconds out. The relief of the slight discomfort reinforces the brain for slowing down breathing in response to the discriminative stimulus of the feeling that hypocapnia induces. Doing exercises 2 and 3 in succession is meant to teach the brain to discriminate the difference between hypercapnia and hypocapnia and to regulate the respiratory rate accordingly. Exercises 2 and 3 are to be done at times

not in the midst of a panic attack. Exercise 1 is the prn for incipient panic attacks, but also should be practiced many times when calm.

Logotherapy

Beyond needs for pleasure, power, attachment, and others, people need to feel a sense of meaningful purpose – that there is something worthy of their effort, something even worth suffering for. People need a sense of responsibility to someone or something beyond the self. Therapy can help the person to discover and commit to that purpose. Victor Frankl looked toward three avenues for this: work (service, contribution, creativity), relationships (love, connection, loyalty), and the stance toward unavoidable suffering. (He found meaning in the latter during time in concentration camps.) You may want to take a look at the Meaning and Purpose Scale on josephstrayhornmd.com. This is not designed to yield a sum with norms. Rather, it's meant to be a menu, an aid to finding sources of meaning and purpose and harnessing those sources that already exist. If a patient rates none of the items as sources of meaning, purpose, and direction, that's a condition in strong need of remediation.

Positive affect treatment

It may be possible to relieve anxiety and depression by the process of planning for, focusing on, and reveling in both the experiences and the cognitions that lead to positive emotions. (Much of this can be conceptualized as increasing the celebratory cognitions that I'll outline later as the last 3 thoughts of the 12 thought categorization, in combination with behavioral activation methods.) Some of the painful parts of therapy involving lots of focus on bad feelings and the situations that bring them out may be unnecessary.

ERP for compulsions

The situations that trigger compulsions --asymmetry, possibility of contamination, stopping counting on the wrong number, something not being "just right," having the urge to repeat something, having uncertainty about whether you did something harmful, feeling the urge to confess or get reassurance ... can be treated as if they were situations for which one is phobic, using the desensitization paradigm. Exposure and Ritual Prevention is another name for this, although for both anxiety and OCD, I resist the idea that the prime therapeutic ingredient is exposure. I believe that the therapeutic element in "exposure-based" treatments is rehearsal of more desirable responses to the situation you are being exposed to. By analogy: if you want to get better at piano, exposure to a piano (either in fantasy or real life) is necessary. But it's not sufficient – exposure to the piano permits you to practice responding to the piano more skillfully. Thus I'd vote to add another letter regarding compulsions, and make it ERPP: exposure, ritual prevention, and practice.

CBT for intrusive thoughts

The "white bear problem" is that the more intensely you try not to think of a certain image, such as that of a white bear, the more strongly the image persists and recurs. (The reference to white bears got started when Leo Tolstoy wrote about a childhood game of trying not to think about a white bear, in a semi-autobiographical fictional trilogy called *Childhood, Boyhood, Youth*. The original translator used the phrase "white bear" which is a literal translation of the Russian term for polar bears.) Intrusive thoughts tend to be of the sort people want to banish from consciousness – images of taboo acts of sexuality, aggressiveness, self-harm, committing disastrous social transgressions. You can avoid the "white bear problem" by directing your efforts, not toward getting them out of your mind, but toward celebrating the thought-behavior distinction, picking something good to do while the thoughts run their

course, and celebrating that you were able to enact a good choice despite the thoughts running in the background. You can practice this sequence in fantasy without going through the gory details of the intrusive thoughts. You are wanting to desensitize yourself to "getting unwanted images of taboo acts" rather than committing the taboo acts themselves. You're not aiming toward the goal of having zero SUD level associated with doing bad things. You're aiming to let the unpleasantness of the intrusive thought be enough, without generating additional SUD with thoughts like "I'm a horrible person for thinking this," or "Why can't I get this out of my head, it's so frustrating!!!" as contrasted with "Having OCD can be a pain in the neck sometimes, but I can handle it," in addition to the ones mentioned above.

Cognitive Processing Therapy for trauma

This is applying the fundamental idea of CBT, i.e. recognizing undesirable thoughts and revising them in a positive direction, as applied to thoughts about traumatic events and their results. Here are 5 domains examined, and one example for each of an automatic thought that is a candidate for revision. 1. Safety: The world is fundamentally unsafe. 2. Trust. People can't be trusted. 3. Power and control. I'm helpless and can't control anything. Or: I must control every little detail to keep bad things from happening. 4. Esteem: I'm damaged and defective. Or: Others are all cruel and selfish. 5. Intimacy: Closeness is dangerous. Possible revisions: 1. Safety: The world is sometimes unsafe, but there are safe places and people. 2. Trust: Some people certainly can't be trusted for anything. Most can be trusted for some but all things, and some can be trusted with just about everything. 3. Power and control. I can control some things and not others; may I develop the "wisdom to know the difference." 4. Esteem: Other people and I have our good and bad traits. The goal is to harness the good traits enough to have a good enough life. 5. Intimacy: Some people are to be avoided. Others I can have fun with but it's good to keep my distance. I may be able to find someone worthy of getting close and intimate with and if so, that is really fulfilling for both people.

Exposure therapy for trauma

This is essentially the application of the desensitization paradigm described above, as if the memories of the traumatic event and the current situations that are reminders have negative emotions attached to them that can be reduced, as if they were simple phobias. **Eye movement desensitization and reprocessing** and **trauma-focused CBT for children and adolescents** involve exposure. BUT there is much preparatory work – psychoeducation about trauma, training in relaxation, training in mental imagery of a safe place or safe person, training of family members in how to be supportive -- that builds the scaffolding for the exposure part. Going straight to "visualize the traumatic experience while watching my two fingers move back and forth" is NOT the way to do EMDR, nor is going straight to making stories or pictures depicting the traumatic event the way to do TF-CBT.

Dialectical Behavior Therapy as skills of getting to "wise mind"

"Wise mind" is an optimal blend of "logic mind" and "emotion mind." DBT was designed for treatment of borderline personality disorder, where the excess activation of emotion mind is almost always a problem. There are various ways of regulating emotion mind: practicing mindfulness, observing what is going on without judgment, choosing activities that tend to compete with unbridled emotion, using cold water on the face, intensely exercising, using paced breathing, listing options, listing pros and cons, getting enough sleep, getting enough exercise regularly in addition to prn, eating healthy food, avoiding recreational drugs, having a goal of distress tolerance rather than complete

absence of distress, cultivating interpersonal skills, practicing a gentle and easy manner; taking "opposite action" to maladaptive urges, and others.

DBT and Acceptance and Commitment Therapy on acceptance and change

It is possible both to accept (or at least avoid self-punishment for) how you are now, and simultaneously to work toward positive change. The idea that you can accept yourself as you are while working to become better is the “dialectic,” or seemingly opposed pair of ideas, in DBT.

Defocusing symptoms in ACT and logotherapy

Sometimes it’s very useful to “defocus” on the symptoms that define psychiatric disorders, in favor of focusing on: What are my values, and how can I take action in keeping with them, with or without symptoms?

Interpersonal therapy

A major area of focus is the nature of the patient’s interpersonal relationships. These tend to be examined in four arenas: grief, role transitions, conflicts, and interpersonal deficits. Examining specific interpersonal incidents is usually a major part of the agenda.

Family system as identified patient

The idea of this is that what insurance foists upon us is incorrect. That is: it’s often short sighted to view psychopathology as residing only within an individual, rather than also within an interacting system where people’s behaviors constantly influence one another. Often the system should be the target of change rather than just one individual within it.

Communication training for family intervention

The idea: Ways that people communicate with one another within a family system (or any other system of relationships) is often a crucial target of intervention. If people can learn to do “good” reflections, to listen with four responses as described earlier, to tell each other about their experiences (including ideas) in a pleasant and supportive way, then doing fun things together becomes much easier, because pleasant chatting makes almost everything more fun to do together. Pleasant conversation and “mutually gratifying activities” make it very much easier to resolve conflicts and make joint decisions together. Regarding joint decision making and conflict resolution, please see the Dr. L.W. Aap criteria discussed later in this handout. In learning to do joint decision making, it is usually much easier to start with hypothetical choice points that do not have a lot of emotion connected with them, and practice with these until the process has become fairly automatic. After this, gradually taking on more emotion-charged choice points forms the next steps – while continuing to pay attention to having fun together.

Appendix 1: Dialogue for Practice: Which Reflection Do You Think Is Better?

Talker: I would really love to be a lover of humanity; I really would. But then every time I turn around I hear of someone doing something horrible to someone else. It's enough to make me want to just retreat into a cave or something.

Listener:

A. You're hearing lots of bad news about people doing bad things.

B. You wish to be filled with love for your fellow human beings, but they always seem to spoil it by being cruel to each other.

Talker: I can't believe how smart people had to be to invent these nuclear bombs. Einstein and Oppenheimer and all those guys. If only they had been smart enough to figure out how to keep people from blowing each other up.

Listener:

A. You're impressed with how smart people have been in inventing weapons, but you wish that people had harnessed more intelligence in figuring out how to have peace, is that right?

B. It sounds like you fear that nuclear war will wipe out humanity, is that right?

Talker: And then we have all these guys who just get their assault rifles and go out and shoot a bunch of people up, for no good reason. People they don't even know! Accomplishing nothing! What is wrong with our society, that it keeps churning out people like this?

Listener:

A. You feel more than exasperated that so many mass shootings have sprung up, that have no possible rationale.

B. You really don't like it that people shoot people that they don't know.

Talker: Whenever there's one of these mass shootings, people always act so perplexed about it. But they aren't perplexed about the fact that most of the teenagers, the males at least in this country, seem to spend most of their existence playing shooter games. It's great fun for kids to do thousands of murders virtually, and then they are supposed to be revulsed at the idea of doing it in real life.

Listener:

A. You think that violent videogames are one of the causes of real life violence?

B. You sense a real disconnect, where people accept that fantasy violence is fun to do, but then people are surprised when someone actually does what they've practiced in fantasy.

Talker: I was reading that with the game, Halo, they somehow kept track of how many "kills" people made. Somebody figured out that in that game alone, there were more people killed in virtual reality than all the people who have ever lived.

Listener:

A. You're staggered and dismayed by the sheer quantity of fantasy practice of violence that is going on.

B. If I understand you right, there must have been billions of "kills" in Halo.

Talker: I'm not holding my breath for people to lose their fascination with violence in entertainment. They've probably been that way since stories were invented. But, back in Shakespeare's day when people watched all the main characters of Hamlet get killed, they had to hike to the theater and sit through a lot of talk first. Now all anyone has to do is press a button or flip a switch, and the body count beats that of Hamlet within a minute or two.

Listener:

A. You're pointing out that even in Hamlet and in lots of other stories that people have flocked to, centuries ago, there was lots of violence.

B. You're worried by the fact that although people have always been attracted to stories about violence, electronic media have made fantasy violence much easier to come by now.

Talker: I read an article that almost all Olympic athletes these days are using some sort of fantasy rehearsal to help them perform better – for example, ski jumpers and divers and gymnasts do their moves in imagination to practice. And people have gotten over fears of flying and other things by virtual exposure and practice. But then some people would have you believe that practicing killing people in fantasy has no effect at all.

Listener:

A. Sounds like it's very impressive to you how people have used fantasy rehearsal in sports and therapy.

B. On the one hand, you've seen lots of evidence that fantasy rehearsal has big effects, and on the other hand, you see people denying effects of fantasy rehearsal spurred by entertainment violence.

Talker: I read that Grand Theft Auto got into the Guinness Book of World Records for things like highest amount of money made by an entertainment product in a day. I read that Grand Theft Auto has sold around 500 million copies. On Youtube you can see clips of where in GTA, the player has simulated sex with a prostitute and then murders her to get the money back; the game incentivizes this. How sad for our society. I wonder if this one game does more harm than the good done by all nonviolence books put together.

Listener:

A. You find it extremely sad that people are doing such a huge quantity of fantasy rehearsal of very bad actions in games like GTA.

B. You're objecting to the depiction of interaction with prostitutes in Grand Theft Auto.

Talker: But there's more for me to rant about than just screens. Why is it that the murder rate here in the USA is so many times higher than it is in Singapore, Iceland, Japan, and many other countries? In those, almost nobody owns guns. Somebody will say, you can kill and hurt people with knives and clubs and fists and shoves, but guns make it much easier. Here in the USA there are more guns than there are people!

Listener:

A. You think that some other countries are doing better than we are in preventing murders.

B. You're very much aware of how many fewer murders there are in some countries where very few people have guns.

Talker: But then I saw that in Switzerland, a pretty high fraction of people have guns – not as many as in the USA – but their homicide rate is also a lot lower than ours. And the researcher said that the number one predictor of a country's homicide rate was the amount of income inequality plus poverty. There is not nearly the amount of that in Switzerland, or Singapore, or Japan, or Iceland, that there is here.

Listener:

A. So not only guns, but also the combination of income inequality and poverty is an important factor that your reading has alerted you to.

B. You're saying that guns couldn't be the whole story, because they have enough of them in Switzerland to be very violent, if they wanted to, huh?

Talker: Some friends of mine came to interview for a job at the same place I work, and they got held up at gunpoint, right in the parking garage. They decided to go to a different place to work! This city has lots and lots of poverty. I can't condone muggers of course, but I can understand how when people see that others have so much more than they do, it seems unfair, and it probably makes them very angry.

Listener:

A. Even though you hate violence, you can empathize with the people who are in poverty and seeing richer people around them.

B. You're saying that you had friends who were held up in the parking garage of your own workplace, and this must be very scary for you, thinking that the same could happen to you?

Talker: I read a book called *Savage Inequalities.* Lots of people say that if poor people would just work harder in school and spend more time studying, they could lift themselves out of poverty. But this book documented that because of the way schools are funded in this country, by local property taxes, schools in poor neighborhoods are themselves poor. Stuff is broken down, teachers don't have the equipment they need, there aren't enough personnel.

Listener:

A. So you're saying that schools in poor neighborhoods aren't funded well enough.

B. You're saying that even though education is held up as a solution to inequality, there's big inequality in schools themselves.

Talker: And then you have these people who think the answer to poverty and violence and everything else is to open up boxing training programs for kids. With that idea, I don't know whether to laugh or cry. The wrong-headed ideas that people can get into are just so upsetting.

Listener:

A. People think that boxing training programs are good for kids, but you disagree, and you feel very confident that you are correct in that opinion.

B. You disagree in the strongest way with the idea that training kids in boxing helps with poverty or violence.

Talker: People have known for decades that getting hit in the head is not good for the brain, right? And there's research now on football players as well as boxers getting very aggressive as a result of chronic traumatic encephalopathy. But with boxing and mixed martial arts, the sorts of blows to the head that would get someone charged with assault and battery anywhere else, help you win the so-called game. The one who can produce the most concussions is the best.

Listener:

A. You're making the points that brain injury is linked with aggression, and that brain injury is an object of the game with boxing and mixed martial arts.

B. You're saying that in football, as well as in boxing, people can get chronic traumatic encephalopathy.

Talker: It's not as though the effects of boxing on the brain are small ones, or that they're in doubt. A recent review I read found that about half of the boxers studied had abnormal cognitive performance, and about half had abnormal CTs or EEGs. The study concluded that more research should be done on headguards, because after all this time it's not clear whether they help. My conclusion is that there was enough evidence to outlaw this barbarian practice several decades ago.

Listener:

A. You think that government should get involved in whether boxing is permitted?

B. The evidence you've seen for brain injury seems very clear that boxing is harmful enough to brains that it should be banned.

Talker: And then there's the idea that boxing is a great way to get out your aggression, so that you drain off all the urge to hurt anybody. And there's even the idea that watching boxing, or other violence, drains off aggression from the spectators. I think one of the most momentous, but underrated and ignored, scientific achievements of the 20th century was the tremendous amount of research that really conclusively disproved the "catharsis" hypothesis. Because of this research, we know that you generally can't get aggression out of your system by pounding on something or watching people hurt each other. But the catharsis myth is still widely believed.

Listener:

A. You reject the idea that you get anger out of your system by watching or doing aggressive things.

B. You're aware of the large amount of great research disproving the catharsis hypothesis, but you're also aware of how ignored that work is.

Talker: But when I think about this topic, I'm not just depressed. I dream about ways to solve the violence problem, and fantasizing about that makes me hopeful and uplifted.

Listener:

A. With all there is about this topic that upsets and dismays you, you are able to maintain hope by dreaming of possible solutions.

B. It sounds like you think there is a solution to the problem of violence.

Talker: I see how good people get at basketball, or other sports, or playing music, by doing lots of practice. And I even manage to take hope from seeing how good they get at certain videogames by practicing things over and over. If we can only get people to very repetitively practice handling conflicts and criticisms and other provocations in rational ways, we can change the course of human history.

Listener:

A. You're pretty amazed to see how good people can get at basketball when they practice enough.

B. Your vision for ending violence involves lots of practice at nonviolent handling of the situations that trigger anger and aggression.

Talker: One of the big things that results in violence is conflict between people. What if people were trained to state what their own needs and wishes are, make sure they understand the other's needs and wishes, generate options for a solution, talk about the pros and cons of the options, and try to agree on a solution, all while being civil and polite to one another? What if they were taught how to do this and started practicing from a very early age, and continued throughout their education?

Listener:

A. Part of your vision is teaching people steps in conflict-resolution, and promoting practice of these, starting in childhood and continuing for years.

B. It sounds like you think lots of time should be devoted to teaching nonviolence in schools.

Talker: Another thing that triggers violence and aggression is when one person insults or criticizes another. Part of universal education could be a list of different possible nonviolent responses to criticism, and practicing generating them and picking among them for all sorts of different criticisms, again practicing the skill over and over.

Listener:

A. You think that people should be able to take criticism from others without getting too upset about it.

B. You envision teaching people options for responding to criticism, and having them repeatedly practice generating those and picking among them for lots of different critcisms.

Talker: And for any sort of situation that can made someone mad, and we can list hundreds of those, people can practice how to think about them: affirming that they can handle the situation, deciding on what outcomes are desired, listing options and rationally choosing what to do to bring about the desired outcome, and celebrating their making a thoughtful and nonviolent choice.

Listener:

A. You're saying that it's possible to list hundreds of situations that could make someone angry, because just about anything that people want, that they don't get, can make them angry.

B. You're envisioning people practicing several rational ways of thinking about situations that might trigger anger, and doing this with very many of the trigger situations.

Talker: What do kids need to practice the most in school? Reading and writing. How about if they read a bunch of models of the exercises I'm talking about, and then write a bunch of them? You don't need to stop doing academic work to practice nonviolence skills; you can practice nonviolence and practice reading or writing at the exact same time.

Listener:

A. What I hear you saying is that academic skills and nonviolence skills are not in competition with each other for time spent in schools, but you can practice both simultaneously.

B. If I understand you correctly, you feel that reading and writing are the most important academic skills that children need to get good at while they are in school?

Talker: I'm not naive enough to think that there's going to be large scale training in nonviolence skills from an early age any time soon, particularly in this country. But it's comforting to me just to believe that there is a way to reach a nonviolent society if enough people make up their minds that this is what they want.

Listener:

A. It sounds like you think other countries might be better suited for your vision than this one.

B. Even though you are not expecting a nonviolent society to arrive any time soon, it still feels good to believe that people can produce it if they can get motivated enough.

Talker: If the human species can ever get its act together to train people to be nonviolent, kind, and able to be friends with one another, from a very early age, I think the impact on mental health will be huge. So much of post-traumatic problems will be eradicated. Lots of anxiety will go away when people aren't fearing each other. People will be able to make each other happy by being friends with each other, and that will reduce depression tremendously. Even people with schizophrenia or bipolar disorder will have better outcomes if they can be in families or groups with positive emotional climates.

Listener:
A. Your vision is that teaching skills like nonviolence, kindness, and friendship-building from a very early age can have a huge positive impact on mental health.

B. You would like for skills training to produce a utopian society.

Appendix 2: Goal-oriented Reframes

Training Dialogue: Empathic Reflections and Goal-Oriented Reframes

When you hear or read the patient's utterance, please compose both an empathic reflection and a goal-oriented reframe, and compare what you generate with the examples given. Or: just notice which is the reflection and which is the goal-oriented reframe.

1. Patient:
I'm starting to see how hard I am on myself. I don't give myself any room to be human.

Therapist #1
You're noticing how harsh your inner voice can be. You are realizing how important self-criticism is in making you feel bad.

Therapist #2
It sounds like you're grasping how life might feel if your inner voice became more supportive, and that could be something you want to work toward; is it?

2. Patient:
By the time I get home, I'm completely wiped out. I don't have anything left for myself.

Therapist #1
It sounds like finding a way to recharge your battery, to replenish your energy stores, would make life lots better. Is that something you'd like to explore?

Therapist #2
You end the day feeling totally drained. You'd like to have energy for something fun or useful, but it's depleted.

3.
Patient:
I've been turning down invitations because I don't want people to see how off I've been.

Therapist #1:
You're keeping away from people because you don't feel like yourself. You feel embarrassed or ashamed for people to see you the way you are these days.

Therapist #2:
It sounds like being able to present yourself to people you care about, without needing to keep secret how you are doing, would be something you'd like to regain. Am I correct?

4.
Patient:
Everyone at work counts on me. If I slow down, I feel like everything will fall apart.

Therapist #1:
You feel a huge weight on your shoulders. You feel that the whole business may fail if you don't do enough.

Therapist #2:
You may want to carry that responsibility without feeling so stretched, or you may want to see if there can be changes so that not so much responsibility rests on you. Are either, or both of these, directions you may want to move in?

5.
Patient:
I almost talked to my sister about this problem, but I stopped myself. I didn’t want to add to her stress.

Therapist #1:
It sounds like finding a way to share with someone what’s going on—without feeling like you’re adding pressure—might be something you’d like to work toward.

Therapist #2:
You wanted to talk with someone about what was going on, but you held back from talking with your sister because you didn’t want to burden her.

6.
Patient:
Part of me wants to just escape the rat race, and take it easy, in a low-stress situation. But part of me keeps saying I should just push through it.

Therapist #1:
It sounds like you’re imagining a life where there's less pressure, either because of fewer external demands or because of a different internal attitude. Are either or both of those things you might want to work toward?

Therapist #2:
You’re caught between two strong impulses: one is to care for yourself, reduce your stress, and be well rested; the other is to work toward success, prevail over the difficulties, and not give up.

7.
Patient:
Things I used to enjoy just feel flat lately.

Therapist #1:
It sounds like reconnecting with a sense of enjoyment is something you’d like to move toward.

Therapist #2:
Activities that once felt meaningful or fun just don’t spark anything right now.

8.
Patient:
My coworker keeps interrupting me in meetings. It makes me feel like my input doesn’t matter.

Therapist #1:
It sounds like figuring out how to respond to this, either with respect to what you do about it, or what you think or feel about it, or both, might be something we should put on the to do list. What do you think?

Therapist #2
It’s really frustrating to feel talked over. And I imagine there's a pretty good degree of annoyance or anger about this.

9.
Patient:
I keep second-guessing every decision I make. Even small ones.

Therapist #1
You’re feeling unsure of yourself, as if you can't trust yourself to make the right choice.

Therapist #2:
Is building more trust in your own judgment something you’d like to move toward? Perhaps by improving the decision-making process itself, or perhaps by changing the "post-decision regret" habit?

10.
Patient:
When I try to tell my partner I’m overwhelmed, they jump straight into “solutions mode,” and it's not what I want at all. It's as though they think I'm incompetent.

Therapist #1:
It feels disparaging when your partner rushes to fix things. You would like to be heard out rather than directed.

Therapist #2:
That sounds frustrating and unpleasant. Would you like to put on our to do list exploring what to do about this? Perhaps working on the art of communicating to your partner what your wishes and needs are?

11.
Patient:
I keep telling myself I’ll start taking better care of myself “next week,” but next week never comes.

Therapist #1:
You’re imagining a version of your life where you consistently take care of yourself. Is that something you want to work toward?

Therapist #2:

It’s been hard to follow through on resolutions to take better care of yourself. You know what you want to do, but you find yourself putting it off.

12.
Patient:
My friend always cancels plans at the last minute. I’m tired of rearranging my schedule for them.

Therapist #1:
It’s irritating to raise your expectations about plans, only to have those expectations dashed. It sounds like this has happened repeatedly.

Therapist #2:
That sounds irritating. Would you like for us to put on the to do list exploring options for what to do about situations like this?

13.
Patient:
My supervisor keeps giving me vague feedback like “be more proactive,” but never tells me what that means.

Therapist #1:
It’s confusing to be told to improve without clear guidance. The abstract language implies you should do something differently without communicating what that might be.

Therapist #2:
It sounds like a situation that keeps recurring. Would you like to put “how to respond to vague directives” on our list of thing to ponder and work on?

14.
Patient:
I used to feel excited about my projects, but now everything feels like a chore.

Therapist #1:
You've lost enthusiasm about your work projects. What to do about this sounds like something important to decide upon and carry out. Should this be one of our goals?

Therapist #2:
You’re missing that spark of enthusiasm about your projects, and it sounds like how you feel now contrasts greatly with how you felt in the past, regarding similar projects; is that right?

15.
Patient:
My brother keeps asking me for favors, and I feel guilty saying no, even when I’m stretched thin.

Therapist #1:
You feel torn: on the one hand you feel guilty refusing your brother's requests for help, but on the other hand you have lots of other obligations, and you need your own time.

Therapist #2:
Figuring out what to do about this could involve various different options. Should we put decision-making regarding your brother's requests on our list of objectives? Or perhaps more generally, responding to people's requests, deciding when and how to say yes and no?

16.
Patient:
I'm realizing I expect myself to be perfect all the time. It's exhausting.

Therapist #1:
It seems like you might like to work toward easing those expectations and developing the skill of deciding when what you've done is good enough. What do you think?

Therapist #2:
You're saying that the quest for perfection doesn't let up. You're worn out from holding yourself to such high standards.

17.
Patient:
Every morning I walk into school feeling like something bad is going to happen. I know that sounds dramatic, but it's like the world is just… dangerous. It's mostly not physical danger -- fortunately my school is not the type where people are knifing each other or knocking each other out. But it's the danger of being rejected or disliked.

Therapist #1:
It's not physical danger, but social danger, that hangs over your head every school day. That must be very distracting and unpleasant.

Therapist #2:
It would be amazing if you could get a feeling of security and even fun in social relationships at school. Should we work toward that, with the idea that even a little progress is better than none?

18.
Patient:
And then teachers pile on all this work, like every assignment is life-or-death. I'm trying, but I don't even know if any of this stuff matters in real life.

Therapist #1:
You're facing a high volume of work that you question will ever pay off for you later on. Should we put on the goals list figuring out how to find motivation, or maybe to find more pleasure, in the work you're doing?

Therapist #2:
You're facing a stream of assignments that you have to somehow motivate yourself to do, even though you question whether there will ever be a payoff outside the school building. Is that right?

19.
Patient:
Everyone else seems to care about popularity and clothes and who’s dating who, and how good-looking people are. I want people to like me, but I don’t have the same values that most other kids have.

Therapist #1:
You want connection with people. But the superficial ways that people judge each other in your school, and perhaps elsewhere in our society, don't fit with your own values.

Therapist #2:
Sounds like life would be lots better with a support system where people respect each other based on higher values. Is that something you think is worth our exploring further, ways to try to get some approximation of it?

20.
Patient:
Sometimes I feel like I’m living in a different world than everyone else. They’re thinking about prom and I’m thinking about climate change.

Therapist #1:
You strongly value thinking and caring about the issues that are meaningful and important for humanity, which is very admirable. For you the downside, though, is that it brings on a sense of isolation from your classmates, is that right?

Therapist #2:
I'm very glad you bring up this sense of isolation. Shall we put on our list of objectives somehow reducing this, while still caring about the things you consider important? Exploring options and strategies for connecting without selling out your values?

21.
Patient:
I keep imagining myself stuck in some dead-end meaningless job forever because I couldn’t figure out how to make my life matter.

Therapist #1:
It's scary to imagine ending up in a future where you're just trying to make ends meet but not doing things that engage a sense of purpose, is that right?

Therapist #2:
Would you like to put on our agenda the task of planning toward a future where your efforts are aiming toward a purpose that you really care about?

22.
Patient:
My history teacher keeps acting like I’m a trouble-maker because I question the assignments. I just want to understand why we’re learning what we’re learning.

Therapist #1:
It’s frustrating to feel disapproved of for trying to make sense of the course and trying to make it more purposeful.

Therapist #2:
I'm glad you identify this problem. It's one where there may be a number of options for how to make things better. Should be put on our to do list exploring the situation more, and perhaps figuring out some strategies to try?

23.
Patient:
I want to do something that matters — like help the environment or work for peace — but I don’t even know where to start.

Therapist #1:
You’re longing to do things that fulfill your wish for purposeful and meaningful effort, but how to find those activities or what steps to take to get into them is a mystery.

Therapist #2:
Perhaps exploring both how to get into purposeful activity now, and how to prepare for doing more of it later in your life, is something that we might devote some time to together, do you think?

24.
Patient:
When I try to talk to people about this stuff, I freeze up. I worry they’ll think I’m weird or too intense.

Therapist #1:
Your wish for meaning and purpose seems so unusual for people your age that you very much hesitate to talk with people about it.

Therapist #2:
It sounds to me as if two agendas are possible: one is fully exploring this topic with me, and the other is finding others who are more kindred spirits with you in this regard. Do you think so?

25.
Patient:
My parents keep telling me to “just focus on grades,” but I want more than that. I want a life that feels meaningful, not just successful on paper.

Therapist #1:
If I understand you correctly, you don't disagree that academic achievement is desirable, but for you it's insufficient. You are in quest of activities that feel truly worthwhile. Doing a good bit of thought about what those are and how to get into them is something we can do together if you want.

Therapist #2:
Your experience is that your parents haven’t yet fully grasped your need for meaning and purpose.

Appendix 3: Psychological Skills Rating Scale: Short, 2 ratings version

This scale contains a list of psychological skills thought to contribute to health and well-being. Please give 2 numbers for each of them, in the blanks that are separated by a comma.

For the first number, please rate functioning in the following over the last month, where 0 is worst and 10 is best functioning.

Please use any number in the interval 0 to 10, including, if you wish, odd numbers or decimals such as 3.8.

Negative or harmful behaviors should pull the rating down, even if there are also positive behaviors. The rating is based on the question, “How desirable would a repeat performance of this interval be?”

0=Very undesirable, very great need for improvement.
2=Definitely undesirable, great need for improvement.
4= In the undesirable range, need for improvement, not very good.
6=OK, adequate, acceptable, but not great. Improvement is desirable.
8=Good functioning in this area. Would be just fine if pattern continued as is.
10=Excellent functioning in this area. Would be great, wonderful if pattern continued as is.
n=Not applicable, not answerable, or not known

For the second number, please rate motivation to improve in that skill.

0=No motivation or desire for improvement
2= Only a little
4=Not very much
6=A moderate amount of motivation and desire
8=A great amount
10=A very great amount of motivation and desire for improvement

For example: 8,0 would mean good functioning and no desire for improvement. 4,4 would mean not very good functioning but not much desire for improvement. 2,8, would mean definitely undesirable functioning and a great amount of desire for improvement.

___,___ P1. Productivity: concentrating, staying on task, getting things finished, working well, having high work capacity
___,___ P2. Joyousness: feeling good about accomplishments; cheerfulness, pleasant mood, being happy, not being depressed
___,___ P3. Kindness: trying to make others happy; sharing, consideration, courtesy, helpfulness
___,___ P4. Honesty: Telling the truth, keeping promises, not cheating or stealing
___,___ P5. Fortitude: handling not getting your way, putting up with hardship, not getting too upset when things don’t go as desired
___,___ P6. Good individual decisions: Thinking before acting, using good judgment

___,___ P7. Good joint decisions or conflict-resolution: acting in ways that make it more likely that problems or conflicts with other people are solved peacefully and sensibly
___,___ P8. Nonviolence: No physical hitting, kicking, etc., no threats to hurt
___,___ P9. Respectful talk: Not being rude, not doing unkind talk, being tactful, expressing approval
___,___ P10. Friendship-building: Having good chats, letting people get to know you, being a good listener, developing positive relationships
___,___ P11. Self discipline: Being able to do what's best to accomplish goals rather than just doing what you feel like doing
___,___ P12. Loyalty: Honoring commitments, preserving relationships, sticking up for friends
___,___ P13. Conservation: Not being wasteful of money, time, or resources
___,___ P14. Self-care: Taking care of your own health and safety, being careful
___,___ P15. Compliance: Obeying rules, directives, and laws when it is right and good to do so
___,___ P16. Positive fantasy rehearsal: Not enjoying violent or cruel fantasies or entertainments; using imagination to rehearse ways of accomplishing good goals
___,___ P17. Courage: Not being hindered by anxiety, unrealistic fear, worrying, or unnecessarily avoiding certain situations.

Appendix 4: The Psychological Skills Inventory (62 Skills Version)

This questionnaire will allow you to rate the psychological skill strengths and weaknesses of yourself or someone else. Each item will ask you to rate the degree of skill in a certain area. Please rate each item according to the following scale:

0 = No skill
2 = Very little skill
4 = Some, but not much skill
6 = Pretty much skill, moderate amount of skill
8 = High amount of skill
10 = Very high amount of skill

Additionally, in the blanks separated by a comma, please rate your desire for improvement in each of these areas. For this question, the question would be, “How much interest in, or motivation toward, improvement in this skill do you have?” (You can be motivated to improve in it yourself, or if you are rating someone else, you can be motivated for the other person to improve.)

0=No motivation
2=Very little motivation
4=Some, but not much motivation
6=Pretty much, moderate degree of motivation willing to do some work on this
8=Highly motivated – willing to work hard on this
10= Very highly motivated – willing to work extremely hard and long on this

Please rate all items.

Group 1: Productivity
____,____1. Purposefulness. Having a sense of purpose that drives activity
____,____2. Persistence. Sustaining attention, concentrating, focusing, staying on task
____,____3. Competence-development. Working toward competence in job, academics, recreation, life skills
____,____4. Organization. Organizing goals, priorities, time, money, and physical objects; planfulness

Group 2. Joyousness
____,____5. Enjoying aloneness. Having a good time by oneself, tolerating not getting someone’s attention
____,____6. Pleasure from approval. Enjoying approval, compliments, and positive attention from others
____,____7. Pleasure from accomplishments. Self-reinforcement for successes.
____,____8. Pleasure from your own kindness. Feeling pleasure from doing kind, loving acts for others
____,____9. Pleasure from discovery. Enjoying exploration and satisfaction of curiosity
____,____10. Pleasure from others’ kindness. Feeling gratitude for what others have done

____,____11. Pleasure from blessings. Celebrating and feeling the blessings of luck or fate
____,____12. Pleasure from affection. Enjoying physical affection without various fears interfering
____,____13. Favorable attractions. Having feelings of attraction aroused in ways consonant with happiness. (Examples: attraction to kind person rather than "bad boy or girl"; avoiding the "only want the ones that you can't get" or the only want the "forbidden fruits" syndromes; avoiding being stuck in novelty-seeking)
____,____14. Gleefulness. Playing, becoming childlike, experiencing glee, being spontaneous
____,____15. Humor. Enjoying funny things, finding and producing comedy in life

Group 3: Kindness
____,____16. Kindness. Nurturing someone, being kind and helpful
____,____17. Empathy. Recognizing other people's feelings, seeing things from the other's point of view
____,____18. Conscience. Feeling appropriate guilt, avoiding harming others

Group 4: Honesty
____,____19. Honesty. Being honest and dependable, especially when it's difficult to be so
____,____20. Awareness of your own abilities. Being honest and brave in assessing your strengths and weaknesses

Group 5: Fortitude
____,____21. Frustration-tolerance. Handling frustration, tolerating adverse circumstances, fortitude
____,____22. Handling separation. Tolerating separation from close others, or loss of a relationship
____,____23. Handling rejection. Tolerating it when people don't like or accept you, or don't want to be with you
____,____24. Handling criticism. Dealing with disapproval, criticism and lack of respect from others
____,____25. Handling mistakes and failures. Regretting mistakes without being overly self-punitive
____,____26. Magnanimity, non-jealousy. Handling it when someone else gets what you want
____,____27. Painful emotion-tolerance. Avoiding "feeling bad about feeling bad."
____,____28. Fantasy-tolerance. Tolerating mental images of unwanted behavior, confident that you will not enact them

Group 6: Good decisions

6a: Individual decision-making
____,____29. Positive aim. Aiming toward making things better. Seeking reward and not punishment
____,____30. Thinking before acting. Thinking, rather than responding impulsively or by reflex, when it's useful to do so
____,____31. Verbal fluency. Using words to conceptualize the world: verbal skills
____,____32. Awareness of your emotions. Recognizing, and being able to verbalize your own feelings
____,____33. Awareness of control. Accurately assessing the degree of control you have over specific events
____,____34. Decision-making. Defining a problem, gathering information, generating options, predicting and evaluating consequences, making a choice

6b: Joint decision-making, including conflict resolution
____,____35. Toleration. Non-bossiness. Tolerating a wide range of other people's behavior

____,____36. Rational approach to joint decisions. Deciding rationally on stance and strategies for joint decisions
____,____37. Option-generating. Generating creative options for solutions to problems
____,____38. Option-evaluating. Justice skills: Recognizing just solutions to interpersonal problems
____,____39. Assertion. Dominance, sticking up for yourself, taking charge, enjoying winning
____,____40. Submission: Conciliation, giving in, conceding, admitting one was wrong, being led
____,____41. Differential reinforcement. Reinforcing positive behavior and avoiding reinforcing the negative

Group 7: Nonviolence
____,____42. Forgiveness and anger control. Forgiving, handling an insult or injury by another
____,____43. Nonviolence. Being committed to the principle of nonviolence and working to foster it

Group 8: Respectful talk, not being rude
____,____44. Respectful talk, not being rude. Being sensitive to words, vocal tones, and facial expressions that are accusing, punishing, or demeaning, and avoiding them unless there is a very good reason

Group 9: Friendship-Building
____,____45. Discernment and Trusting. Accurately appraising others. Not distorting with prejudice, overgeneralization, wish-fulfilling fantasies. Deciding what someone can be trusted for, and trusting when appropriate
____,____46. Self-disclosure. Disclosing and revealing oneself to another when it's safe
____,____47. Gratitude. Expressing gratitude, admiration, and other positive feelings toward others
____,____48. Social interaction. Starting social interaction; engaging well in social conversation or play; listening well; using tones of enthusiasm and approval; knowing what is "appropriate," and not, to say and do.
____,____49. Reasonable expectations. Not having unreasonably high expectations from relationships; not feeling too entitled. At the same time, being able to insist on being treated justly; not tolerating abusive or unreasonable behavior from the other.
____,____50. Sending value messages. Being able to communicate to the other that they, and the relationship, are valued, through channels that the other can receive.

Group 10: Self discipline
____,____51. Self discipline. Delay of gratification, self-control. Denying yourself present pleasure for future gain

Group 11: Loyalty
____,____52. Loyalty. Tolerating and enjoying sustained closeness, attachment, and commitment to another, keeping commitments to others. Repairing rifts in relationships. But also deciding when not to give unfair advantage to your friends or relatives, and deciding whom you don't owe loyalty to.

Group 12: Conservation
____,____53. Conservation and Thrift. Preserving resources for ourselves and future generations. Forgoing consumption on luxuries, but using resources more wisely. Financial delay of gratification skills. Using time wisely, not wasting this resource.

Group 13: Self-care
____,____54. Carefulness. Feeling appropriate fear and avoiding unwise risks
____,____55. Habits of self-care. Healthy habits regarding drinking, smoking, drug use, exercise, diet, noise exposure, sleep, sun exposure, auto safety, fire safety, etc.
____,____56. Relaxation. Calming yourself, letting the mind drift pleasantly and the body be at ease
____,____57. Self-nurture. Delivering assuring or care-taking thoughts to yourself, feeling comforted thereby

Group 14: Compliance
____,____58. Compliance. Obeying, submitting to legitimate and reasonable authority. Doing your part for the rule of law. But also deciding when to disobey misguided commands or rules.

Group 15: Positive fantasy rehearsal
____,____59. Imagination and positive fantasy rehearsal. Using fantasy as a tool in rehearsing or evaluating a plan, or adjusting to an event or situation. Avoiding entertaining yourself with violent images.

Group 16: Courage
____,____60. Courage. Estimating danger, overcoming fear of non-dangerous situations, handling danger rationally
____,____61. Depending. Accepting help, being dependent without shame, asking for help appropriately
____,____62. Independent thinking. Making decisions independently, carrying out actions independently

Appendix 5: Cognitive Distortions

All or None Thinking
Evaluating things, in only two categories, all good or all bad, worthwhile or worthless, winner or loser, etc.
Examples: I didn't get a perfect report card; therefore I'm a total failure. I can't do what I could do before; therefore I'm broken.

Overgeneralization
Drawing a sweeping conclusion from too few data points.
Examples: My car won't start, just before I have an important appointment; therefore, bad things *always* happen to me. Someone speaks in a very disrespectful way to me; therefore, people (in general) don't like me.

Mental filter
Letting the mind dwell much more on the negative aspect of a situation than the positive aspects.
Examples: I see violent, cruel, and stupid human acts reported on the news; I dwell on thinking about how the world is a hostile place, without thinking much about any of the good things people do. I make a little mistake when putting on a performance; I dwell on that without thinking about the fact that people really enjoyed the performance as a whole.

Disqualifying the positive
Not just ignoring positive experiences, but finding ways to look at them negatively.
Examples: Someone compliments me; I think, "They're just saying that because they feel sorry for how pathetic I am." I write a paper and get positive feedback; I think, "I'm really a fake, because someone else suggested the idea to me."

Mind reading
Assuming that other people are thinking negative things, without checking this assumption out.
Examples: Someone looks preoccupied and inattentive in a conversation; I think, "This person finds me boring." (In actuality, the person is preoccupied with a pressing issue that is bothering them.)
I cut my face and get a scar. I assume, "My partner now finds me ugly and is no longer attracted to me at all." (In actuality, the partner is not affected by the scar.)

Fortune-teller error
Predicting a bad future without sufficient evidence.
Examples: I get a very unpleasant hyperventilation episode and think, "I'm going to die from a heart attack!" or "I'm going to go crazy!" I feel very depressed, and quit my job because I think, "I'll never be able to work competently again!"

Mind-reading and/or the fortune-teller error are sometimes referred to as "Jumping to Conclusions."

Magnification and minimization
Blowing up the importance of your own imperfections and errors, and minimizing the importance of your strengths.

Examples: I get nervous when speaking in public; therefore, since there are meetings as a part of this job, I'm unqualified for it. (I minimize the fact that 95% of the time there are not meetings, and I am competent enough at what goes on then to be a major asset to the organization.)
I have some low back pain; therefore I think, "My life is ruined." I minimize that I have competences, goals, relationships, and the capacity to accomplish good things and to experience pleasurable things.

Emotional Reasoning
Taking your emotions as evidence for factual matters.
Examples: At a social gathering, I feel embarrassed and self-conscious. I infer from this emotion the conclusion that the people there are judging me negatively. When I start a job, I feel very scared that I will fail. I infer from this that I can't do the work competently. I have an assignment of work, and I feel dread before starting it. I infer from this that actually carrying out the assignment will be very painful. I lie in bed, and feel bad at the idea of getting up and getting going. I infer from this that I'll be better off staying in bed than getting going.

Misuse of shoulds
Shoulds are misused often when they are directed at other people, by those who have the idea that I am entitled to other people's acting the way they should, and as a result feel very angry when people don't act that way. They are also misused when my standards for what I should do and be are unrealistic or harsh and serve only to bring on unnecessary mental suffering.
Example: The neighbor runs a leaf-blower when I'm trying to sleep. I think, "He's a bad person (or some expletive); he should know not to do that," rather than thinking "What do I want to do to make this situation better?"
When directed at the self, "shoulds" are sometimes a way of getting down on oneself excessively.
Example: I have an assignment that is late. I say to myself, "I should have started a lot earlier. I shouldn't be so irresponsible. I shouldn't keep getting into this situation. I shouldn't even pretend I can be a student." These thoughts reduce my motivation and energy to get the work done. In all these examples the word "should" is meaning "it's bad not to."

I'm not as down on the word *should* as some writers are. Suppose, when I'm late on an assignment, I think, "I should just get started now, and I should try to feel good about every little step of progress along the way," I'm using the phrase "I should" to be more synonymous with "I resolve to," or "I have decided to," or "When I weigh the pros and cons this option comes out best." In such circumstances the word *should* is not a problem.
The word *should* or its synonym *ought* is central to ethical philosophy. (See, as one of many, David Hume's writings regarding what has since been called the "is-ought problem.") We *should* not abandon the word *should*, despite what some therapists have averred!

Mislabeling
Name-calling is another word for this.
Examples: I interview for a job, but I don't get it. I think, "I'm a loser." I eat too much at a meal and think, "I'm a pig." Someone pulls into the lane in front of me while driving, and I think, "What an idiot!"

Personalization
Assuming responsibility for something you didn't cause, or assuming total responsibility for something you contributed to in a minor way.

Examples: A student I'm tutoring doesn't do his homework; I think, "This is because I'm a bad teacher." Someone goes on an errand to help me out and gets into a car wreck. I think, "I caused this bad event to happen." Someone I hardly knew drops out of school because of loneliness and depression. I think, "I could have been nicer to that person; I caused this."

Catastrophizing, sometimes referred to as Awfulizing
Overgeneralizing or overestimating how bad a situation is.
Examples: I'm cooking something, and I burn and ruin it. I think, "I can't stand it! Why does everything have to go wrong!?!" I feel some back pain. I think, "I'm never going to be able to do anything again!"

Appendix 6: Twelve Types of Thoughts: Frequency Rating Version

One of the biggest discoveries in mental health is that people can improve their lives through consciously choosing what to say to themselves. The result is called “cognitive therapy.”
Here are twelve types of thoughts that people very often use. They are all useful at various times. People often make themselves feel bad by “overdoing” the first three, even though each of the first three can be very useful from time to time when not overdone.

Please rate, for each of these, how frequently you have used this type of thought or self-talk.
Please also rate, using the same scale, how frequently you would *like* to use each type, in the blanks, separated by commas.

0=Never or almost never
2=Quite seldom
4=Not very often
6=From time to time, sometimes
8=Often
10=Very often

So, for example, for Celebrating your own choice, (1,10) would mean that you almost never do this, but you would like to do it very often. (4,4) would mean that you do it not very often, and that’s just how often you’d like to do it. (10,0) would mean you do it very often, and would like to stop doing it altogether.

1. ____,____Awfulizing. This is telling yourself how bad a situation is that you’re facing. Examples of not overdoing it: “This course isn’t going well. I’m in a lot of danger of failing.” “Looks like the event I was looking forward to is cancelled; I don’t like that one bit.” Examples of overdoing it: “I can’t stand this – I can’t take it. This is just too horrible for me. [Because of this] I hate my life!”

2. ____,____Getting down on yourself. This is telling yourself that you have messed up, made a mistake, are unskilled at something, or need to improve in some way. Examples of not overdoing it: “I was rude to that person. I wish I had thought more before acting.” “I got lazy and didn’t study, and that’s why I failed that test.” Examples of overdoing it: “I’m a worthless person.” “I’ll never amount to anything.” “I’m just not likeable and that’s why people will never like me.”

3. ____,____Blaming someone else. This is telling yourself about the badness of someone else’s actions, or of their personality. Examples of not overdoing it: “This person often tells people things that aren’t true, in a very harmful way. The person is dangerous because of that.” “This person has tried to take advantage of me several times, in a very selfish and uncaring way.” Examples of overdoing it: “That ____ ____!(blanks are filled in with curse words).” “That person is a worthless loser, and ugly as well.”

4. ____,____Not awfulizing. This is not just the absence of awfulizing. It is specifically reminding yourself that the situation can be handled. Example: “I may not like this, but it’s not the end of the world. This will take some time and money to fix, but it can be fixed.” “This is a bad situation, but it’s not so bad that it will defeat me. I can handle this.” “I’ll bet if I put my mind to this, I can figure out a way to make things better.”

5. ____,____Not getting down on yourself. This is not just the absence of getting down on yourself. It’s specifically telling yourself that you have better ways to use your time and your mind than criticizing yourself – even when you’ve made a mistake. Example: “I’ve made a mistake, but there’s nothing to be gained by continuing to beat myself up about it. I can use my mind in better ways, and I will.”

6. ____,____Not blaming someone else: This is not just the absence of blaming, but specifically telling yourself that you have better ways to use your time and your mind than going over how bad someone else is. Example: “I wish they wouldn’t do that. But I don’t want to just keep going over and over in my mind how blameworthy they are. I want to use my mind in a more constructive way than that.”

7. ____,____Goal-setting. This is identifying what you want to accomplish in this situation. Examples: “That person did a bad thing, but my goal is not to get revenge or to teach the person a lesson. My goal is to make things turn out as well as I can, with me coming across as reasonable and with no one getting hurt.” “My goal is to figure out how to do really well on the next test I take.” “My goal is to relax and cool off for a while, and then think about the next step I should take.” “My goal is to use this time well, so that not only am I not bored, but I get to feel good about what I’ve achieved.”

8. ____,____Listing options and choosing. In this, you make a decision about what to do. You think about the different possible actions you could take, probably think about their pros and cons, and try to pick the one that will work out best. Example (when someone has criticized something I’ve done): “If this criticism is helpful in any way, I could say thanks. I could tell the person I’ll think about it. I could agree with it in part rather than defending myself. I could ask the person to explain more. I could just reflect back what I heard the person say, to make sure I understand. I could say nothing. In this situation the criticism is not helpful, so I think I’ll not reinforce the other person, but will just give them a curious look and say nothing.” Doing this well means thinking of very wise options and making wise choices, which is often not easy.

9. ____,____Learning from the experience: This is telling yourself what you’ve learned that may be helpful the next time you are in a situation like this. You can learn from good experiences as well as from bad ones. “I learned from this that when I want to get some support for a problem I want to pick someone else other than this person.” “I learned from this that when I’m giving a performance in front of people, it’s really worth it to practice a whole lot beforehand – that really paid off for me, and will in the future.” “I learned from this experience that if I want to invite someone to do something with me, I get better results if I don’t wait until the last minute; I can learn from this success!”

10. ____,____Celebrating luck: This is thinking about the goodness of a situation that wasn’t a result of what you or someone else did. Examples: “Wow, how lucky it is that it didn’t start raining until I was ready to come inside!” “I’m glad I happened to be born in a place where there isn’t warfare going on all around me.” “How lucky that I happened to run across such a helpful book, with such good information in it.”

11. ____,____Celebrating someone else's choice: This is thinking about the goodness of someone else's action or actions. Examples: "That person was really nice to me!" "That person didn't have to do that for me, but they did!" "I'm grateful to these people for making and furnishing the things I need." "I'm grateful to the persons who invented the vaccines for this bad illness."

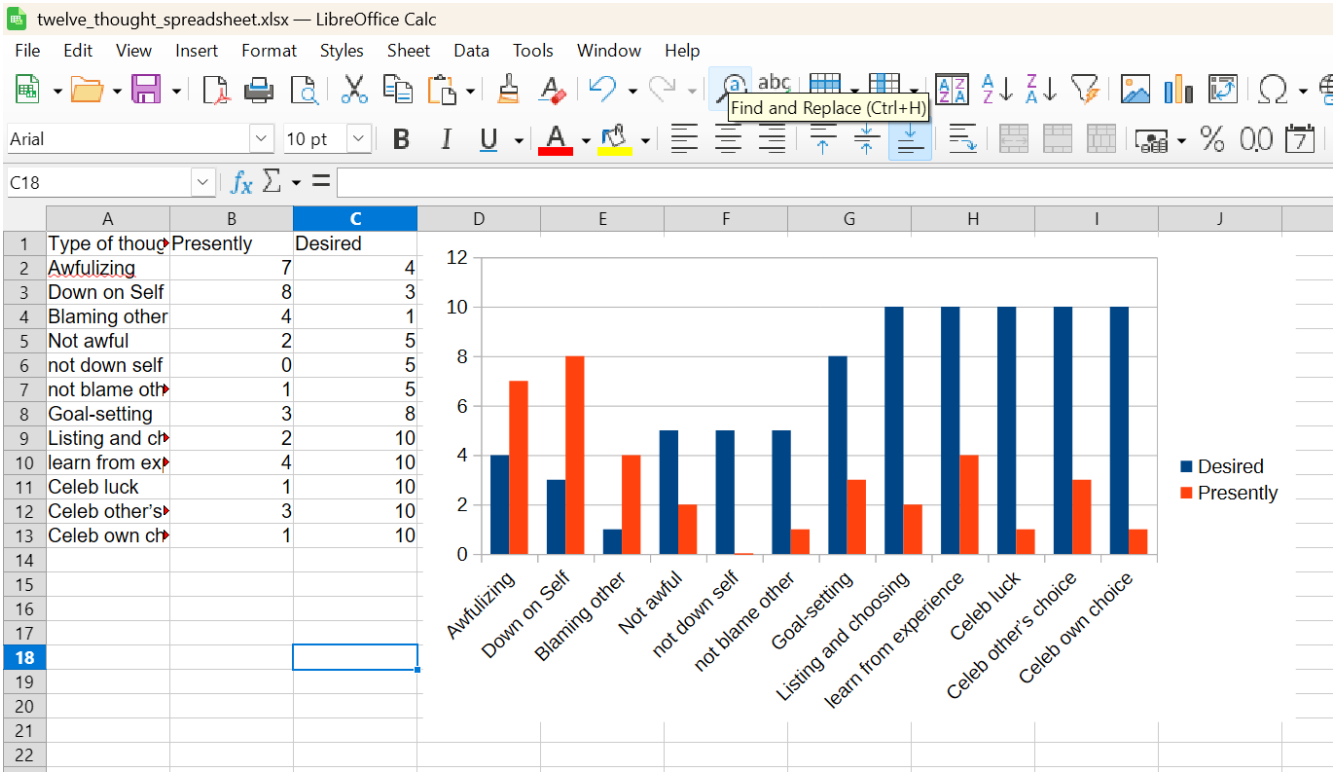
12. ____,____Celebrating your own choice: This is taking the time to say "Hooray" or something like that when you have made a good choice and have done something smart or good. Examples: "Yay, I did some good work, I really accomplished something." "Yay, I did a kind act, and I think I made the other person feel really good!" "This was a tough situation, but I made a good choice of what to do. Congratulations, self!" "I made a mistake, but at least I was able to talk about it openly. Hooray for my honesty triumph!" "Other people tried to get me to get drunk, but I wouldn't go along with them. A self-care and courage celebration!"

Suppose you imagine a bar graph, with 12 bars. The height of each bar represents how frequently you think each of the 12 types of thoughts. Sometimes when people are depressed, they do a huge amount of getting down on themselves and very little celebration of anything. Sometimes when people have anger control problems the bar for blaming someone else is very tall and the bar for listing options and choosing is very short. Sometimes with anxiety the bar for awfulizing is very tall and the bars for not awfulizing, listing options and choosing, and celebrating your own choice are short. The purpose of the labels for the thoughts is not to tell you what and how to think, but to help you decide what type of thinking is most useful to you in any given situation -- what will help you the most to be happy and help others to be happy. If you wish, you can over time change what the heights of the different bars look like. Sometimes such a change results in a huge improvement in the quality of life. Just wishing that you will gradually come to do more of this and less of that, in and of itself tends to have a positive effect over time. And noticing yourself thinking in unwanted or unhelpful patterns is worthy of celebration, because that is a helpful step in shifting toward more desirable patterns. The goal is definitely not to eliminate any one type of thought from your repertoire -- each of these patterns is useful on occasion. The goal is for you to gradually get more control and choice over what you say to yourself.

In the "twelve thought exercise," you practice making up an example of each one of these thoughts about the same one situation. This teaches your brain that there are lots of different ways to think about any situation. If you can pick the thoughts that are most useful to you, rather than just using reflex habit, this too can result in a huge improvement in the quality of life.

In the "four thought exercise," you practice a smaller set of thoughts: not awfulizing, goal-setting, listing options and choosing, and celebrating your own choice. You may, or may not, want to make these four types of thoughts the "default reflex" for provocations or anxiety triggers. Some people have made great gains in anger control or anxiety reduction just by doing this.

Appendix 7: Example of Bar Graph Made Regarding Present and Desired Frequencies of Types of Thoughts



In Excel, Sheets, and Calc, you can just enter the data in 3 columns, Insert>Chart and perhaps fiddle with the result a little bit.

Appendix 8: The Skill of Appointment-Keeping

Psyching ourselves up for the goal

When people start out on a mental health treatment mission, they meet for ***appointments***. If the mission is to work, both people need to show up for these appointments. Missed appointments are one of the major reasons why treatments don't work. Missed appointments are a big problem in all parts of health care. Getting or keeping a good habit of appointment-keeping is an important goal, whenever people start a plan for treatment.

Let's think of appointment-keeping as a skill. For those who are already really good at this skill, you have something to celebrate. For those who are not very good at it ***yet***, improving at this skill can change life for the better.

Appointment-keeping is one of a cluster of skills that make up the trait of conscientiousness. Conscientious people tend to care strongly about whether they keep their promises, and whether they have a reputation for reliability. Conscientiousness is a very strong predictor of success in work and school. It's a strong predictor of health and life span. It strongly predicts financial success and positive relationships. The skills that make up conscientiousness are very desirable ones. And appointment-keeping is one of the most important ones: someone said, "80% of life consists of showing up." Showing up reliably and on time is a habit helpful in all areas of life, not just health treatment.

Lots of medical clinics try to increase appointment keeping by giving people lots of reminders by text and phone, and sometimes telling them that the appointment will be canceled unless they confirm. But psychotherapy may be an opportunity for those who are not already expert at this skill to develop the skills of taking responsibility for reminding themselves. That way they own the skill of keeping track of appointments, rather than depending on someone else to do the remembering.

Studies have shown that the rate of no-shows and canceled appointments people have had in the past predicts the rate in the future. In other words, appointment-keeping seems to be a stable trait. But people can change stable traits, just as they change traits like anxiety, pessimism, temper problems, and others.

So: during psychotherapy, if someone can get very skilled at appointment-keeping, there are two major benefits. First: it greatly increases the chance that psychotherapy will be successful. Second: It increases the chance of success in all sorts of other things. What does it mean to be very skilled in appointment-keeping? I would say that it means usually keeping appointments at the original time without rescheduling, and also, not missing an appointment without calling ahead of time (that is, not doing a no-show no-call) more than once every two or three years.

It helps in psyching up for this goal to understand that people who miss a lot of sessions result in a major financial loss to either the therapist or the clinic; this does not depend on the reasons for missing. People who miss frequently also deprive the therapist of an even more important source of reward, the good feeling of the work's producing steady progress. Rescheduling appointments takes up therapists'

time that could be devoted to helping people. Appointment-keeping difficulties are a major problem for the health care system. Some providers have instituted policies in response to this; it's good for therapist and patient to get clear at the beginning of treatment what the clinic or provider policies are regarding cancellations and no-shows. Are there charges? Is there discharge from the clinic after a certain number of misses? Does it matter whether the absence is "excusable" or not? Is there anything that happens if the provider cannot keep the appointment?

One of the big first tasks of psychotherapy is deciding upon goals. I suggest a universal goal as follows: "If I'm not great at appointment-keeping, the goal is to become great at it. If I'm already great at appointment-keeping, the goal is to stay that way, and to feel good about this strength!" These can be goals for both the therapist and the patient – you are in it together!

At the beginning of treatment, you can take inventory of yourself. How have you done with appointment-keeping so far with other appointments – meeting with friends, getting to doctors' and dentists' appointments, and so forth? If your record is spotty, it's highly recommended to bring this up in one of the first sessions, and talk about this with the therapist, and make appointment-keeping skill an important goal of therapy. In improving any skill, positive reinforcement for good performance is key. So if you're working on the skill of appointment-keeping, it's a great idea to celebrate and feel good every time you show up for an appointment on time. If you can keep track of your winning streak of lots of appointments in a row kept on time, you have reason to feel great. As a mental health strategy it's great to feel good about the things you're already doing well, to celebrate your strengths. So if you're already really good at appointment-keeping, a goal of therapy can be to celebrate and feel good about this important skill.

One of the important principles emphasized in various types of therapy is that to recognize an imperfection in oneself and set the goal of self-improvement is an act to feel good about, not to be ashamed of. Working at improving a skill or habit is a very courageous thing to do. It is very possible to have self-acceptance and work for improvement at the same time.

It's good for therapist and patient to agree at the beginning of therapy that if an appointment is missed, an automatic and expected agenda for the next session is to analyze what happened, and to try to learn from the experience. The purpose is not to shame the patient, or to judge whether the reason for missing is excusable or not. The purpose is to see if anything can be learned that will help in improving this important skill for the future. This may not take very long and may not displace much time from other agenda items.

And despite all of the points made above, it is much better to cancel an appointment, even at the last minute, than to show up with a contagious illness or with any condition that makes a productive session impossible. And it's good for all to keep in mind that unpredictable things happen.

Don't rely on memory

When an appointment is made, if someone just verbally agrees to the day and time and walks away, that's a setup for failure right there. No one should be expected to keep appointments in their memory! There's too much else to remember. A little card with the appointment written on it is sometimes offered, but then the problem is, where is the little card kept, and how can you remember to look at it just at the right time? So at the time an appointment is made, people need to pull out either a pen and a

paper appointment calendar (this method still can work great) or, more likely, their cell phone. If you are not already very familiar with your calendar app on your cell phone, this can be a very useful thing to go over. You and your therapist may want to examine how your particular app works, right in the session. One of the benefits of a cell phone appointment calendar is that you can set "alerts," little alarms that go off before the appointment to remind you to get ready or get going. If you already know your calendar app inside and out, that's great. If not, I recommend getting very familiar with it as one of the first goals of therapy – unless you want to use the pen and appointment calendar method.

How to be on time

There's really only one way to be on time consistently for appointments: to plan to get there early, and to do something useful while you're waiting. If you plan to show up right at the appointment time, you'll probably be a little late a good fraction of the time. If you get to a psychotherapy appointment 10 or 15 minutes early, that provides an opportunity for you to review your goals of therapy (which, ideally, you also have written down, in your appointment calendar or your cell phone). You can think about what you've done to make progress on those goals since the last appointment. You can celebrate in your own mind any positive examples of psychological skills you've carried out since the last appointment – or ever. If there are handouts or books about psychological skills you've decided are worth reading or reviewing, you can read them while waiting. Or you can do anything else pleasant or useful that you come up with!

Over time, you can get better and better at predicting when to start. If the appointment starts at a certain time, I plan to get there earlier than that; I plan to leave for the appointment earlier than that; I plan to start getting ready to leave earlier than that. Pay attention to how much time you need to give to each of those parts of the mission of arriving on time.

What if you can't show up?

Things happen to all of us that keep us from keeping appointments: we get sick, there's a need to take care of a family member, transportation breaks down or fails to show, and even, some opportunity comes up that we consider even more important than the therapy appointment.

Here's what ***not*** to do when that happens: wait until the appointment time, and if you get a phone call after a few minutes, let the person know why you couldn't come. Here's what's even more what ***not*** to do: fail to show for the appointment and avoid answering the phone because you're embarrassed.

Here's what to do: as soon as you realize that you can't show up, call or text or email or otherwise communicate with the person or the clinic staff who can notify the person. Calling and texting are better than emailing, unless it's far ahead of time, because people don't check their email continuously. Try conscientiously to make sure the message gets through. In order to do this, have the number logged away somewhere where you won't lose it. If you become aware that you have done a no-show no-call, call as soon as you become aware of this. Most people would agree that the impact of a no-show for an appointment is softened if the words "I'm sorry," or "I apologize," are uttered to the person who waited in vain for the appointment.

Telehealth

Sometimes a provider can convert an in person appointment to a phone or videoconference appointment. For example, if you have to stay home with a sick child who doesn't need constant attention, you may be able to have a telehealth appointment. If a car breaks down or a bus fails to show up, if you connect by phone as soon as possible, you may be able to have the appointment by telehealth. Please check with your therapist as to whether this is a possibility. You and your therapist may want to set up guidelines for when telehealth is acceptable, for example whether you can be in a private, quiet, non-distracting, non-interrupting, situation and whether the electronic transmission is adequate. For some people, telehealth appointments just don't work well. It's good to plan ahead regarding whether telehealth is an option.

If despite your best efforts, you forget the appointment or otherwise do a no-show no-call, be aware of what number you may be contacted from, so you can answer the phone. You and the therapist may be able to salvage the appointment by converting it to telehealth. But: no one should feel entitled to getting a phone call if you miss an appointment. To no-show for an appointment and then blame someone else for not calling you is a behavior that ranks very low on the conscientiousness rating scale.

If you need to reschedule

If you need to reschedule an appointment, sometimes the way this is done is by messages rather than conversation. Sometimes the messages go back and forth like this: "Can we reschedule to next Thursday?" "Yes, 10 am Thursday is open." "I'm not free until 3 pm on Thursday." "How about 6 pm on Thursday?" "I can't do it that late." If the first message had been, "Is it possible to reschedule to some time between 3 pm and 530 pm next Thursday?" then wasted energy would have been saved. The bottom line is that when asking for an appointment, it's good to specify precisely the times you can say "Yes" to.

Appointment-Keeping Checklist

1. Are you very highly motivated to demonstrate high skill in appointment-keeping? Are you aware of reasons why this skill helps you, helps your therapist, and helps any organization of which your therapist is a part?

2. If your track record for appointment-keeping has not been the greatest, have you acknowledged that to yourself and your therapist, and have you set a goal for developing this skill? Do you plan to celebrate each positive example?

3. If your track record for appointment-keeping has been the greatest, can you and your therapist plan together to celebrate this strength, as you continue to show it?

4. Have you and the therapist communicated clearly about what the policies are regarding cancellations and no-shows?

5. Have you and your therapist agreed that if a session is missed, you will review the reason on the next session, in order to learn from the experience?

6. Do you either have a pen-and-paper appointment book that you refer to often, or an appointment calendar app on your phone that you are expert at using?

7. Whenever you make an appointment, does it go in writing onto your calendar?

8. If you use an electronic calendar, do you use alerts to go off to remind you when to get started?

9. Do you plan to get to appointments early, and spend the time in some useful way while waiting?

10. Do you learn from your experience how far ahead of time you need to get started toward keeping the appointment?

11. If you learn that you can't come for an appointment, do you call to cancel and perhaps reschedule as soon as you become aware you can't come, rather than waiting?

12. Have you talked with your therapist about the circumstances under which the two of you may convert an in-person appointment to telehealth?

13. If you reschedule an appointment by messages, do you include in your message the range of offered dates and times that you can say "Yes" to?

Appendix 9: Some Methods Referred to in This Booklet

I hope to follow up with you and ask you: 1) Have you used this in your sessions? 2) If so, how useful did it appear to be? You can answer using a scale of 10, where for the first question, 0=not used at all, and 10=used it a very large amount. For the second question, 0=not useful at all, 10= useful a large amount. Or you can answer with sentences and narration!

1. Conscious attention to tones of voice.
2. Reflections. Cultivating your own use of them.
3. Reflections. Teaching the use of them to patients.
4. Listening with four responses. Cultivating your own use.
5. Listening with four responses. Teaching to patients.
6. Talking about the overarching goals of the well-being of self, and others one affects
7. Goal-oriented reframes
8. Celebrating goal-formation
9. Constructing an internal sales pitch with patients
10. Socializing to the Model: Talking with patients about how psychotherapy works
11. Thinking or talking about stages of insight, redecision, practice
12. Goal-setting using the psychological skills axis
13. Goal-setting through generalization from patient's narratives
14. Goal-setting of broad competence in psychological skills
15. Goal-setting through the twelve thought categorization
16. Using the bar graph for picturing twelve thought frequency goals
17. Using the shaping paradigm: reinforcing steps in positive direction by patient
18. Doing the celebrations exercise
19. Skills stories.
20. Doing the twelve thought exercise
21. Doing the four thought exercise
22. Brainstorming options with hypothetical situations
23. Brainstorming options with real situations
24. Using the SOIL ADDLE decision-making paradigm
25. The divergent thinking exercise.
26. The shaping game.
27. Pros and cons.
28. Joint decision role-play (Dr. L.W. Aap).
29. STEBC fantasy rehearsals
30. The loving-kindness meditation
31. Use of books or handouts for psychoeducation
32. Use of the desensitization paradigm for fear, anger, traumatic memories, or other
33. Use of relaxation training
34. Breathing retraining for panic
35. Use of search for sources of meaning and purpose
36. Use of behavioral activation
37. Use of communication training of family members
38. Going over, with the patient, the handout on appointment-keeping skill