Psychotherapy Guidelines

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Why Should a “Prescriber” Learn Psychotherapy?

1. Decisions about when psychotherapy is better than prescribing.
2. Discriminating effective from ineffective therapy.
3. Maximize impact of prescribing encounters.
4. Spending time with big questions: how to live well, how to help others do so.
5. You can do psychotherapy in your practice if you choose.
6. Psychotherapy may turn out to be less replaceable.

Two factors (of many) that affect therapeutic relationship

Tones of approval and enthusiasm:

- large
- small to moderate
- neutral
- disapproval

Empathic reflections

Doing them can be learned quickly; doing them expertly is an art to be cultivated over time. Please see Appendix 1 for an exercise on “Which Reflection is Better?”

Compose a reflection, if you please?

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.

(What I hear you saying is ____...)

Which reflection 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 seem to spoil it by being cruel to each other.

Part 1: Goals and Structure

Avoiding directionlessness
Transforming complaints to “do more often” goals
Goal-oriented reframes
Overarching universal goals
Talking with the patient about how psychotherapy works
3 stages of psychotherapy
Using the psychological skills axis
Using the 12-thought classification
Using shaping
Dealing with obstacles including appointment-keeping problems

Translating complaints to “do more oftens”

“I feel so depressed.”

“I have so much anxiety around people – I just stay away from people because of that.”

“I can’t control my temper. I just have these angry outbursts, and I regret them later. I particularly lose it when anybody criticizes me, even a little.”

“I’m addicted to goofing off online. I waste huge amounts of time scrolling around and accomplishing nothing.”

Question by therapist: Can we imagine what you’d be doing (or thinking or feeling) more often if that problem were solved?

Exercise: Make up a reflection and a goal-oriented reframe

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

Sample responses:

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?

After patient agrees on a goal:

Let’s celebrate a bit of progress: first step in accomplishing something is figuring out what you want to accomplish!

Write the goal in a goals list.

Why want to accomplish this – how will it make you or someone else happier or better off? The “internal sales pitch.”

Happiness rating now, how accomplishing this will raise it?

Wishing helps make things happen, when the wish applies to my own thoughts, feelings, and behaviors

To do: Please think about ways of promoting progress toward this goal, and I will too.

To do: When there are bits of progress, please tell me, and let’s celebrate.

Overarching goals

1. Happiness, well-being, of self, long-term.
2. Happiness and well-being of others, we affect, long term.

And:

3. Having patience and fortitude and not giving up during unhappy times.

Interesting to see statements of various philosophers to this effect, over the ages.

How is psychotherapy supposed to work?

Some preconceived notions, each with at least a little truth:

1. Talk therapy. Patient's job is to talk about their life, period.
2. Catharsis. Get those bad feelings discharged.
3. Hired friend. Therapist to be nice and supportive.
4. If only I could figure out why I… why someone else… then everything after that will be easy.
5. Advice columnist.

Idea I find most useful is:

6. Learning psychological skills. Handling situations better.

3 stages of psychotherapy

1. Insight: What am I doing, thinking, feeling? What are the important situations?
2. Redecision: What would I like to be doing more often, less often? What would I like to do instead of the problematic responses?
3. Practice: Rehearse the desired patterns until they become “prepotent,” automatic, have habit strength that will exceed that of the problematic responses. Fantasy rehearsal is a very important method.

Goal-setting via the psychological skills axis

1. Productivity
2. Joyousness
3. Kindness
4. Honesty
5. Fortitude

6a. Good individual decisions

6b. Good joint decisions

7. Nonviolence
8. Respectful talk
9. Friendship-building
10. Self-discipline
11. Loyalty
12. Conservation
13. Self-care
14. Compliance
15. Positive Fantasy Rehearsal
16. Courage

Psychological Skills Inventories

See appendices 3 and 4 for rating scales.

These ask 2 questions: How skilled are you presently; how strongly do you wish to get better at this?

These are often not answerable accurately without some talk about these and some self-observation by the patient between sessions. So an option is to give the patient the scale but ask them not to fill it out yet, but to think with you about the meaning of each, and to notice their positive and negative examples between now and next session.

Generalization from patient’s narratives

When patient talks about incidents in their life: what type of situation were they responding to? Proficiency in what skill would have helped them respond better?

Example: Hearing one example where there was a maladaptively uncontrolled reaction to criticism raises the hypothesis that the skill of handling criticism (a subskill of fortitude) is an important goal for the patient. As more examples accumulate, the probability of the truth of that hypothesis rises; as counter-examples accumulate, it falls.

Choose the teachable moment to share the inference with the patient.

Goal of global increase in psychological skills

There are some people who are good at almost all the skills but just need to focus on one or two for improvement.

There are lots more who illustrate that the skills, like psychiatric symptoms, are highly intercorrelated. Many can benefit from the idea that “All human beings can benefit from improvement in all of these. Thus we can and should celebrate bits of progress, or positive examples, of any one of them!”

Goal-setting through the 12-thought categorization

1. Awfulizing
2. Getting down on yourself
3. Blaming someone else
4. Not awfulizing
5. Not getting down on yourself
6. Not blaming someone else
7. Goal-setting
8. Listing options and choosing
9. Learning from the experience
10. Celebrating luck
11. Celebrating someone else’s choice
12. Celebrating your own choice

Activities with the 12 thoughts

The twelve-thought exercise: take any situation, and take turns making up an example of each of the 12 thoughts about that situation. Goal is cognitive flexibility and getting into the repertoire all the ones not currently there.

Referring to the 12 thoughts when considering the redecision question, “How would you like to respond to a situation like this?”

Assessing relative frequencies of the 12 thoughts currently, and deciding what more desirable frequencies would look like. Appendix 6 for rating, and Appendix 7 for bar graph.

Four-thought exercise: Not awfulizing, goal-setting, listing options and choosing, celebrating own choice. Good for fear and anger triggers as a reflex to cultivate.

Using the shaping paradigm with goals

Shaping means reinforcing successive approximations toward goals. That means celebrating each positive example of a skill, each good choice of self-talk, each practice in fantasy, each reading of handout or part thereof, each goal that is set, each moment of visualizing what it would be like for the goal to be reached, each wishing for success…

Question at beginning: What have you done to promote progress? Question at end: What might you do to promote progress? With display of written list.

The most important reinforcement is the patient’s self-reinforcement. This in itself is an important skill (a subskill of joyousness). I believe that the therapist’s social reinforcement gets internalized and aids the patient’s self-reinforcement.

With children and with many adults, the shaping game is a way of getting the shaping paradigm into the mind.

Appointment-keeping skill

Low competence in this skill can be a major obstacle to goal attainment.

The profession tends to be accepting and empathic with low skill in emotional regulation, interpersonal relations, and tends to develop modules for training people in those skills.

But with low appointment-keeping skill, the most common responses are threats of discharge, charges for missed appointments, and nonresponse.

Appendix 9 presents a psychoeducational module aimed at teaching appointment-keeping skills. Theory: this can be a therapy goal like any other, and if accomplished, can greatly improve the patient’s life.

Part 2: The idea of psychological skills exercises

For physical fitness: cardio, strength, flexibility, agility, balance exercises

For math: Problem-solving exercises

For music: Playing or singing scales, doing pitch training...

For basketball: Repetitive practice of shooting from every position, dribbling, rebounding, observing which teammates are open ...

For mental health: ???

The celebrations exercise

Question: What have you done, that you’re glad you’ve done?

2nd question: Which psychological skills is that an example of?

I get much better results if I take turns with the patient. I pick examples that are not too intimate, but more mundane.

I have found that this can bring out very impressive positive narrations in sessions where otherwise negative topics would have dominated.

If the patient can’t think of one thing: 1. note that. 2. go to celebrations interview, directly asking for certain types of examples.

Skills Stories

Exactly like the celebrations exercise, only the narratives can be made up, and the protagonist can be some imaginary person.

This is based on the principle of positive fantasy rehearsal: the more times you run positive, skillful patterns through your neuronal pathways, the more “wired” those patterns become. The celebrations exercise is not just to reinforce the positive patterns but to fantasy rehearse them also.

Divergent thinking exercise

You pose a question for which there can be many possible answers, and you take turns generating alternatives.

Someone found something. What did they find?

Someone was proud of themselves. Why?

Someone gave someone a present. What was it? Etc.

This exercise is a superset of the brainstorming options exercise and the pros and cons exercise. Those are great exercises for decision-making skill. The divergent thinking exercise is a fun way to rev up the RIG (random idea generator) in preparation for those two.

Brainstorming Options Exercise

There’s a hypothetical (or real) choice point or problem, and therapist and patient take turns thinking of options for responding to it.

Someone has something at work or school that they are assigned to do, but they don’t know how to do it. What are options?

Someone at work or school is repeatedly verbally abusing someone else. A third person generates options about what to do.

One person in a household likes to cook a certain dish, but the other person finds the smell of it very unpleasant. What are possible plans for them?

Why the brainstorming options exercise?

Research has found that:

1. Skill in it is correlated with mental health and a lower incidence of a variety of disorders.
2. The skill is teachable and learnable.
3. When it is taught, there is improvement in a variety of mental health outcomes.

Ergo: Just about all psychotherapies should consider well-prepared modules on this skill.

How many do so? Not a large fraction.

Pros and cons exercise

Hypothetical (or real) choice point, a certain option is on the table. Therapist and patient take turns generating advantages or disadvantages for the option.

Someone considers adopting a dog.

A government considers requiring that people pass a test on fetal alcohol spectrum disorder and other alcohol effects before they can have a license to buy or consume alcohol.

A high school boy considers trying to join the football team.

Someone considers becoming vegan.

The Loving-Kindness Meditation

Three wishes, first regarding myself, then one for one other person after another:

May I become the best I can become.

May I give and receive kindness.

May I live with compassion and peace.

There have been a handful of studies finding slower progression of aging parameters, i.e. telomere changes, in practitioners of this.

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

1. Defining. Each person defines the problem from their point of view, without blaming, accusing, or bossing the other.
2. Reflecting. Each of them does at least one reflection of the other person’s point of view.
3. Listing. They list options for a possible plan they could agree on.
4. Waiting. They wait till they have finished listing before critiquing options.
5. Advantages and disadvantages. They talk about advantages and disadvantages of options (not the deficits in the other person).
6. Agreeing. They try to agree on something, if only to table.
7. Politeness. They don’t yell, insult, interrupt, keep talking too long, but speak respectfully even when they disagree.

Part 3. Big idea and strategy: Desensitization

It bothers me to see people who have been treated for years for anxiety, anger, ocd, ptsd, or other disorders where certain situations elicit too much negative emotion, who have never heard of:

SUD levels, or a synonym

Relaxation strategies

Generating hierarchies of situations

Fantasy rehearsal or imaginal exposure or some synonym

Why escape contingent on high distress is counterproductive

Steps in Desensitization

Step 1: Decide, is the unpleasant emotion desirable or undesirable? Are any fears realistic or unrealistic?

Step 2: List the situations that elicit the fear, anger, or aversion. Sometimes these are abstract interpersonal situations, like closeness, a possibility of abandonment, perceived disapproval, etc.

Step 3: Rate the Subjective Units of Distress (SUD level) associated with each situation. (0 to 10 or 0 to 100)

Step 4: If there are not situations with low SUD level, imagine some in the same “response class.” Someone else doing it, on a screen, as a cartoon, viewing from far away are possibilities.

Steps in Desensitization, continued

Step 5: Train relaxation strategies. Muscle relaxation is a tried and true one. Mantra meditation, mindfulness, meditation with movement, acts of kindness meditation are all possibilities. JMS's anxiety book describes about 10 of these in a chapter.

Step 6: List the trigger situations in order of SUD level, from lowest to highest. Called generating a hierarchy.

Step 7: Start with the lowest SUD situations. For each, decide on the thoughts, emotions, and behaviors that are desirable to do in that situation.

Step 8: Starting with the lowest SUD situations, do fantasy exposure and fantasy rehearsal of the desirable responses. Coping rehearsal=imagine a SUD level, but handling it. Mastery rehearsal=imagine you've mastered the situation so much that there's no distress at all when handling it.

Steps in desensitization, continued:

Step 9: If possible, add in real-life (a.k.a. in vivo) exposures and rehearsals.

Step 10: Celebrate *either* lowering of SUD levels or ability to be in situations one had to escape from earlier.

Step 11: Gradually work your way up the hierarchy, celebrating each bit of progress.

Why avoid escape contingent on distress?

Suppose someone tries an exposure and rehearsal. The SUD level shoots way up. The person thinks, “I can’t take this! I’m ending this!” and the person terminates the exposure.

When they escape the situation, the SUD level tends to fall quickly.

This is negative reinforcement, or the reward of terminating something unpleasant.

What is being reinforced? The behavior of escaping. Thus next time the urge to escape will be greater.

The urge to escape is more or less synonymous with fear or aversion. So the whole experience has in this example made the fear worse.

Desensitization is well studied

Over 1000 studies

Mary Cover Jones’s case report was written in 1924

Joseph Wolpe (who called Jones the mother of behavior therapy) studied desensitization in the 1950s through 1970s.

Effect sizes in meta-analyses usually in the “large” region with fear, medium to large with anger.

The chance of any patient having either too much fear or too much anger about certain trigger situations is very high.

Ergo: Psychotherapists, use desensitization, please.

Breathing training for Panic Attacks

A good fraction of panic attacks have hyperventilation at the core problem.

Good for patients to understand physiology: fear > breathing faster>low CO2>uncomfortable feeling>brain mistakes it for not getting enough air>breathing faster

Oxygen doesn’t have anything to do with it, except when we’re not dealing with a panic attack, but with a cardiac or respiratory mimic.

Cure for hyperventilation is to produce more CO2 by exertion, or much more conveniently, to breathe more slowly. Rebreathing CO2 using a bag has major disadvantages.

Exercises for hyperventilation prevention

1. 5 in and 5 out. Look at the seconds display on cell phone stopwatch function, start inhale when it ends in 0, start exhale when it ends in 5. This is the prn to do when one feels an episode coming on. It, like the others, should be practiced in calm moments.
2. Hold the breath and cure the high CO2. Hold the breath, notice when the slightly unpleasant feeling of air hunger comes on. When it does, cure it by starting breathing again.
3. Hyperventilate and cure the low CO2. Breathe deep and fast for 5, 10, or 15 breaths, enough to generate a very slight lightheaded feeling. Then cure that by taking a very slow breath, e.g. 15-20 seconds in and 15-20 seconds out. Practice 2 and 3 and teach the brain to discriminate hypercapnia and hypocapnia.

If you have a patient with panic attacks...

You are invited to contact me and consult regarding preparing a case report. My advice is to try breathing retraining before starting SSRIs. If you start both simultaneously, the patient will attribute the improvement to the meds and you have a big task to get the patient off them.